SOCIAL SAFETY NETS, HIV/AIDS & ORPHANS AND VULNERABLE CHILDREN IN QUTHING, LESOTHO: AN EXAMINATION OF COPING STRATEGIES AND HOW COMMUNITIES SURVIVE

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Abstract

This dissertation explores four key questions within the HIV/AIDS paradigm[1] and the impact it is having on orphans and vulnerable children in the district of Quthing, Lesotho. These questions are: What is the status of social safety nets? How are communities surviving with the growing number of orphans and vulnerable children? What might be the early warning signs of community breaking points as a new category of child-headed household emerges? What are the human drivers of the pandemic in terms of behaviour and attitudes towards HIV/AIDS, orphans and vulnerable children, and sex; and in terms of reasons why people are not heeding the warning signs and adopting behaviour change?

The findings of the dissertation reveal that communities are overwhelmed with the demands placed on them to support orphans and vulnerable children to the point where culture, traditions, and society at large are showing early warning signs of irreversible strain. Despite the efforts of government, donors, the humanitarian sector and the communities themselves, awareness of HIV/AIDS is not translating into behavioural change and as such the spread of the virus continues unabated among the youngest and most vulnerable groups.

[1] The set of assumptions, concepts, values, and practices that constitutes a way of viewing reality for the community that shares them, especially in an intellectual discipline.

Declaration

I declare that this dissertation is my own unaided work. It is submitted for the Degree, Master of Arts in Development Studies at the University of Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination in any other university.

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(Name of Candidate)

_____day of _____, 2007

To my family for a lifetime of support and encouragement to ‘stay focused’ throughout this process and to Charles Mather and Jaqui Goldin for their unflagging interest, advice, and patience in helping me bring this project to fruition. Special thanks also go to my own organisation for giving me the time to undertake this dissertation and to my colleagues in Lesotho, who helped facilitate the research. Lastly, my sincere appreciation goes to the people of Quthing, who opened their hearts and minds to make this work possible.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Treatment
C-SAFE	Consortium for Southern Africa Food Security Emergency
DMA	Disaster Management Agency
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
ILO	International Labour Organisation
LAPCA	Lesotho AIDS Programme Coordinating Authority
LDHS	Lesotho Demographic Health Survey
NAC	National Aids Council
NAPCP	National AIDS Prevention and Control Programme
NGO	Non Government Organisation
OVC	Orphans and Vulnerable Children
PMTCT	Prevention of Mother to Child Transmission
SADC	Southern Africa Development Community
STI	Sexually Transmitted Infection
TB	Tuberculosis
TEBA	The Employment Bureau for Africa
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCCT	Voluntary Confidential Counselling and Testing
WFP	United Nations World Food Programme
WHO	World Health Organisation

Chapter 1

Introduction

The southern African region is home to 32 percent of the 40 million people in the world living with the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). It has 34 percent of AIDS deaths globally. In 2006, there were a staggering 2.8 million new infections in sub-Saharan Africa, more than the sum total of all the other regions in the world (UNAIDS: 2006).

More than any other sub region of the planet, the scale and severity of the pandemic in southern Africa[1], combined with chronic poverty and food insecurity (De Waall & Whiteside: 2002), is overstretching the capacity of governments and communities to function effectively. The HIV/AIDS pandemic has been exacerbated by drought and crop failure over the last four years, resulting in a regionwide food security crisis[2]. Lack of food and poor nutrition has contributed to a more rapid progression of HIV into full-blown AIDS and higher mortality rates among adults living with HIV and AIDS.[3] This has also led to a rapid increase in the number of orphaned children.[4]

Southern Africa has nine of the ten highest adult HIV prevalence rates in the world. With an average adult HIV/AIDS infection rate of 23.2 percent, Lesotho is the third most affected country in the region (and the world), behind Swaziland and Botswana. Of the three, it is the poorest. The country is experiencing a tremendous strain on its already limited resources. Government is especially overstretched due to the rising number of

[1] For the purpose of this dissertation, southern Africa will mean Bostwana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. This shortened list of what normally comprises the southern African region is to better hone in on the problems associated with HIV/AIDS and orphans and vulnerable children.
[2] WFP Protracted Relief and Recovery Operation 2005-2007 appeal document
[3] Currently the number of orphans is defined as any person under 18 who has lost one or both parents due to death. It is estimated that of the app. 100,000 orphans in Lesotho app. 22 percent have lost both parents, app. 55 percent have lost the father and 18 percent have lost the mother. It is also estimated that the number of orphans is steadily growing and all attempts to turn around the infection rate have been unsuccessful so far (UNAIDS 2004).
[4] Ibid

people in need of treatment and care services, leaving a significant gap in its ability to mitigate the impact of HIV/AIDS.

One group that has been particularly hard hit is orphans and vulnerable children (OVC), whose existence is a relatively new phenomenon in the country (and Africa). Traditionally, Basotho children are the responsibility of the community in which they live – not just of the parents. Siblings, grandparents, relatives and indeed any adults in the community will actively participate in caring for all children, including orphans and vulnerable children, living within the community. Socio-cultural contexts further support this behaviour; for instance, it is believed that the ancestors would not approve of orphans being institutionalised.

According to a 2001 study conducted by Lesotho's Ministry of Health and Social Welfare, the extended family system has historically been capable of absorbing a large number of orphaned children, but the current crisis is affecting the traditional coping systems. The growing number of adults dying from AIDS has reduced the number of foster families and resulted in an increasing number of child-headed households. Communities try to lend support but are struggling to cope with the increased demand for the care of orphans and vulnerable children. The lack of knowledge of where to access available services and resources further limits their ability to support orphans and vulnerable children at the scale necessary. As the number of foster families decreases, orphaned children in Lesotho are increasingly cared for by the elderly and women, many of whom already live on the edge of poverty and are struggling to provide for themselves and their own families. Often orphans and vulnerable children will come second in line to biological children. They tend to be malnourished and are often denied access to education or health services, or are forced into the labour market or even exposed to sexual exploitation or early marriage.

Social safety nets, formal and informal, are fundamental for the survival of vulnerable populations during difficult times, but how these systems continue to function and support the needy during these unprecedented pressures remains a grey area in research.

This dissertation will examine the many drivers of Lesotho's epidemic and its impact on orphans and vulnerable children; the social safety nets that are in place and the possible threats to their sustainability; and the strategies used by other countries to tackle the impact of the virus.

Chapter 2 will examine the debates and issues around orphans and vulnerable children, prevention strategies that affect social safety nets for orphans and vulnerable children and communities at large, and the challenges faced by communities battling to contain the impact of the virus. It will also offer insight into poverty and vulnerability, the economic implications of the virus, policy response in Lesotho, government capacity to respond, and the drivers of the pandemic in Lesotho.

Chapter 3 will draw upon survey results from a high school in the research district, to examine the attitudes of adolescents towards HIV/AIDS, orphans and vulnerable children, and sex. This chapter will look at behavioural issues and the factors that drive the spread of the virus.

Chapter 4 will provide an insight into the concerns and problems faced by people directly and indirectly involved on the 'frontlines' of the 'war' on HIV/AIDS in Lesotho, including government employees such as healthcare workers and police, and community caregivers who provide a crucial and indispensable support structure for the people affected by the virus. This chapter will examine in more detail the changing face of Basotho culture and traditions, as they are forced to adapt to keep pace with the impact of the virus, especially on orphans and vulnerable children.

Chapter 5 will answer the dissertation's research questions drawing upon the information contained in the previous chapters and will demonstrate that while social safety nets are operational in Quthing, they are over worked and under resourced from the strain of trying to cope with the rising number of parentless and destitute children. It will also suggest ways forward for government and civil society to better control the impact of the

virus on this vulnerable population and development, including increasing transparency, ensuring equitable resource distribution, increasing decentralisation from central organs, and improving the link between research and policy creation and implementation.

Research Question: Are Lesotho's Social Safety Nets Reliable?

Social safety nets, formal and informal, are being strained by a rising number of orphans and vulnerable children and increasing poverty in Quthing, Lesotho, yet communities still manage to survive, albeit under an evolving social landscape. This dissertation will attempt to answer four key questions: First, what is the status of social safety nets in district of Quthing? Second, how are communities surviving with the growing number of orphans and vulnerable children? Third, what might be the early warning signs of community breaking points as a new category of household emerges, namely extended families that have expanded their size to take in orphans and vulnerable children, as well as the category of child-headed households? Fourth, what are the human drivers of the pandemic in terms of behaviour and attitudes towards HIV/AIDS, orphans and vulnerable children, and sex; and in terms of reasons why are people not heeding the warning signs and adopting behaviour change?

Aim and Rationale

The aim of this research is to better understand the impact HIV/AIDS is having on orphans and vulnerable children and the strain placed on the social safety nets, both traditional and state-provided, of a specific community (Quthing) as a new category of household emerges around these children. Another rationale for this research is to add to the very little information existing on formal and informal safety nets in Africa. Even though Lesotho stands out among other countries of the world as one of the worst affected by HIV/AIDS, very little information can be drawn upon concerning social safety nets at the country and community specific levels. Academics have examined regional trends, thematic causes and impacts in countries and communities (Nattrass, 2004; Barnett & Whiteside, 2002; Freudenthal, 2001; Richter et al, 2004) but Lesotho, and particularly Quthing, are not in the mainstream of discussion on HIV/AIDS. While this dissertation will draw upon these works, it is hoped this research will add information to the dialogue on social safety nets in general, as well as specifically for Lesotho and the community of Quthing.

This primary research can therefore be broken down into the following specific aims: to examine the deterioration of traditional social safety nets due to HIV/AIDS at the household level in the district of Quthing, with particular attention to the effect on orphans and vulnerable children; to examine and describe the breaking point of households when community coping strategies can no longer support those affected by HIV/AIDS; and to evaluate state-supplied social safety nets for those affected by HIV/AIDS.

Ethics

Everyone who participated in this research was asked to give their prior consent to be part of the study for this dissertation. In addition, minors that partook in the research were included only with the prior consent of their parent, guardian, teacher, or a community leader. No independent approaches were made to minors without this consent. Once permission was given, the purpose of the research was meticulously explained to respondents in simple and concise vernacular. Respondents were also informed that they could choose not to answer a question or could withdraw from the interview at any time without any form of penalty.

The identities of all interviewees, particularly those affected by HIV/AIDS, have been kept anonymous or recorded under a pseudonym. In Chapters 3 and 4 respondents have been coded to protect their identities and a generic proxy coding was supplied for respondents. The wish of any respondent to decline an interview was respected. Interviewees were also informed that they should not reveal any information deemed illegal or against Lesotho law and if they did so, the writer would be compelled to inform the relevant authorities. Ethical clearance approval was given by the Ethics Committee of the University of the Witwatersrand. (Protocol Number 60803.)

It is worth noting that many respondents were clearly intimidated by the application of the thorough guidelines and principles provided by the Ethics Committee for the ethical conduct of interviews. This unintended consequence was most notable when people were requested to sign a consent form prior to the interview taking place.

It is worth a brief deviation in the discussion to contextualise this mistrust. Basotho are deeply suspicious of outsiders, especially those residing in South Africa. This mistrust was underlined by the 1998 invasion of Lesotho by the South African Defence Forces, Operation Boleas, which was sanctioned by the Southern African Development Community (SADC). Widespread arson, violence and looting occurred despite the presence of SADC soldiers. Troops were pulled out in May 1999, after seven months of occupation. Maseru was heavily damaged, requiring several years for rebuilding. Given this background, most interviewees were reluctant to sign anything provided by someone coming from South Africa, even though they were clearly informed the writer was not of South African origin.

Such suspicions were compounded by the fact that many of those selected for interview were of rural origin, had limited education, and in many cases were illiterate. Even though translated documents were offered for respondent perusal, and a translator was on hand to answer any questions arising from the documentation, most refused to sign them. To better understand this dilemma, it must be acknowledged that Basotho are rarely, if ever, asked to sign a document. This is particularly true of women, who do not have formal decision-making authority in any facet of Basotho culture. If formal approval is needed for any purpose, then a chief or another patriarchal figure traditionally plays a deciding role.

Birth, death and marriage certificates are a relatively new concept for Basotho, particularly rural people, who seldom venture beyond their village's limits. Many people are born, marry, own land, have children, grandchildren and eventually die without ever accumulating a single piece of official documentation. When people are compelled to obtain documentation (and this is becoming a more regular requisite) it is done through government offices, with employees who are invariably connected in some way to their village. These small communities were never conquered by outside ethnic groups and rarely see inter-ethnic marriages, so everyone seems to be related to each other in some way, or at least to know of someone who knows another's family. Basotho are a tightly knit ethnic group, with family and community linkages reaching across the country. This interconnection increases feelings of distrust, as individuals do not believe they will

remain anonymous in an interview, medical test or survey. Healthcare workers cite this factor as a problem when trying to convince ill patients to find out their HIV status.

During the research period it was also observed that seeking signatures inhibited the natural flow of dialogue between the interviewee and interviewer. Normally, lengthy salutations are conducted with the person about to be interviewed before explaining the purpose of the visit. After going through this time consuming process, it was observed that respondents who were asked to sign documentation were more guarded once the 'formal' questions started. It was therefore difficult to explore the full parameters of a discussion subject, with respondents seeming more anxious and limited in their responses. Furthermore, people in general do not like having their word questioned, especially those who play important roles in the community or village life. Once they have said something is acceptable, it can be perceived as mistrust on the part of the 'outsider' to then request a signature.

In addition, it was observed that when dealing with guardians, caretakers or those intermittently responsible for orphans and vulnerable children and children in general, such as doctors and teachers, few felt comfortable signing a document on behalf of a more legal authority. The signing of documents for permission to conduct interviews was therefore problematic.

Nevertheless, the researcher and translator at all times stayed within the parameters of the guidance offered by the Ethics Committee, reading documentation to respondents who were illiterate and obtaining their verbal consent. Others who were literate and able to read the documentation also gave their verbal consent prior to the commencement of the interview, although in many circumstances this involved walking a fine line between trying to achieve research goals and causing no offence to the respondents.

Case Study

The severity of the virus combined with deepening socio-economic difficulties form the backdrop of policy frameworks established by government and civil society to respond to the crisis in Lesotho. This country should be viewed as a progressive state in how it deals with HIV/AIDS, particularly compared with South Africa. To understand the challenges faced by Lesotho in responding to the virus it is important to reflect on the pathology of vulnerability in the country. Lesotho is entirely surrounded by South Africa, making it vulnerable to policy changes in its neighbouring republic. Three-quarters of the country is classified as highland areas rising to 3,500 meters above sea level, making most of the country not arable. The remaining lowland areas range from 1,500 to 2,000m in elevation and, much of it is affected by extensive soil erosion, which further limits potential agricultural production.

In addition, Lesotho lacks natural resources, which means it has few large-scale employment options for its people, and the State has few alternatives for raising revenue. It is not surprising, then, that South Africa has been the employment destination for many Basotho for many years. Remittances play an integral part in keeping impoverished households from becoming destitute households by acting as financial buoy. However, this has begun to change in recent years. Between 1991 and 2002, employment for Basotho in the mines of South Africa fell by 50 percent. At the same time, average remitted income of those employed nearly trebled[5], indicating that it was lower skilled workers who were retrenched, limiting their employment opportunities both in South Africa and at home in Lesotho. This coincided with rapidly increasingly HIV/AIDS infection and death rates. Even though remittances and employment opportunities in South Africa are not as plentiful as they once were, both are key to helping Basotho survive, particularly in a household affected by HIV/AIDS.

[5] Information received from correspondence with Mr Mahula, the Director of the Employment Bureau for Africa (TEBA) in Lesotho. September 19 2006.

In Lesotho, the immediate effects of the extent and nature of the virus are crudely noticeable. The country has a population of between 1.8 million and 2.2 million people[6]. More than 350,000 adults are infected with HIV and some 70 people die each day from AIDS-related illnesses. The first Basotho was identified with HIV in 1986[7]. Today, according to the Joint United Nations Programme on HIV/AIDS (UNAIDS), an average of nearly one in four people in the country is infected with the virus. HIV prevalence among urban adults aged 15-49 years is 29 percent in comparison with 22 percent in rural areas. An estimated 13,780 women and 12,480 men became infected in 2005. The overall trend indicates that adult prevalence may be stabilising, although it is not declining. There are an estimated 270,000 people living with HIV in Lesotho, and some 23,000 people die each year from HIV-related conditions. There are an estimated 18,000 children in Lesotho living with HIV/AIDS (UNAIDS 2005).

Impact of HIV/AIDS on Development Indicators

The country has shown a steady decline on the Human Development Index (HDI) since 1990 and an estimated 36.4 percent of the population live on less than one US$1/day. Lesotho is ranked 149 out of 177 countries by the HDI (UNDP: 2006). Of those infected with the virus, it is estimated that at least 60 percent are part of the general workforce (Kimarayo: 2004). The country's healthcare and education systems and civil service have been particularly hard hit by HIV/AIDS[8]. For such a small country with comparatively poor human resource capital, the virus is proving disastrous for maintaining services, and even more alarming for economic and social reproduction.

At the country's main referral hospital, Queen Elizabeth, 70 nurses tend to approximately 3,400 patients around the clock. Many nurses have either left the country for more lucrative job opportunities abroad, have succumbed to the virus themselves, or have left the profession to take care of infected or affected family members. It is estimated that the country needs at least 600 nurses to fill all the positions currently open (Kimarayo: 2004). The government is trying to hire nurses from Kenya and as far away as India to help fill

[6] Results from the latest census were supposed to be released in 2006 but were not.
[7] www.usaid.org – Lesotho profile
[8] Obtained during research with hospital and government workers in Lesotho.

the void.[9] Two doctors from Sri Lanka and one from Zimbabwe, together with a dentist from India, fill the main posts at the hospital in Quthing. Cubans filled the posts several years before.

According to key informants in Lesotho, there are multiple drivers of the epidemic. First of all, cultural values have a major influence on behaviour. Basotho have multiple concurrent sexual relationships. Results of the Lesotho Demographic and Health Survey 2004[10] (LDHS) indicate that 89 percent of men and 42 percent of women aged 15-24 have had sex with a non-marital, non-cohabiting sexual partner in the preceding 12 months. Coupled with low condom usage, such relationships are reputed to be a leading factor in the spread of HIV infection in the country.

Gender inequality, gender-based violence and the legal status of women are some of the most important forces propelling the spread of HIV. Intergenerational sex takes two forms: sexual relationships between older women and young men, and sexual relationships between older men and young women. Whiteside and Erskine (2002) argue that older people tend to have more financial resources at their disposal and can afford to fulfil the "sugar daddy/mommy" role; older people seek younger partners because they are less likely to be infected with HIV; and females, particularly younger girls, are coerced into sex as they have little power to refuse and even less power to negotiate safe sex. Basotho also start having sex at an early age. The LDHS (2004) estimates that 27 percent of young men and 15 percent of young women have had sexual intercourse before the age of 15 years. In Lesotho, adolescents as young as 13 years old claim to be sexually active. There is also a lack of guidance and communication between parents and children on sexual matters. Traditionally parents do not discuss sex with their children even though it is becoming apparent that such a culture is no longer tenable in the era of HIV and AIDS.

[9] . Source: www.irinnews.org, 28.04.2006, *Lack of Healthcare Workers a Drain on new HIV/AIDS Plan*
[10] Commissioned by the Ministry of Health and Social Welfare to provide countrywide, population-based information on maternal and child mortality, nutrition, fertility levels, family planning, sexually transmitted infections, HIV/AIDS, and tuberculosis.

The second significant driver for the epidemic in Lesotho is linked to poverty, unemployment and food insecurity. Household-level food insecurity and poverty increase vulnerability to HIV infection as they drive people into risky behaviours in exchange for food and other materials. High unemployment in Lesotho tends to drive young women into transactional sex and young boys into substance abuse, exposing them to HIV transmission[11]. Alcohol and substance abuse, particularly binge drinking and marijuana smoking, is also common. HIV/AIDS is linked to substance abuse as it decreases an individual's judgment and increases the likelihood of risky sexual behaviour, including sexual violence (Richter et al, 2004). High mobility is also a factor. Migrant labour, both within and outside of Lesotho, separate workers, particularly men, from their spouses. As a result, they seek out other sexual partners, and this behaviour contributes to high HIV prevalence.

The third driver of the epidemic is more diverse but concerns aspects of communication. For instance, public service communication designed to change social behaviours has not been sufficiently coordinated, nor has it taken into account the different languages spoken in the country. In addition, messages designed for radio and television fail to reach the whole country due to the terrain. In addition, there is ineffective vocal leadership from civil society leaders: faith-based organisations, traditional leaders, traditional healers, NGOs and government are not doing enough to ensure that communities acquire the knowledge and skills to respond to the impact of HIV/AIDS.

One critical area of communication is the need to dispel myths about condom use, such as: condoms contain a substance that spreads HIV/AIDS and are part of an American plot to wipe out Africans; condoms affect women's wombs if used regularly; condoms contain a substance that produces worms during sexual intercourse.
There was an initial, prolonged state of denial about HIV/AIDS at national level that has still not sufficiently been dispelled, leading to a persistent lack of awareness about the pandemic. HIV/AIDS has been perceived as a foreign disease that was brought into the

[11] Based on interviews conducted in Quthing with healthcare workers and educationalists, which are discussed in more detail in Chapter 4.

country by *Makoerekoere,* meaning African people from outside Lesotho, Botswana, Swaziland and South Africa. This misconception allowed the epidemic to spread widely before control measures were initiated.

Due to many of these factors, the disease has surpassed malaria, tuberculosis (TB), and diarrhoea to become Africa's (and Lesotho's) number one leading cause of death (UNAIDS: 2006). There are an estimated 3.3 million orphans in southern Africa alone due to AIDS (ibid). Many of these factors mentioned above will be discussed throughout this dissertation.

Government Policy

Unlike most of the nations in the region, the government of Lesotho adopted a national HIV/AIDS strategic plan and an AIDS policy framework as far back as 2000. Both were based on multisectoral approaches to fighting HIV/AIDS and included support to the civil service and communities playing a prominent role in containing the virus. Thereafter a National AIDS Strategic Plan 2000–2005 was developed to guide the country's response.

In 2000, the King of Lesotho, Letsie III, declared the epidemic a national disaster (Kimarayo: 2004). The country has more than 100,000 orphans due to HIV/AIDS. Life expectancy has dropped to 34 years of age, one of the lowest in the world, from a high of 58 in 1990(UNDP: 2005), primarily due to the impact of HIV/AIDS. In 2001, the Lesotho AIDS Programme Coordinating Authority (LAPCA) was set up under the Prime Minister's office, with district structures to coordinate and guide national response. HIV/AIDS focal points were established in ministries, and two percent of every ministry's recurrent budget was set aside to finance HIV/AIDS activities. Other developments included the establishment of a cabinet sub-committee, parliamentary committee, and district AIDS task forces to strengthen coordination and advocacy on HIV and AIDS. In 2005 the National AIDS Prevention and Control Programme (NAPCP) was restructured and elevated to a directorate level: Sexually Transmitted Infections (STI), HIV/AIDS Directorate within the Ministry of Health and Social Welfare. The Ministry of Health and Social Welfare is the ministry mandated to spearhead the

facilitation, coordination and implementation of STI and HIV interventions in the health sector. This was followed by the launch of Turning a Crisis into an Opportunity – Strategies for Scaling Up the National Response in October 2003, the launch of the Prevention of Mother To Child Transmission (PMTCT) programme in November 2003, and the Maseru Declaration on Combating HIV/AIDS in SADC in 2003, the antiretroviral treatment (ART) programme in May 2004, and the launch of the Know Your Status campaign in 2004 by the Prime Minister, who was tested publicly for HIV. King Letsie III officially launched the Know Your Status national operational plan on World AIDS Day, 1 December 2005.

The government also adopted the principles of the Three Ones which are the basis of national HIV/AIDS responses around the world: one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority, with a broad-based, multisectoral mandate; and one agreed country-level monitoring and evaluation system. By using this methodology, governments are expected to achieve the most effective and efficient use of resources, and ensure rapid action and results-based management. Steps towards full implementation of the Three Ones are still in progress. The enactment of the National AIDS Commission (NAC) Act in 2005 marked the introduction of one national coordinating authority. The country has also a national strategic plan for HIV/AIDS, which is strengthened in some districts by local versions. It is hoped that implementing these plans will pave the way for the development of the one national HIV and AIDS monitoring and evaluation system in the near future.

The government has also factored HIV/AIDS action into relevant development initiatives, including the Poverty Reduction Strategy paper and other public expenditure frameworks, such as the Common Country Assessment and United Nations Development Assistance Framework.

Indeed, the government of Lesotho is regarded by many as doing its best to try to contain the impact of HIV/AIDS. Stephen Lewis, the UN Special Envoy for HIV/AIDS in Africa,

remarked after a February 2006 visit to Lesotho that the country had embarked on an undertaking unique in Africa by announcing its intention to offer HIV counselling and testing to every household in the land by the end of 2007. Lewis added that "Lesotho knows it is fighting for survival: words like extinction and annihilation are commonplace… Fortunately, Lesotho has one of the most gifted and committed political cabinets in all of Southern Africa. If the country can be saved, they will save it."[12]

Government's commitment to contain the impact of the virus distinguishes it from other countries in the region, and therefore makes it worthy of research into how its fundamental support structures are continuing to function and support the country's most vulnerable populations. Lesotho adopted a significant piece of legislation in January 2007 called the National Policy on Orphans and Vulnerable Children. While Lesotho is not alone in having such a policy, parliament passed the document in January 2007, when the body was technically disbanded, ahead of February elections. This underscores the seriousness with which the government takes the problems faced by orphans and vulnerable children in the country. As this dissertation will reveal, there are still many gaps in the government's response. Bureaucracy, misuse of resources and widespread denial of the virus's impact, depth, and legacy are all factors that must be taken into consideration when examining the research problem.

Chronic food insecurity and recurring natural disasters undermine the ability of communities to cope with the impact of HIV/AIDS. Even in a year without drought, 95 percent of Basotho involved in agricultural production cannot grow enough food to meet their own requirements. For those who have adequate land, home-grown food often lasts less than five months. HIV/AIDS is weakening the most productive members of society, primarily those working in the agricultural sector as a whole, although subsistence farmers are thought to be more affected (WFP: 2006). Lesotho imports about 50 percent of its staple grain needs, although during drought years this has climbed to as high as 70

[12] (www.stephenlewisfoundation.org, 'UN press briefing by Stephen Lewis on his February 2006 visit to Lesotho and Swaziland', March 17).

percent. However, the country is unable to finance this level of grain imports and requires donor funding or food assistance to meet these needs (ibid).

Although the research is concerned with the broad response of the Lesotho government, it also draws on detailed field research in the district of Quthing: a unique district in Lesotho, primarily because of the leadership shown by its female district administrator. Although hamstrung by male-dominated politics and idiosyncratic in her own leadership decisions, which sometimes prove counterproductive, the district administrator is well respected by the community and has helped pioneer several significant initiatives to combat the impact of HIV/AIDS and support orphans and vulnerable children. These include empowering men to take the lead on incorporating HIV/AIDS education into initiation schools, creating a child protection unit within the police department, and driving moves to protect child inheritance rights. Some of these initiatives have since been adopted by other districts. She has also been instrumental in trying to bring resources to the district and is an outspoken constructive critic of inept policies – a difficult stance for a woman to take in Lesotho. It is because of this impressive track record that Quthing was selected for closer research.

Quthing: Vulnerability and Ethnicity

Quthing is Lesotho's southernmost town, about 180 kilometres south of the capital Maseru. It is unique in Lesotho because of its cultural and language differences. The district has three distinct ethnic groups: Basotho, which make up about 70 percent of the population; Baxhosa, about 20 percent; and Baputhi, about 10 percent. This fact alone complicates all forms of communication from the district capital to rural areas and contributes to the difficulties faced by communities in receiving effective support from the state and other agencies to tackle the HIV/AIDS epidemic and underpin social safety nets for orphans and vulnerable children.[13] Quthing is also known by the Basotho as Moyeni, meaning 'place of the wind'. For the purpose of this dissertation, Quthing District should be considered to include five constituencies: Mount Moorosi, Qhoali,

[13] In a February 2006 report for the String Game Activity Report, a village-level HIV/AIDS outreach programme, it was noted that participants of the three language groups attended a meeting and found it difficult to understand the stories being told.

Sebapala, Moyeni and Tele Tele. The district's catchment area has a population of about 135,000

Figure 1: Map of Lesotho

Source: Cartography Unit, School of Geography, Archaeology and Environmental Studies

An important source for this dissertation is a survey[14] conducted by Lesotho's Disasters Management Authority (DMA) and the United Nations World Food Programme (WFP) in 2006. The survey examined the livelihood status of more than 39,000 households, or 195,000 people, across Lesotho and included participation from government, the UN, non-government organisations and various civil society organisations. In the district of Quthing, the majority of people in 17,629 households across 435 villages that were surveyed claimed to have only one source of income, while a significant proportion claimed no income and only two percent claimed two sources of income. Most households ranked as poor or very poor. Some 27 percent cited casual labour as an income source, while 19 percent ranked beer brewing as a source of income. A further 17 percent benefited from a pension provided to an elderly person in the family.

[14] Uncovering Chronic, Persistent Vulnerability to Hunger in the Southern Lowlands and Senqu River Valley – Report of the DMA-WFP Targeting Exercise, Maseru, Lesotho. March 2006.

Agricultural practices[15] provide a relatively small proportion of income for poor and very poor households, with only three percent of households in Quthing receiving an income from the sale of crops, and only two percent of households using the sale of livestock as a source of income. Remittances play an important role for about 10 percent of households in Quthing, with households in Mount Moorosi, Tele Tele and Moyeni more reliant on this strategy than households in Sebapala and Qhoali.

The survey revealed that 26 percent of households in Quthing stated that they had a chronically ill household member, while 31 percent stated that illness existed in their household. Some 2,697 households in Quthing were identified by the community as hosting single orphans, of which about 1,568 were considered vulnerable. A further 1,208 households were identified to be hosting double orphans, of which 739 were considered vulnerable[16]. Over nine percent of interviewed households were considered to have a high burden of care, hosting two or more double orphaned children. Lastly, the survey revealed that there were 86 child-headed households in Quthing District, the second-highest number in the country. Nationally, the DMA/WFP survey recorded 1,857 orphans as heads of households.

In Lesotho, ten percent of households interviewed in the survey were shown to have a high burden of care, hosting two or more double orphans. Child-headed households represent just one percent of vulnerable households in Lesotho, but they are particularly exposed to hunger and livelihood insecurity. Even though orphans and vulnerable children may continue to live in their deceased parents' home, in many communities they will not be considered child-headed households by the community because an adult will be assigned responsibility for their welfare. The role of the adult in such cases becomes the equivalent of a social worker in a less poverty-stricken context and more state-involved environment. Therefore the true extent of orphans and child-headed households could still be masked by the community's definition and interpretation of the categories. During routine surveillance over the last year, health workers connected to Quthing

[15] There are appropriate technologies used in the field of food production that provide a number of households with some food security, such as key-hole gardens, which will be discussed in more detail in Chapter 4. However, these are not enough to meet food consumption needs of all vulnerable households.
[16] See page 36 for definition

Hospital noted an increase in double orphans staying alone in the district, although usually someone from the community council kept an eye on the children.

Marriage practice may also be a factor in increasing prevalence rates among some groups, according to some health practitioners. It is culturally unacceptable for Basotho, who practice monogamy, to have more than one wife, while men in Baxhosa and Baputhi ethnic groups are actively encouraged by their communities to take more than one wife if they can afford the expanded family that follows. However, statistics show that only 2.6 percent of surveyed men in Quthing District have more than one wife, although the sample size was only 70 men (LDHS: 2004) and the ethnic groups engaged in polygamy are minorities in some of the remoter areas of the district. Quthing's HIV/AIDS Strategic Plan for 2006-2011 calls on polygamy to be formalised to help reduce the number of women infected by HIV through dry sex[17]. Even without this recognition, there is anecdotal evidence to suggest men and women in all three ethnic groups engage in casual sex outside the marital relationship, but due to the monogamous shackles placed on Basotho, some may engage in more extramarital affairs than their polygamous counterparts. This phenomenon was also noted by Gomo et al (2005), who found that married men and women were more likely to be infected than their single counterparts, although no explanation was offered.

The origins of this practice can be traced back to the early 20th century, when men started migrating to South Africa to work in the mines. The practice of having multiple extramarital relationships is referred to as *bonyatsi* (Kimble J & Bonner P, 1997). Women became frustrated as their husbands squandered earnings, prompting them to look for

[17] This practice is used by women to heighten sexual pleasure for men during intercourse. It also often causes a tearing of the vaginal wall during intercourse and as such is a driver of HIV transmission. Dry sex promulgates HIV/AIDS in three ways: the lack of lubricant results in lacerations in the delicate membrane tissue, making it easier for the lethal virus to enter; the natural antiseptic lactobacilli contained in vaginal moisture are not available to combat sexually transmitted diseases; and finally, condoms break far more easily due to the increased friction. News article: Hyena H, December 10, 1999. www.salon.com. "'Dry sex' worsens AIDS numbers in southern Africa. Sub-Saharans' disdain for vaginal wetness accelerates the plague."

multiple partners as well in order to get gifts or money to feed their children.[18] While this dissertation notes this phenomenon, it does not explore it in further detail.

According to interview respondents, men face ingrained cultural pressures, particularly if they are wealthy, to symbolically assert their affluence and prowess by engaging in sexual activities with as many women as they can afford. Culturally this often includes young women, who will perform transactional sex for as little as a few rand, the price of a beer in a bar, or transport from point A to point B.

Research Methodology for Dissertation Fieldwork

The writer spent 10 days living in the local community to conduct the study, in particular the research presented in Chapters 3 and 4. The research methods of secondary data collection, direct observation, qualitative research and a survey were selected, based on their potential to provide useful and relevant data during the fieldwork phase. Interviews were conducted with a translator.

The research methods provided an opportunity for community members involved with orphans and vulnerable children to speak about traditional community safety nets that are used to support people affected by HIV/AIDS. The data collection techniques included surveys, qualitative methods, literature review, direct observation, focus group discussions and key informant interviews.

Secondary data collection: This is desktop research in the form of a literature review. It helps clarify concepts and provides the background on the research topic and issues around local knowledge, coping strategies, and the impact of HIV/AIDS on communities.

Direct observation: This technique was important, as it allowed observation of everyday life of the study area and the opportunity to interact and ask questions about key issues.

[18] News article: Fleming K, September 28, 2006. Ithacan newspaper online: http://www.ithaca.edu/ithacan/articles/0609/28/news/9anthropol.htm. *Anthropology professor fights for AIDS relief in Africa*

This method was carried out at the hospital (to see who comes and goes, and in what physical condition); at communal meeting points; and at the household level.

Qualitative research: This involved the use of semi-structured interviews with key informants:

- Government: district administrator; doctors, nurses, teachers; social workers; directors of orphanages or child-welfare agencies.
- Community leaders/groups: village chiefs; women's committees; community leaders; HIV/AIDS support groups; civil groups engaged in child protection; groups supporting orphans.
- Individuals: adults and children affected/infected by HIV/AIDS; patients in hospital; individuals engaged in helping children; non-state-provided caregivers; foster families; random villagers.

Survey: During an interview at a high school in Quthing, the writer was asked by the principal to conduct a survey of pupils across all grades, to examine the extent of HIV/AIDS awareness and prevention as well as sexual behaviour. Some 120 copies of a questionnaire were distributed to teachers at the school, but since learners were involved in term examinations, no time was allocated for their completion, other than indicating that they would be completed within the day. Furthermore, the principal deemed it inappropriate for the writer or translator to be present while the questionnaires were completed, which led to some inconsistencies (which are examined in Chapter 3). However, the research does reveal important information that supports the dissertation's premises.

Focus group discussions: This method was employed to establish basic understanding of the issues, needs and attitudes, and the manner in which respondents see their community and the problem of the increasing number of orphans and vulnerable children. This also served as a crucial opportunity to discuss traditional coping strategies as well as possible 'breaking' points for communities. Focus group discussions were conducted after the

completion of research with key informants. For this reason, this stage of the research was left until the end of research collection process.

Chapter 2

Literature Review

Introduction

Extensive academic material, policy and discussion papers, books, news articles and other information have been written on HIV/AIDS around the world. All areas of the pandemic's tentacles have been explored to varying degrees including: antiretrovirals, impact on food security, prevention, treatment, and awareness, orphans and vulnerable children, gender, stigma, socio-economic consequences, psycho-social repercussions, and, social protection. This literature review will examine the programmatic responses that affect social safety nets for orphans and vulnerable children, as well as the challenges faced by communities battling to contain the impact of the virus.

The pandemic's toll is multi-faceted, affecting economies, life expectancy, healthcare, education, infant, child and maternal mortality, governance structures, cultures and traditions, and sexual attitudes (Nattrass: 2004, Barnett & Whiteside: 2002, Richter et al: 2004). Because of the complexity of the impact of HIV/AIDS, the subject of this dissertation cannot be considered in isolation. This literature review, although organised under headings, reflects the interconnected themes and complexity of the topic. The key themes of this chapter are vulnerability and social safety nets, orphans and vulnerable children, and the specific characteristics of the HIV/AIDS impact on Lesotho, including the economic implications, the policy response, government capacity, the role played by civil society, and some of the behavioural and cultural aspects driving the epidemic.

AIDS, Economic Impact, State and Civil Society Responses

In the 14th Century, the bubonic plague, referred to as the Black Death, swept Europe and Asia, killing an estimated 40 million people[19]. It had a devastating impact on economies, caused widespread misery, and saw an unprecedented stigmatisation of affected families (New Scientist: 2002). It was the worst pandemic in history, until now. The impact of

[19] New Scientist 2002 and www.wikpedia.com

HIV/AIDS on the planet has now surpassed the toll wreaked by the Black Death,[20] (Ainsworth: 2002, Whiteside & Erskine: 2002). Despite medical advances, HIV/AIDS is expected to claim more than 65 million lives by 2010 (BMJ: 2002). The number of people living with HIV has increased in every region of the world since 2004, with the biggest increases being recorded in East Asia, Eastern Europe and Central Asia.[21]

Its impact on economies and productive labour forces around the world has not been authoritatively estimated, given the magnitude of the present pandemic and the multidimensional impact for the future (O'Grady: 2005, Barnett & Whiteside: 2002). One often cited study in South Africa showed long-term economic growth would decline by 0.4 percent per year because of HIV/AIDS (Barings: 2000). Other research suggests this study may have been too linear in its approach, by neglecting the impact on human capacity and disruptions to organisations and institutions (Barks-Ruggles et al: 2001). UNFPA (2004) estimated that if 15 percent of a country's population is HIV-positive, its GDP would decline by one percent per year (UNFPA: 2004). The International Labour Organisation (ILO 2004), which used macroeconomic data from 2002, showed a GDP decline of greater than one percent in seven of 12 southern African countries impacted by HIV/AIDS between 1992 and 2002, while Swaziland and Botswana, which still have the top two adult HIV prevalence rates in the world, was nearly three percent over the period (ILO: 2004). The projections, whether accurate or not, are founded on the current staggering death rates of affected countries.

With up to 3.5 million deaths occurring globally in 2006, and almost three quarters of the toll being in sub-Saharan Africa (UNAIDS 2006), the economic, social, and human repercussions are starkly clear. The impact of the pandemic is concentrated in southern Africa which is widely recognised as the global epicentre of the virus. The sub region is home to one-third of all people with HIV worldwide, and accounted for 34 percent of all deaths due to AIDS in 2006 (ibid). One writer suggests the labour forces of 38 affected

[20] New Scientist 2002 and www.wikpedia.com
[21] It should be noted that HIV/AIDS prevalence rates, as recorded by the UNAIDS Epidemic Update 2007, declined in most countries because of a recalculation and more precise sourcing of data. In real terms, the rates did not decline.

countries could be up to 35 percent smaller by 2020 because of AIDS (Pickrell: 2006). The true death toll and extent of the problem may not be realised for another 20 years according to projections for the epidemic (Whiteside & Erskine: 2002). More than any other region of the planet, the severity of the pandemic in southern Africa has been compounded by entrenched poverty, food insecurity and overstretched capacity of governments and communities to respond (De Waall & Whiteside: 2002).

Even where policies are in place, governments in southern Africa are struggling to deliver services due to declining human capacity. This is because of shorter life expectancy due to HIV/AIDS and the 'brain drain' of trained personnel looking abroad for higher salaries and better work opportunities. (Whiteside & Barnett: 2002, O'Grady: 2005). The salaries of some doctors in Lesotho, for example, are one-third that of their South African counterparts, while nurses earn more as child minders across the border and gladly give up their professional status for higher incomes.[22]

Cohen (2002) has chastised governments, labour unions and employers for concentrating their efforts on health issues at the expense of a wide range of labour and industry-related matters affected by the virus.[23] He argues that all parties have a role to play in maintaining productive capacity to sustain human capital, and that a rethink is required to engineer a multisectoral programme of action to tackle the issues facing countries. Kgamadi (2004) also discusses the need to broaden the spectrum of the way the impact of the virus is viewed. Cohen (2002) goes on to give a stark warning through a case study on Malawi claiming that if moribund ministries are not activated to combat the crisis, services over time will collapse under the weight of the impact of HIV/AIDS. Cohen's argument is valid but its implementation is likely to be difficult, particularly in the case of Lesotho given the complexity of intra-government relations and the willingness or ability of ministries to adopt and activate strategies, for example the Three Ones of HIV response or decentralisation.

[22] Revealed during interview with doctor at Quthing Hospital, September 12 2006, 14h30
[23] These include gender, technology transfer, production output, shortages of skilled labour etc

Governments often complain that they are unable to mitigate the impact of the virus because they lack resources and international donors routinely fund initiatives through civil society rather than central structures (Hachonda: 2005). However, the Centre for Conflict Resolution, University of Cape Town, pointed out in its final report from a policy group meeting in Addis Ababa on HIV/AIDS and Human Security, that only part of the massive amount of international funding given to combat the pandemic ever reaches the intended beneficiary because of widespread poor governance and lack of capacity[24]. To add to the paradox, Richter et al (2005) argue that the current policy ethos towards HIV/AIDS is 'all over the place',, that there is no consistency in approach or targeting, and that programmes are tiny in proportion to the need. Ty add that government and non-government funding, whether from external or internal sources, should be channelled to households and communities to dramatically scale up the response to match the extent of the problem (Richter et all: 2005).

Whiteside & Erskine (2002) suggest that programmatic time frames should be longer than five years, to take account of scaling up, implementation and behavioural change. One of the problems in taking such an approach is that donors have developed a "take-it-or-leave-it" attitude (Hachonda: 2005, Mihailovic & Olupot-Olupot: 2006), informing NGOs of what they want done and with whom, and few take the long-term approach when dealing with development strategies. One of the ways of combating this, which has worked well in South Africa, is through strengthening civil society to ensure progressive solutions are found to challenges and donor dollars are transparently directed. The benefits of a strong civil society have been well documented in South Africa, where government has been taken to task on several occasions through legal proceedings (Nattrass: 2004, O'Grady: 2005). The result is that the changes needed were in fact precipitated by civil society intervention and pressure on the state .

Indisputably, available resources to address HIV in developing countries have increased dramatically from an estimated US$300 million in 1996 to US$9 billion in 2006

[24] Seminar report, Hilton Hotel, Addis Ababa, Ethiopia, 9 and 10 September, 2005. HIV/AIDS and Human Security: An Agenda for Africa.

(UNAIDS: 2006). While still inadequate to effectively respond to the crisis, the question is how to use these funds effectively. Funding for AIDS treatment often competes with funding for prevention, and funding for both often overshadows spending for reproductive health. Ashford (2006) argues that short-changing reproductive health programmes may be counterproductive to increasing knowledge about sexuality, family planning, and safe pregnancies; this knowledge can serve to reinforce HIV prevention efforts. Furthermore, better access to contraception and counselling can reduce maternal and child deaths and enhance efforts to empower women (ibid).

Setswe (2005, 2006) argues that the relationship between policy, research and implementation of HIV/AIDS programmes represents a bridge over troubled waters – research and policies being the bridge, and implementation the troubled waters. He goes on to say that there are relatively few research gaps and where these gaps do occur, they are not obstacles to successful HIV/AIDS prevention and mitigation. He claims the problem lies with the fact that research results are seldom utilised in the implementation of prevention and care programmes. (See also Ekambaram: 2004). Freudenthal (2001) and Trubo (2004) concede that incorporating research into programmes remains a serious issue, yet they argue that there are still important areas requiring research that could improve knowledge and response, as well as assist in researching specific groups. Freudenthal (2001) argues that these areas, in broad terms, include: protection of young people and future generations; healthcare research; research on and for policy; and the social and economic consequences of the HIV/AIDS epidemic. Trubo (2004) says a lack of research into prevention strategies tailored to minority communities has impeded efforts to reach certain populations. He cites minority groups like the black and Hispanic communities of the United States, which together make up a significant proportion of the population.

Freudenthal (2001) also refutes the argument of Setswe (2005, 2006) that policy acts as a bridge over troubled research waters. He urges the establishment of stronger links between research, policy and implementation, including incorporating plans for dissemination of research results to policy makers in all research proposals. Policy

makers must show commitment and willingness to listen to researchers and use independent research results in the design of projects and programmes (ibid). Court (2005) argues that it is difficult to find a larger and more devastating gap in development than that between research and policy on HIV/AIDS, as it has clear implications for human survival, quality of life, and national development. HIV in many countries has been allowed to spread, deepening the crisis, because of the lack of appropriate policy response (ibid).

There is near total consensus on several points: HIV/AIDS is on the agenda in most developing countries; poverty and gender inequality are the main forces driving the pandemic; and, an interplay of factors are facilitating sexual transmission. Among these factors, as noted by Freudenthal (2001), are: little or no condom use; a large proportion of an adult population with multiple partners; overlapping (as opposed to serial) sexual partnerships; wide sexual networks (often due to work migration); women's economic dependence on marriage or poverty driven commercial sex work and their lack of power in negotiating sexual relationships; age differences between sexual partners - typically older men and young women or girls; high rates of sexually transmitted infections, especially genital ulcers.

Research shows that most people in Africa have a good knowledge about AIDS[25] (ibid). This paradox between knowledge of the pandemic and what amounts to reckless abandon in people's actions will be a recurring theme that is examined in this dissertation.

Vulnerability and Social Safety Nets

The ever-increasing adult deaths from HIV/AIDS have led to the rise of a new category of vulnerability – orphans and child-headed households. Today these vulnerable groups are increasingly found in villages across southern Africa, exacerbating the inability of governments and traditional coping strategies in the region to respond to what is becoming a humanitarian tragedy (Scott: 2003). To better understand the plight of

[25] It should be noted that many other drivers of the pandemic were outlined in the introduction to this dissertation. These include cultural and socio-economic factors. Individual drivers will not be examined by this dissertation unless they bear relevance to the research question.

orphans and vulnerable children in the region, it is critical to examine three subjects in more detail: poverty and vulnerability; social safety nets; and breaking points.

Poverty and Vulnerability

The links between these two conditions are explicit. The term 'vulnerability' is commonly used in the sense of being weak or defenceless in the face of a shock (De Waal & Whiteside: 2003). Writing on poverty and vulnerability in India's state of Uttar Pradesh, Parker and Kozel (2005) argue that poverty and vulnerability not only coexist but are mutually reinforcing and that if they are to be effectively addressed, the processes that drive them must be understood separately. Although many definitions for poverty and vulnerability exist, the most appropriate for the HIV/AIDS context in southern Africa, and specifically Lesotho are:

> **Poverty:** "People are living in poverty if their income and resources (material, cultural and social) are so inadequate as to preclude them from having a standard of living which is regarded as acceptable by … society generally. As a result of inadequate income and other resources, people may be excluded and marginalised from participating in activities which are considered the norm for other people in society." Ireland's Office for Social Inclusion, Department of Social and Family Affairs. [26]

> **Vulnerability:** "Vulnerability refers to exposure to contingencies and stress, and difficulty in coping with them. Vulnerability has thus two sides: an external side of risks, shocks, and stress to which an individual or household is subject; and an internal side, which is defencelessness, meaning a lack of means to cope without damaging loss." Chambers (1989, p1). Or, to put it more succinctly, 'vulnerability denotes both exposure and sensitivity to livelihood shock' (Devereux: 2001, p1).

Vulnerability is forward looking in that it describes susceptibility to future acute capacity loss (Alwang et al, 2001). Vulnerable families are more likely to be poor and to suffer from several deprivations at the same time because they are exposed to greater shocks or risks, such as dangerous working conditions, poor nutrition, lack of preventive healthcare, and exposure to environmental contaminants; and they have fewer safety cushions in the form of savings and insurance (Parker & Kozel, 2005). The impact of these shocks on

[26] http://www.socialinclusion.ie/about.html

vulnerable households can be devastating during a crisis as they absorb a larger share of scarce resources in comparison to better off households, and they can push a poor family into destitution, which is difficult if not impossible to recover from (ibid).

There is broad acceptance among academics that poverty and vulnerability are increasing as countries struggle under massive debt burdens, poor governance and the impact of HIV/AIDS (Nattrass: 2004, Barnett & Whiteside: 2002, Gulaid: 2004, Salaam: 2005, Richter et al: 2004). HIV/AIDS is not only a contributor to vulnerability but it increases the risk of heightened mortality because it is directly linked to malnutrition, undermines coping strategies and leaves people less able to manage other illness (Harvey: 2004, De Waal & Whiteside: 2003, Hoogeveen et al 2003). Therefore vulnerability is a central theme in writing and research on HIV/AIDS. Many of the academic and policy papers relating to southern Africa reviewed for this dissertation cited falling life expectancy, rising unemployment, elusive food security, and the decline of institutions that provide healthcare, education, and social services as key areas that need to be addressed to mitigate the impact of the pandemic (Nattrass: 2004, Barnett & Whiteside: 2002, Gulaid: 2004, Salaam: 2005, Richter et al: 2004).

Safety Nets

While policies that promote economic growth are central to poverty reduction, social protection measures, also known as social safety nets (or social assistance programmes when implemented on a broad scale by government structures), have a role to play in reducing vulnerability, and protecting the welfare of the poor. However, choosing the appropriate mix of social protection programmes and policies requires a careful approach, particularly when it comes to addressing specific risks faced by groups such as orphans and vulnerable children. Responses should strengthen pre-existing community coping strategies rather than supplant them.

To achieve this, it is broadly recognised that community-driven interventions at the household level are the most cost effective and efficient way to help vulnerable groups, particularly orphans. (Devereux: 2002, Desmond et al: 2002, Subbaroa et al: 2001,

Bendokat & Tovo: 1999, Coudouel et al: 2000). But people's livelihood chances are determined not just by local level events but by political, social, and economic trends that national, regional and even global in character (Ellis: 2006). The typical state response to vulnerability in developing countries is to provide social assistance programmes that use targeted transfers in the form of food parcels or government social security grants, such as pensions and child welfare grants (Hoogeveen et al:2003). These systems are extremely costly and can be unaffordable for most developing countries. A 2000 World Bank report (Coudouel et al: 2000) outlines several such systems:

Common state-provided social safety net programmes

Labor market interventions: Improve the ability of households to provide for themselves through work via the development of efficient and fair labor policies, active and passive labor market programmes, and pre and in-service training programmes.

Pensions: Help governments take care of their older and aging populations by creating or improving private pension provisions, mandatory savings, and public old-age income support schemes. Governments intervene heavily in both regulation and expenditure in this area.

Social safety nets: Provide income support and access to basic social services to the poorest population groups, and/or those needing assistance after economic downturns, natural disasters, or household specific adverse events that lower income.

Child-labor reduction programmes: In partnership with governments, communities, and international organizations, promote the development of human capital and increase equity and education for all groups by designing comprehensive strategies for broadly based poverty reduction, and craft appropriate legislation and programmes specifically for child laborers to reduce the occurrence and mitigate the risks of harmful child labor.

Disability programmes: Help the disabled through community-based services, including family support (respite care, child care, counseling, home visiting, domestic violence counseling, alcohol treatment and rehabilitation), support for people with disabilities (inclusive education, sheltered workshops, rehabilitation, technical aids), help for the elderly (senior citizen centres, home visits), and out-of-home placements (foster care, adoption).

Social funds: Through agencies, channel grant funding to small-scale projects to help poor communities design and implement their own projects to meet their self-defined needs.

Informal arrangements: Support community or family members through informal insurance arrangements. Arrangements can include marriage; children; mutual community support; savings or investment in human, physical, and real assets; and investment in social capital (rituals, reciprocal gift giving).[27]

[27] Source: Coudouel et al, World Bank, 2000

As Graham[28] (2002) points out, in instances where public opinion is deeply entrenched, such as the highly emotive HIV/AIDS paradigm, reforms or the creation of social assistance or other social policies can have high political costs and can even jeopardise macroeconomic efforts. This has been clearly seen in South Africa, which has had a consistent policy of denial in addressing the impact of HIV/AIDS through broad social assistance programmes (Hayward: 2005), primarily for faux financial concerns[29]. For these reasons, Graham (2002) suggests that while temporary and externally financed safety net programmes can avoid these concerns more easily, social assistance policies that form part of a longer-term social contract must take public opinion and macroeconomic implications into account. An example of this is the food transfer schemes operated by the United National World Food Programme (WFP) in southern Africa, which work within government frameworks (WFP: 2005) to achieve long-term poverty alleviation goals.

In cash-strapped developing countries, where governments lack the financial means or human capacity to easily respond to crises, a shock such as drought, poor harvest or illnesses such as HIV/AIDS can push an already poor household further into poverty (Hoogeveen et al:2003). Conning & Kevane (2001) argue that government failure in reaching and engaging the poor has led to the growing awareness of the importance of social safety nets. Demand-driven social funds that elicit community support have increased in popularity with governments, donors and international organisations to the point where the World Bank now insists on community participation as a prerequisite for funding approval for many projects (World Bank: 1996, WFP: 1998). Examples of what has been coined the 'bottom-up' safety net approach to service delivery and poverty alleviation, because it involves the poor and communities, include the decentralisation of public services to local governments, community management of forests and other natural resources, and vulnerable group-based, micro-credit programmes (Conning & Kevane:2001).

[28] Graham's research has relevance primarily for democratic and wealthy nations that are able to afford changes to, or the creation of new social service provisions.

[29] The Associated Press article, South Africa Refocuses AIDS Programme-Health Minister Sidelined After Protest by Leading Scientists, September 11, 2006

Community-based social safety nets are often seen as anti-poverty interventions, particularly by donors, and as such they are viewed within the social welfare category. An unfortunate consequence of this, according to Devereux (2002), is that institutionalised systems of social protection are often dismissed as unaffordable luxuries for poor countries because of an artificial perception that livelihood protection is distinct from livelihood promotion, when in fact the two are conjoined. Devereux (2002) argues that even tiny transfers invested in income-generating activities, education, social networks, or the acquisition of productive assets, can play a significant role in reducing chronic poverty, particularly within the HIV/AIDS context, even if they are immediately consumed, such as in the case of food transfers. When social welfare systems are not in place or community coping strategies collapse entirely, vulnerable populations can be pushed even deeper into deprivation. This was seen during the fall of communism in Russia when the state-run welfare system collapsed, forcing the country's most vulnerable populations below the poverty line.[30]

Breaking Points

In lieu of external financial assistance or government intervention, families and communities play an integral role in identifying and providing about 90 percent of support and care through social safety nets for vulnerable households in Africa, particularly for those affected by HIV/AIDS and orphans (D'Allesandro et al: 2006). Yet there is increasing evidence that traditional safety nets in southern Africa are beginning to fray at the edges under the weight of the ever-increasing number of orphans and vulnerable children, compounded by rising poverty and destitution caused by HIV/AIDS (ibid). As this dissertation will also examine household 'breaking points' – the moment when coping strategies and social safety nets become overwhelmed by the demands placed on them – it is also important to discuss what might constitute such a pivotal development.

[30] www.claimscon.org/forms/allocations/Social%20Safety%20Nets.pdf

The first stage of an economic crisis in communities in southern Africa is the removal of children from school so they can find piecemeal employment or just so the family can save on school fees. In addition, families cope by selling assets, reducing meals and consuming a higher proportion of wild foods.

The second stage is far more serious, and could be categorised as a breaking point because it involves much more drastic measures that are far less talked about, including prostitution, migration, the sale of children for labour, chronic depression and anger, and the early marrying off of girls. The shame of undertaking such drastic measures prevents people from admitting to taking them, but if asked most would say they "know of people" who had taken these steps (Nattrass: 2004, Barnett &Whiteside: 2002, Salaam: 2005, Richter et al: 2004).

An example of the consequences of a household breaking point in Ethiopia is the number of street children. A 1993 UNICEF study in Addis Ababa estimated that there were about 40,000 children living on the streets of the capital, 10,000 of whom received almost no support from state or traditional social safety nets. The children were sent to find work or beg on the streets because supplementary income was needed by their household, and not, in general, because their families were too ill to take care of them. Culturally, Ethiopian children are brought up to be active members of the workforce, so child labour is common. Lesotho also enlists children in household and agricultural chores, yet very few children are ever found begging on the streets of Maseru or other urban centres. The community in the past stepped in to ensure children were protected as much as possible. Whether these protective community measures can be maintained in the future is questionable, as is the quality of the protection.

In Zimbabwe, Mawoneke et al. (2001, cited by Gillespie:2005), noted that half of all street children in two cities were orphans, more than twice the proportion found in the general population. The main factors that led children to the street were poverty, a desire to be financially autonomous, ill treatment by parents or guardians, orphanhood, religious influence and overcrowding at home. The majority of double orphans (56 percent) and of

maternal orphans (58 percent) lived on Zimbabwe's street most of the time, while the majority of paternal orphans (68 percent) and of non-orphans (71 percent) lived at home or with a guardian. As Zimbabwe has the fastest growing number of orphans in the world (UNICEF: 2006), currently estimated at more than 1.3 million children, it is safe to assume that a good proportion of these children are affected by HIV/AIDS. In another study cited by Gillespie (2005), in Zambia in 2002, the majority of street children in Lusaka were orphans – 22 percent double orphans, 26 percent paternal orphans, and 10 percent maternal orphans. Given Zambia's average adult HIV/AIDS prevalence rates, estimated at between 16 and 18 percent[31], it is reasonable to assume that the majority of these children have been orphaned due to AIDS. With 1.1 million orphans, Zambia has the fourth-highest number of orphans in southern Africa (UNICEF: 2006). In the cases of both Zambia and Zimbabwe, it is reasonable to assume that the large numbers of street children are a possible indication of households reaching a breaking point, coping first with chronic poverty, food insecurity and unemployment, followed by the multifaceted strain of HIV/AIDS.

Latin American countries generally have much lower rates of HIV/AIDS than those in southern Africa, yet they also have high populations of street children – again as a result of households reaching 'breaking points', even without the considerable added burden of a viral pandemic to further weaken state and non-state systems. After examining why Latin America's notorious street children existed, Scanlon et al (1998) concluded that economic, social, and political factors such as land reform, unemployment and poverty all played a role in their steadily rising numbers. Their arrival was not cultural as in the case of Ethiopia, nor was it typically as a response to a particular 'shock' as in Lesotho with HIV/AIDS, or Zimbabwe with abuse or economic concerns. Some of the suggestions cited for this phenomenon include children being turned out of home for uncontrollable behaviour or, in other words, a divergence of attitudes between their parents and traditionally structured society.

[31] Rates in Zambia go above 30 percent in parts of the country such as the Copper Belt. (UNAIDS: 2005)

As the next section explains, responses to orphans and vulnerable children need to be carefully co-ordinated, planned and executed as a community's coping ability is intertwined with, and underpinned by, traditional and state-provided structures, such as community services, education, and the healthcare sector.

OVC: Impact and State Response

UNAIDS (2004) defines an orphan as *"a child under 15 years of age who has lost their mother (maternal orphan) or both parents (double orphan) to AIDS"*. This definition, as Gillespie et al (2005) point out, excludes paternal orphans, orphans aged 15-18, and non-AIDS orphans. This gap has prompted some to expand the definition to consider children up to the age of 18 as orphans (UNICEF: 2005).

In 1990, according to UNICEF, there were fewer than one million children under the age of 15 in sub-Saharan Africa who had lost one or both parents to HIV/AIDS. In 2003, the region had 34 million orphans, 11 million of them due to HIV/AIDS (UNICEF: 2005). By 2010, 19 million children are expected to be orphaned from this single cause[32]. Tragically, as Cohen (2000) points out, these children, if not already infected by the virus, are likely to adopt the behaviour patterns that led to their parents becoming infected, and so are likely to cause the pandemic to intensify.

Not every vulnerable child is an orphan and not all orphans are vulnerable (River et al: 2004). Orphans are deprived of the material, social, emotional and psychological support of one or more of their primary caregivers. This could result in lower levels of investment in their human capital such as schooling, clinic visits, care time and food access (Gillespie et al: 2005). Orphans are also thought to have a weaker voice in redressing discrimination. This combination of lower potential investment and weaker voice is considered to make orphans very vulnerable to other shocks and deprivations including food insecurity and malnutrition (ibid).

[32] http://www.afro.who.int

The long-term effects of the pandemic are equally alarming. According to a World Bank survey in Tanzania, children who become maternal orphans before the age of 15 are 2cm shorter in adulthood than children whose mothers did not die, and those affected by maternal and paternal orphanhood achieve substantially lower education attainment. The younger the child at the age of becoming an orphan, the less likely that child is to advance in school (Beegle et al: 2005). Children are often robbed of their childhood, as they must care for their ailing parents before they die (Richter et al: 2004). The emotional scars of dealing with such a loss, as well as the likely inheritance of responsibility for siblings, are tremendous (UNAIDS: 2006).

Orphans and child-headed households face a disproportionate level of social exclusion from society (Barnett & Whiteside: 2002, Nattrass: 2004). Resources in an AIDS-affected household tend to be limited and decrease further once the productive member of the family dies. As a result, these households tend to be poorer, consume less food, and have less disposable income, if any. Children from these households tend to be less well nourished, and are more susceptible to nutrition-related conditions such as stunting and wasting, both of which have long-term and irreversible effects (Barnett & Whiteside 2002).

Without protection or financial support from their families, orphans are often forced out of school and are therefore much more likely than non-orphans to be exploited as labourers in the commercial agricultural sector or domestic service, street vending or the sex industry. There is a growing consensus that education is pivotal in improving the lives and future prospects of children orphaned or made vulnerable by HIV/AIDS (Gulaid: 2004)

An estimated 34 percent of girls and 37 percent of boys between the ages of five and 14 years are engaged in child labour activities in sub-Saharan Africa. Some 47 percent of children working as prostitutes in Zambia were found to be double orphans, while 24 percent were single orphans. (UNICEF: 2005). The reaction of families and communities to the plight of orphans and vulnerable children has been compassionate and remarkably

resilient. However, they are struggling under the strain. To date few resources are reaching families and communities that are providing frontline response, and little attention is given to orphans and vulnerable children in most national agendas in developing countries. Moreover, donors have yet to put forth comprehensive programmes on this issue. Responding to the crisis of children affected by HIV/AIDS is clearly not yet seen as a global priority (D'Allesandro: 2006).

Whiteside & Erskine (2002) note that with the number of AIDS cases and deaths, with consequential social economic and political impacts certain to rise, providing care for the millions of affected and infected orphans and vulnerable children should be of central importance. They noted that there is little evidence that governments or civil society in developing countries are planning for the future, although this could easily be because they are overwhelmed by immediate challenges.

The following table shows the number of orphans and vulnerable children in southern Africa as a result of losing one or both parents.

Table 1: Children orphaned by AIDS versus all orphans

	Children orphaned by AIDS Aged 0-17 (000s)*	Orphans due to all causes Aged 0-17 (000s)*	Total human population (million)**
Botswana	120	160	1.8
Lesotho	100	180	1.8
Malawi	500	1000	12.3
Mozambique	470	1500	19.1
Namibia	57	120	2
South Africa	1100	2200	46.9
Swaziland	65	100	1
Zambia	630	1100	11.3
Zimbabwe	980	1300	12.9

*Estimates from 2003 reflect children who had lost one or both parents. *The State of the World Children 2006, UNICEF.*
*** UNDP Human Development Report 2005.*

Governments with significant populations of orphans and vulnerable children face a barrage of issues, including a surging population of street children; a rise in child labour, child prostitution and other forms of exploitative work; vulnerability to crime, militias and terrorist organisations; a growing population of uneducated and unskilled labourers; and long-term dependence on foreign aid (Salaam:2005).

Because orphans are deprived of an education, they miss normal socialisation with their peers and they are less likely to break free from the shackles of poverty. They become trapped in a vicious cycle. Growing up with fewer assets than non-orphans, no formal education, and often deprived of access to basic services, the orphaned adult stands little chance of improving his or her economic position or social standing. Education is the crucial safety net for an orphan's future: it is the key to the job market and other opportunities that can generate income (www.avert.org, HIV/AIDS and Education). However, orphans cared for by extended families are likely to be the first to be pulled out of school when the families cannot afford to educate all the children of the household. This inability can be a major factor in deciding whether the extended family will 'adopt' children who are orphaned by AIDS (ibid).

Some commentators believe that orphans do not necessarily face more vulnerability than non-orphans. The 2004 meta-analysis from Tulane University (Rivers et al: 2004), for example, examined orphans, food security and nutrition status, and concluded that there was no consistent evidence that orphans are more vulnerable than non-orphans in terms of nutrition status. A report by the International Food Policy Review Institute (2005), while acknowledging the Tulane findings, cites other studies (from Tanzania, Zambia and Uganda) with evidence to the contrary, and suggests that stunting is affected and that the type of orphanhood is significant (i.e., maternal vs. paternal vs. double orphanhood), as are the child's specific living/family arrangements.

The 2005 UNICEF survey from Zimbabwe finds that "orphans, particularly maternal orphans, were more likely to be stunted than non-orphans", contrary to the Tulane findings. In contrast, a study in Kenya (Lindblade: 2003) found that although maternal

orphans face a greater health risk because of the loss of their primary caregiver, children who lost only a father were more likely to be malnourished than non-orphans, raising the strong possibility that the loss of either parent has severe repercussions for a child.

In terms of food security, the Tulane study found generally that while households with one orphan do not appear to be any less food secure than non-orphan households; one of the Tulane case studies (Blantyre, Malawi) showed that in households that host more than one orphan, "food insecurity and child hunger" were significantly greater.

D'Allesandro (2006) notes that millions of dollars have been promised by donor governments to support people affected by HIV/AIDS in developing countries, but failure to keep these commitments, funding bottlenecks, and a lack of focus on supporting children in their families and communities means the money has not reached many of those most in need. According to the 2005 UNAIDS Global Task Team, it will cost an estimated US$6.4 billion, or 12 percent of the total resources needed over the next three years to address HIV/AIDS, to support children living in families with the virus or orphaned by the pandemic. Only the US, UK and Ireland have committed funding for this purpose (ibid).

Despite the broken promises and problems associated with funding, the apocalyptic forecasts of orphan numbers, and the increasing number of people becoming infected with the virus, communities continue to survive. One reason suggested by Scott (2003) is that the international community and even governments in the region continually underestimate the role played by traditional coping strategies in communities, primarily because they are so poorly understood by outsiders. These realities will be examined in more detail in Chapters 3 and 4.

However, given the impact and scale of the HIV/AIDS pandemic in southern Africa, few would argue that traditional coping strategies alone can help communities overcome the challenges. Devereux and Sabates-Wheeler (2004) suggest that vulnerability and poverty should be considered as social and economic deprivations that require an engagement in

social protection to bolster vulnerable and marginalised groups, like those suffering the effects of HIV/AIDS.

In her paper, delivered to the Wilton Park Conference, on Strengthening National Responses to Children Affected by HIV/AIDS: What is the Role of the State and Social Welfare in Africa? Green (2005) argued that continually boosting informal (community-based) social safety nets and expecting them to be able to support increasingly vulnerable households is only increasing the burden on them to perform in a climate where their capacity is already stretched. In her conclusion, Green (2005) calls for a rethink of the way aid agencies do business within the HIV/AIDS paradigm.

A community's coping ability is often intertwined with, and underpinned by, traditional and state-provided structures, such as community services, education, and the healthcare sector. However, because these sectors are among the worst affected by HIV/AIDS and professional 'brain drain', southern African countries are losing more key personnel than they can replace through education and training. (Barnett & Whiteside: 2002, Fourie & Schönteich: 2001). Once this infrastructure is weakened, orphans and vulnerable children lose yet another stabilising pillar from their world.

In addressing issues of risk and vulnerability, the role played by civil society helps to explain the different approaches taken by Lesotho in addressing HIV/AIDS. Evans (1996) recognises that 'state-society synergy' acts as a catalyst for development through the combination of strong public institutions and organised communities.

Synergistic relationships between the state and local actors are endorsed by Ostrom (2000), who argues that government agents can strongly affect the level and type of social capital that is available for sustainable development efforts. However, for this 'top down/bottom up' approach to be successful, the style of government is critical in determining the outcomes of the interaction[33].

[33] Inspired from work by Goldin (2005) in the water sector but it remains highly relevant within the context of the debate presented here.

Lesotho

It will become clear by the end of this dissertation that Lesotho must overcome a host of challenges if it is to get a handle on the HIV/AIDS epidemic. Casual sex remains commonplace, for example, and condom use is infrequent[34]. Two-thirds of men and one-third of women say they have had sex with someone other than their long-term partner in the past year; fewer than half of them used a condom during the encounter (UNAIDS: 2006).

Recent steps to ease the strain on those affected include the government's passing by Parliament of the Legal Capacity Married Persons Bill in November 2006, which was first drafted in 2000. The Bill received royal ascension in December and once it is gazetted, it will become law. The Bill addresses a whole host of issues, some of which will be discussed later in the dissertation, but perhaps the most important is that it enables Basotho women for the first time to own land, receive inheritance, and be liberated from centuries of culturally patriarchal control.

The other major of piece of legislation the National Policy on Orphans and Vulnerable Children, expected to bring sweeping changes once it enters into law sometime in the first quarter of 2007. The policy, which will cost about US$1.3 million a year over a five-year period, aims to provide orphans and vulnerable children with free education, health services, sports and recreation facilities; and to set up small-scale businesses to make the children and their caregivers economically self-sufficient. The policy is expected to better coordinate other interventions for orphans and vulnerable children; and, most importantly, to monitor existing programmes to ensure that they are providing quality services and targeting those most in need.

Prior to this bill, there was a very weak legal framework to protect such children. Instead, they were protected by the Child Protection Act, which was so skeletal in content, and so rarely invoked, that it was deemed redundant by child protection advocates[35]. The National Policy on Orphans and Vulnerable Children also addresses intra-country

[34] Freudenthal (2001) puts forward a number of additional factors driving the spread of HIV/AIDS.
[35] Revealed during interview with UNICEF child protection officer in Lesotho.

adoptions, protection of inheritance laws, and restorative justice for children. However, NGOs hastened to add, one of the major challenges will be the policy's implementation and enforcement, as well as ensuring that people in remote areas know they can be prosecuted for exploiting children -- or, to put it another way, they can be prosecuted for treating children the way children have always been treated.

It should be noted that Lesotho signed the United Nations Convention on the Rights of the Child in August 1990, and then ratified it in March 1992, but did not sign the annexes that govern child abuse and sexual exploitation, among other important child protection recommendations, until November 2001. Given this pace of commitment, it is plausible that the National Policy on Orphans and Vulnerable Children will not be passed within the expected timeframe. Lesotho has had 15 years to put in place national legislation to strengthen the rights of the child following the signing of the Convention on the Rights of the Child in 1992 even though the convention is founded on varied legal systems and cultural traditions to allow for its easy adoption by different national structures.

Lesotho is also formulating an Action Programme on the Elimination of Child Labour, with the assistance of the ILO programme, Towards the Elimination of the Worst Forms of Child Labour. A programme advisory committee on child labour, representing government departments, organised labour and business, and civil society, guides the development and implementation of the programme. Underpinning this process are the ILO Minimum Age Convention (C138) and the ILO Worst Forms of Child Labour Convention (C182) which Lesotho ratified in 2001. Lesotho has also signed the African Charter on the Rights and Welfare of the Child in 1990. Therefore, one could argue that the regulatory framework exists for better protection of orphans and vulnerable children, yet they appear to be more exposed than any other group in the country.

Conclusion

This chapter examines the multifaceted aspects of HIV/AIDS, the worst pandemic to ever hit the human race in recorded history (Ainsworth: 2002, Barnett & Whiteside: 2002). While extensive research has been conducted on all aspects of the pandemic,

incorporating research findings into policy and programmatic response remains problematic (Setswe: 2005, 2006, Ekambaram: 2004, Freudenthal: 2001, Trubo: 2004). Setswe (2005, 2006) in particular argues that this is the case even though few research gaps remain, and therefore civil society and governments have no reason not to have adopted better measures to combat the impact of HIV/AIDS.

In contrast, Freudenthal (2001) and Trubo (2004) argue that important research needs to be explored, such as the impact on minority groups, the protection of young people and future generations, healthcare research, and the social and economic consequences of HIV/AIDS. However, these gaps do not explain the lack of acquiescence by government, civil society and donors to research findings and Freudenthal's (2001) critique that there is dissonance in the way research, policy and implementation interact.

Cohen (2002) takes up the argument that labour unions, governments and employers are not embarking on multisectoral campaigns that encompass labour and industry-related problems in sectors other than the health sector. According to Cohen (2002), the health sector gets a disproportionate amount of attention while other sectors that are equally affected by the pandemic receive very little support. Cohen's argument depends on better intra-governmental relations, an area of government that is problematic because it relies on complex intra-government adoption of strategies for the common good that may not always be in line with the outlooks of individual ministries. The resistance by individual ministries in Lesotho to fully embracing all facets of decentralisation was touched upon in the introduction of this dissertation.

The incoherence between policy and implementation is also evident in discussions around the economic impact of HIV/AIDS. The ILO (2004) noted that the economic consequences on government are significant, with the two worst HIV/AIDS-affected countries in the world, Swaziland and Botswana, experiencing an estimated 3 percent decline in GDP between 1992 and 2002. Lesotho is the third worst affected country and therefore the economic impact on GDP could be expected to be approximately the same.

Despite the evidence of such a stark economic impact, government responses are insufficient to mitigate this crisis. In human terms, the toll of HIV/AIDS is proving disastrous for countries with high prevalence rates. This point has been adequately examined in the introduction of this dissertation but it was well backed up by the theoretical writings reflected in the literature review, such as: failing life expectancy, rising unemployment, elusive food security; and the decline of institutions that provide healthcare, education, and social services. These key areas need to be addressed to mitigate the impact of the pandemic (Nattrass: 2004, Barnett & Whiteside: 2002, Gulaid: 2004, Salaam: 2005, Richter et al: 2004).

The human legacy is also felt across the employment sector, which is discussed in more detail in Chapters 3 and 4. The most critical area of concern, particularly for this dissertation, is the impact on orphans and vulnerable children, and the failure or inadequacy of social safety nets to support communities.

While effective and appropriately scaled state interventions to support people and communities affected by HIV/AIDS are beyond the economic and human capacity of most developing countries (Hoogeveen et al: 2003), Lesotho has recently taken significant policy steps by approving the Legal Capacity Married Persons Bill and a National Policy on Orphans and Vulnerable Children, both of which should pass the final approval hurdles within the first quarter of 2007. These documents set out a legal framework to protect both groups from discriminatory practices, some of which are cultural and engrained in Basotho traditions.

However, the same problem of gaps between knowledge and policy change is apparent, and the delay with which policy follows awareness or knowledge on this matter is highly problematic. Government's responses to combating poverty and vulnerability are critical because the links between poverty and vulnerability are inextricable, particularly if the household is affected by HIV/AIDS and is supporting orphans and vulnerable children (Harvey: 2004, De Waal & Whiteside: 2003, Hoogevan: 2003).

It has been established in this chapter that while an orphan is not necessarily more vulnerable than a non-orphaned child (Rivers et al: 2004), the orphan stands a much greater chance of being stunted if the mother has died and of being adversely impacted by specific living/family arrangements (IFPRI: 2005). Research has shown, for instance, that maternal orphans can also be up to two centimetres shorter at age 15 than their non-orphaned counterparts (Beegle et al: 2005), and they are more likely to be exploited (Gulaid: 2004). Nearly half of all children working as prostitutes in Zambia were found to be double orphans (UNICEFc: 2005). Salaam (2005) goes further. arguing that governments with significant populations of orphans and vulnerable children face a barrage of issues, including increasing numbers of street children, a rise in child labour, child prostitution and other forms of exploitive work, vulnerability to crime, a growing population of uneducated and unskilled labour, and long-term foreign aid dependence. In addition, children are often robbed of their childhood as they are forced to care for ailing parents before they die, leaving a traumatised generation that may also have to contend with supporting siblings (Richter et al: 2004). The psycho-social repercussions are immense, augmented by stigma and social exclusion, particularly from higher education (www.avert.org, Barnett & Whiteside: 2002).

Donors prefer to follow their own agenda; for assistance, they show a preference for 'dictating' programmatic responses (Hachonda: 2005). Richter et al (2005) argue that donors have no consistency in approach, with programmes that are often too tiny in proportion to the need. The donor community argues that one of the reasons for taking this approach is because recipient governments rarely have the capacity to implement large-scale projects, nor do they have the systems in place to ensure transparency[36].

Despite the enormity of these problems, the apocalyptic forecasts of orphan numbers and the increasing number of people becoming infected with the virus, communities continue to survive. Scott (2003) posits that the role played by traditional community coping strategies are underestimated, primarily because they are so poorly understood by

[36] Seminar report, Hilton Hotel, Addis Ababa, Ethiopia, 9 and 10 September, 2005. HIV/AIDS and Human Security: An Agenda for Africa.

outsiders. Traditional coping strategies are examined more closely in Chapter 4 but community-driven interventions that act as social safety nets are central to responding to the virus. Programmatic responses must strengthen pre-existing community coping strategies, rather than supplant them (Devereux: 2002, Desmond et al: 2002, Subbaroa et al: 2001).

Another problem is that social safety nets are often viewed as social welfare strategies and as such are considered to be the responsibility of the affected government and not the donor community. Donors view such strategies as unaffordable luxuries for poor countries (Devereux: 2002), although it has been shown that even tiny transfers for income-generating projects have been proven to play an important role in reducing chronic poverty (ibid), and this is particularly relevant within the HIV/AIDS context.

This chapter has shown that when support systems are not in place or are overburdened, as is the case for much of southern Africa, then orphans, vulnerable children and their households start heading towards deeper deprivation and 'breaking point' (D'Allesandro: 2006 -- one of the themes repeated throughout this dissertation. The first stage of crisis is when parents or guardians remove children from school so they can be put to work in piecemeal jobs. Families reduce meals, sell assets and consume higher amounts of wild foods. The second stage of crisis is categorised as a breaking point because the consequences are far riskier and often irreversible. This stage includes prostitution, migration, the abandonment or sale of children and the early marrying-off of girls, although many of these practices are highly stigmatised and not openly talked about (Nattrass: 2004, Barnett & Whiteside: 2002, Salaam: 2005, Richter et al: 2004). The consequences of these breaking points were outlined in four case studies presented here involving street children in Ethiopia, Zimbabwe, Zambia. In such cases, the deprivation of formal education has devastating effects on the orphan's future and therefore its role cannot be underestimated: it forms a pivotal support mechanism for the affected children (www.avert.org). Many of the themes discussed in this chapter will be scrutinised in the next two chapters, which examine more closely the relevance of theoretical outlines to empirical findings at the national, district and community level in Lesotho.

Chapter 3
HIV/AIDS, Orphans and Attitudes to Sex

Introduction

This chapter explores in detail attitudes towards sex, HIV/AIDS, and problems impacting orphans and vulnerable children. Information has been sourced from a target population of mostly adolescent children. The research was conducted at a high school in Quthing that has more than 700 learners, one-third of whom are either single or double orphans, according to the principal.

This part of the research project was unplanned at the outset of the thesis. It came about as a spontaneous response to a request by the principal of a school, who was one of the key informants for this research component of the project. During the interview, the respondent expressed his concern about the rising number of young people becoming infected with the virus. In particular, he was keen to gauge the successes and failures of information given to the learners about HIV/AIDS as well as to gauge the moral fortitude of his learners in the face of the pandemic in the school's district. The principal also expressed concern about the number of pregnant female learners at his institution.

The suggestion of a survey was an excellent fit with the dissertation, as it offered an opportunity to delve into the psyche of adolescents, their sexual attitudes and behavioural patterns. It also offered a unique opportunity to strengthen the research contained in this dissertation by giving valuable insight into the lives of the people most affected by HIV/AIDS. Of all the people in the community, learners have the greatest access to information about the virus through the school and the community, and are arguably more open to the idea of using contraception, as opposed to married men and women, who may feel they are revealing their extramarital intentions by trying to obtain condoms from a public source.

The high school is a strong advocate of HIV/AIDS awareness. A 20-foot-tall red AIDS ribbon, painted on the side of a classroom, is clear to all who enter the school grounds. According to the principal and other respondents interviewed during the research, learners routinely discuss issues related to HIV/AIDS within the classroom environment. The principal has been head of the school since 2003, although he has taught there since 2000. He was well informed regarding matters that face the learners on a day-to-day basis in their communities and in the district as a whole.

Some 210 girls board at the school and 80 of these are double orphans. The principal estimates that there are probably 700 to 800 additional double orphans in the surrounding communities who would want to come to his school if the facilities and funding were available. Boy learners cannot board at the school because there are not adequate facilities to house both sexes separately. There is a growing demand for accommodation to house both girls and boys, and to house orphans as well as non-orphan learners.

The United Nations World Food Programme (WFP) supports the school by providing food for one meal per day per learner, and those who board at the school are given additional meals that are sponsored by a number of agencies. There is considerable pressure on the principal to expand boarding facilities given the increased incidence of sexual harassment of girls in the villages during the night. The burden on the school is already considerable and it is difficult for the principal to meet the growing needs placed on it because of HIV/AIDS and poverty. In the third quarter of 2006, the principal organised a fundraising event to purchase shoes, blankets and school uniforms for the learners who were most in need.

There is increasing pressure on the school to fill a gap in providing for learners. Caregivers, including the state, are unable to provide enough assistance. Although the state has announced its intention to make secondary education free for double orphans in 2007[37], at the time of writing this thesis it was unclear not only whether this would go ahead but also how the state would be able to provide for the expected avalanche of

[37] Ministry of Education interview, corroborated by UNICEF and district administrator

learners who would need this subsidy. Class sizes are already huge, with up to 87 learners per class. Although there are 23 educators at the school, 17 are paid for by the state while the wages of the others come from school fees. The school already needs an additional seven teachers, more classrooms, and boarding facilities, but the source of funding for this is not known.

A number of concerns were raised by the principal and it was deemed pertinent to incorporate these into the questionnaire, the results of which are examined in the analysis that follows in this chapter. The main concerns raised by the principal include the fact that: almost everyone in Quthing is touched by the virus in some way; few learners heed warnings around the spread of HIV/AIDS; few learners abstain from sex or use condoms during intercourse; the girl child is most affected with girls from the school found in bars selling sex in exchange for luxury items like make up, perfume or shoes; sex is exchanged for rewards as small as 'a coke' or transport; learners are becoming increasingly uncontrollable due to the breakdown of the family structure; there are four to five funerals of students' parents per month; children often nurse their ailing parents waiting until they are double orphans before applying for a school scholarship; the girl child does not adequately understand the consequences of pregnancy with an average of nearly one girl falling pregnant each month; the community at large does not play a role in reinforcing messaging to learners about sexual responsibility.

Only some of these concerns were incorporated as themes into the questionnaire, due to the limited amount of time available to put the survey together and to allow the students in class to complete it. Other issues raised in the questionnaire are discussed in more detail in the next chapter. This chapter examines responses from 120 questionnaires that were administered to the learners. However, because exams were taking place at the time, individual teachers committed themselves to distributing the questionnaires at suitable times during the course of the day. At the request of the principal, neither the researcher nor the translator was present during the administration of the questionnaire, to create a minimum of disruption at this critical time. However, the following information was included at the top of the questionnaire:

> "This research questionnaire is designed to better understand how people in Quthing are coping with illness and poverty associated with HIV/AIDS, particularly orphans and vulnerable children. The information gained from answers will hopefully help to design better programmes to aid orphans and vulnerable children and their caregivers. It will also aid university work in Johannesburg.
>
> "I therefore wish to invite your participation into this study. However, you will not be penalised for not participating. You may withdraw from the study at any time since participation is voluntary. The study will be confidential. This means the information you give will be written down and will not be shared with anyone else."

It was evident from learner responses that there was some error in the completion process: questions were not always completely understood. However, the data remains extremely useful and informs this study.

This chapter is divided into three subsections: methodology, results, and analysis. The methodology will explain the questionnaire and data capturing process; the results section will be self-explanatory; and the analysis will review the responses to inform the dissertation.

Methodology

The questionnaire and question setting: The questionnaire consisted of 22 open-ended and closed questions. Closed questions, in this case, prompted a Yes or No answer, whereas open questions provided for texts or narratives to expand on the response category, or they provided an opportunity to respond to a question in an open-ended way. For the purposes of the analysis, open and closed questions were captured separately, for example:

Question 3.1: Are you afraid of AIDS (closed)
Question 3.2: Why are you afraid? (open)

Standardisation and data capture: For the purposes of this analysis, open-ended questions were coded and general trends were categorised. In cases where respondents either did not answer questions at all or the responses provided were misinterpreted,

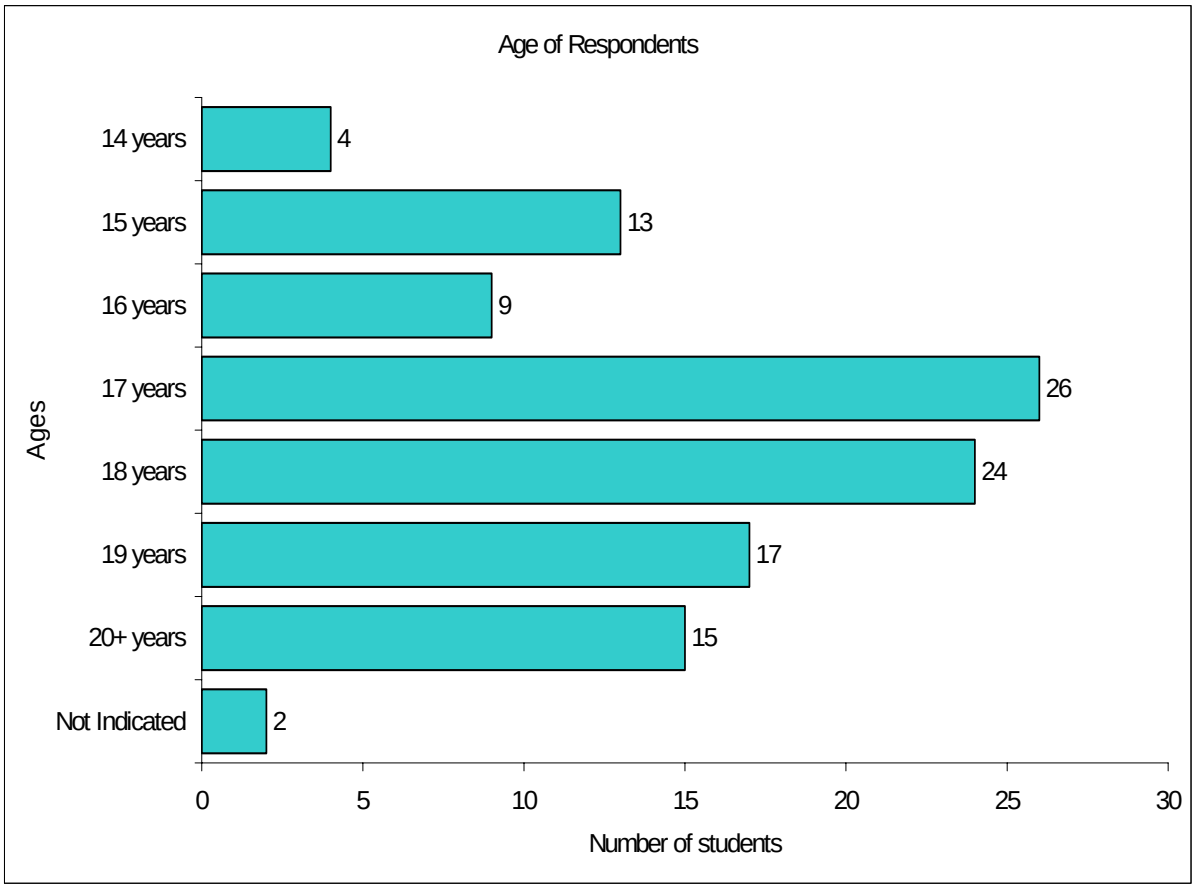
values 0 (missing value) and 999 (invalid response) were given. The data from the survey were divided into quantitative and qualitative sections. Quantitative data consisted in the main of closed questions (Yes/No answers) and qualitative data were collected from the open-ended questions. The calculation of percentages in the quantitative fields was derived from the Yes and No response categories. Data was captured using Microsoft Excel. More detailed analysis incorporates per age cohorts or gender of respondents.

Data validity and reliability: Despite individual irregularities in the data – such as two or three learners possibly copying the same answer – group variations were picked up. Answers were very similar in 60 percent of the survey questionnaires. This could be accounted for by the possibility that the learners copied one another's responses; the learners provided socially desirable and 'learnt' responses; or the invigilator (educator) prompted responses. Despite concerns around this issue, the data still reflect trends that merit discussion.

Gender: The gender skew was biased towards female learners (60 percent) with male learners representing only 31 percent of the population, although there were missing values on the gender question for almost 10 percent of learners. Despite these missing values, there was quite evidently a female gender bias in the targeted population.

Age: Figure 3 illustrates the number of learners per age cohort. Just under half of the learners were aged between 17 and 18 years (n=26 and n=24). Ages 15, 19 and 20+ were more or less equally represented (n=13, n=17 and n=15 respectively). Only four learners were 14 years old, while nine were 16 years old. Since more than 70 percent of learners were aged 17 years and above, those aged 16 and younger would be under-represented in the sample.

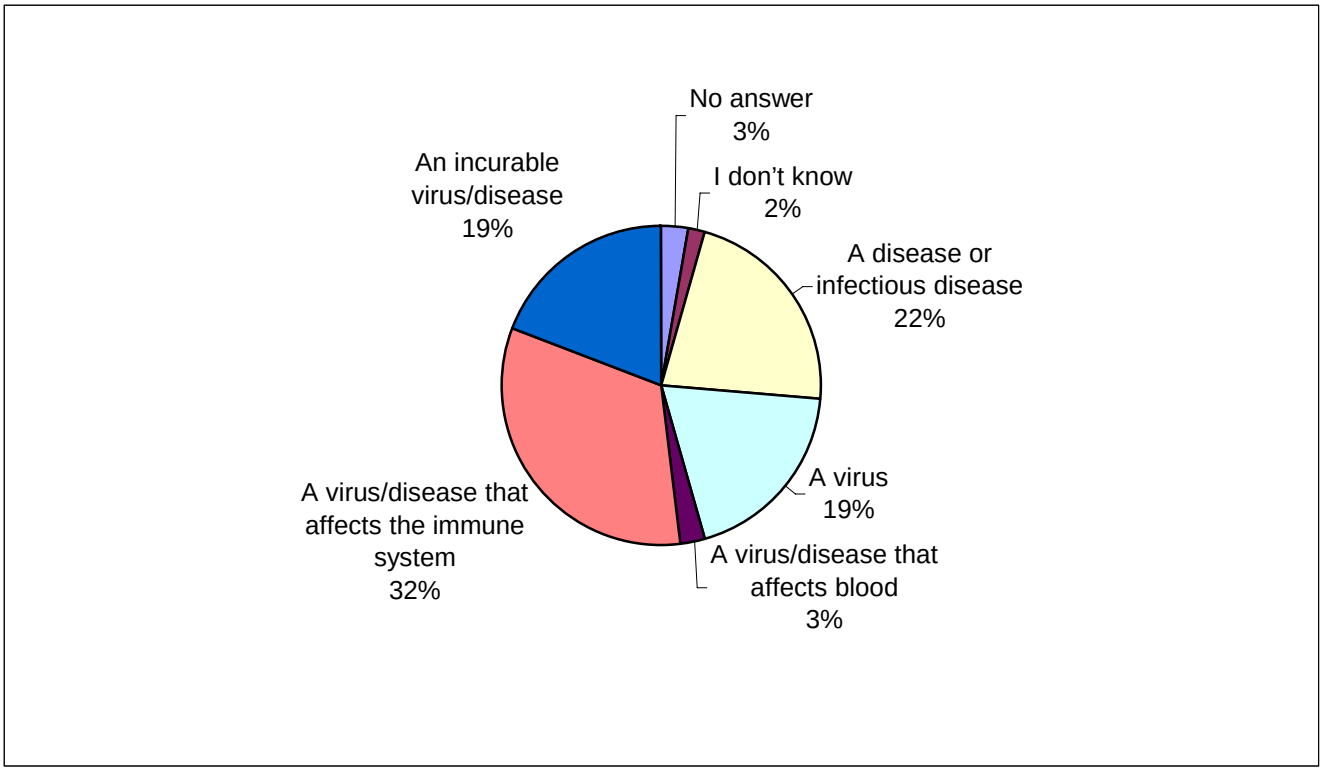
Figure 3. The number of learners in the sample per age class.



Results

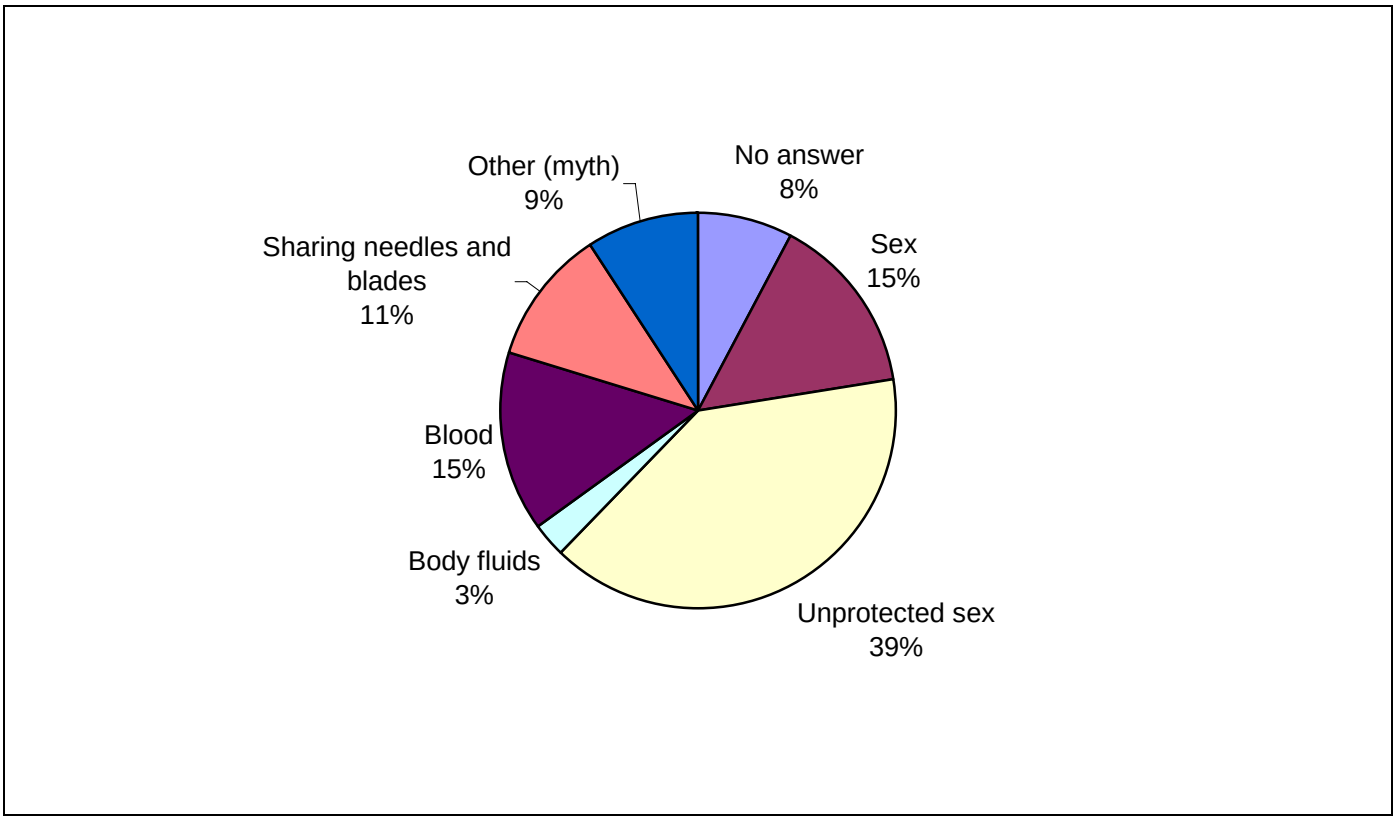
In the first question, learners were asked what they thought HIV/AIDS is and how it spreads (Figure 4). For the first part of the question, 32 percent of learners knew that HIV/AIDS is a virus or disease that affects the immune system. Three percent associated HIV/AIDS with a virus or disease that affects the blood system, while 19 percent were at least aware that HIV/AIDS is incurable. Of the remaining answers, 22 percent identified HIV/AIDS as a disease and 19 percent as a virus.

Figure 4. Learners' responses to the question: 'What is HIV/AIDS?'



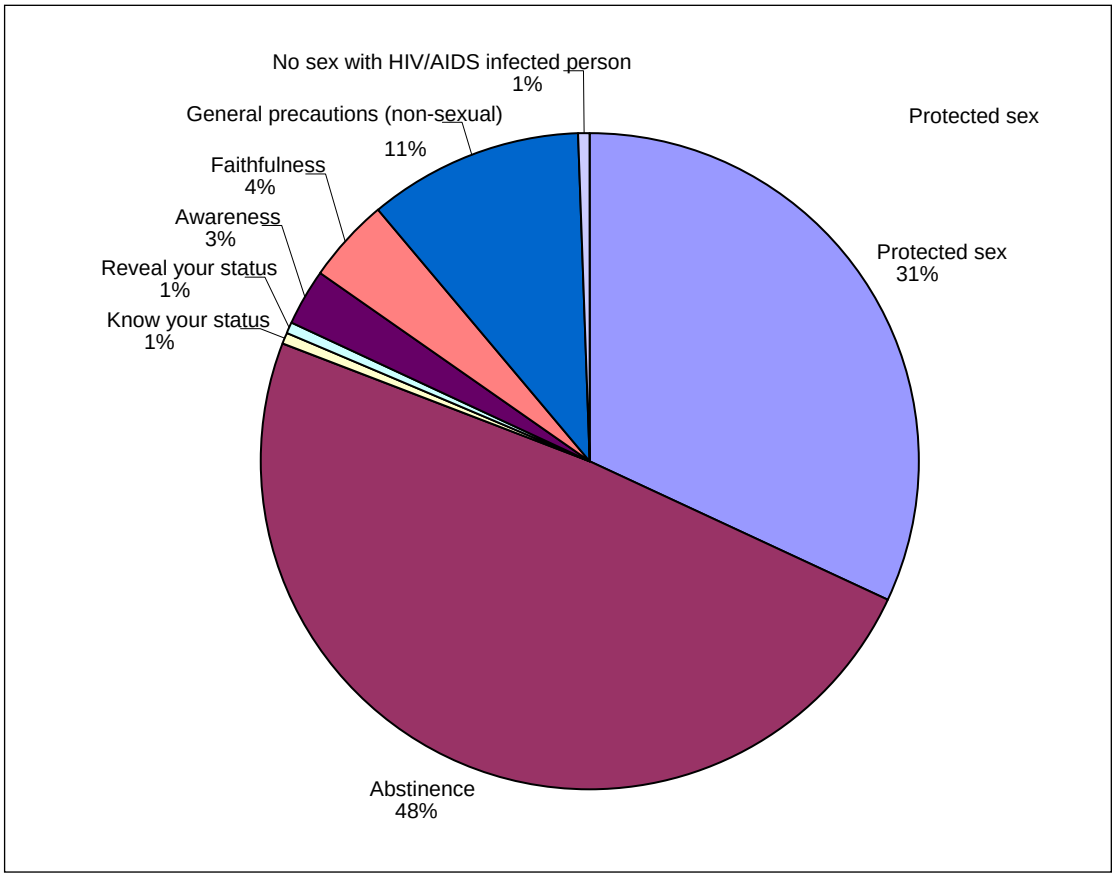
The second part of the question queried the causes of HIV/AIDS, asking how one can contract HIV/AIDS. Figure 5 shows that almost 54 percent of the learners knew that HIV/AIDS could be contracted through sexual intercourse; of those learners, 39 percent specified having unprotected sexual intercourse. Fifteen percent associated HIV/AIDS with blood, either through open wounds or blood transfusion. The sharing of needles, blades and sharp objects constituted 11 percent of answers. Nine percent listed causes that for the purpose of this study have been categorised as 'myths'. Some of these answers include sharing hair clippers, toothbrushes and blankets. Only 3 percent selected the category 'body fluids' as a means of contracting HIV/AIDS. Eight percent did not answer the question.

Figure 5. Learners' responses to: 'How do you catch it?'



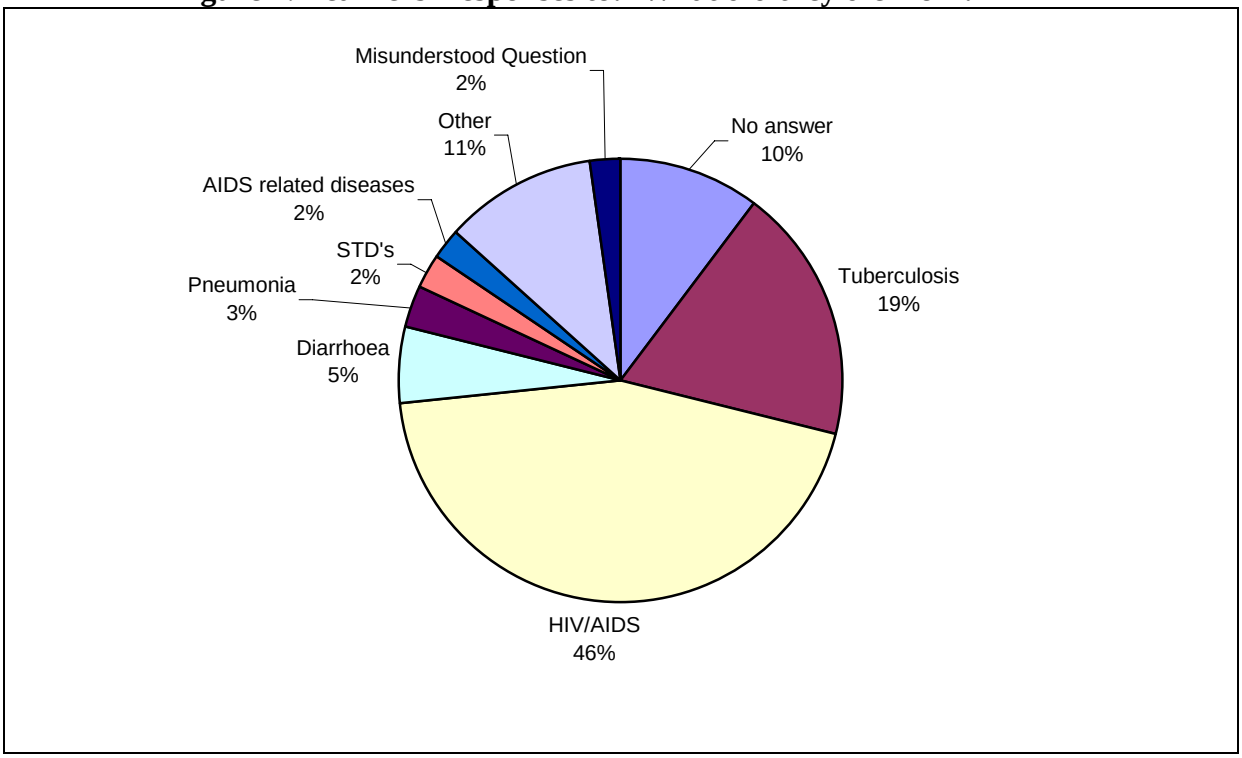
The second question, 'How can someone stop the spread of HIV/AIDS?' (Figure 6), indicates that 48 percent of learners suggest abstinence from sexual intercourse and 31 percent suggest having protected sex (i.e. using a condom). The remaining respondents chose the following response categories: non-sexual, general precautions such as wearing gloves while helping a bleeding person (11 percent); being faithful (4 percent); creating HIV/AIDS awareness through campaigns and workshops (3 percent); not having sexual intercourse with an HIV+ person (1 percent); knowing one's status (1 percent); and telling your partner your status (1 percent).

Figure 6. Learners' responses to: 'How can someone stop the spread of HIV/AIDS?'



When learners were asked if they knew someone who had become ill and died in the last year, nine percent answered yes. Although learners mention a long list of causes (Figure 7), HIV/AIDS is by far the most common cause of death. Forty-six percent of learners knew of someone who had died of HIV/AIDS in the last year, followed by 19 percent who knew someone who had died of TB. Learners also mention diarrhoea (5 percent), pneumonia (3 percent), STI (2 percent) and AIDS-related diseases (2 percent) as the cause of death. In addition, 11 percent of learners knew someone who had died from other causes, such as sugar diabetes, hypertension, cancer, cholera and accidents. Twelve percent of respondents did not answer.

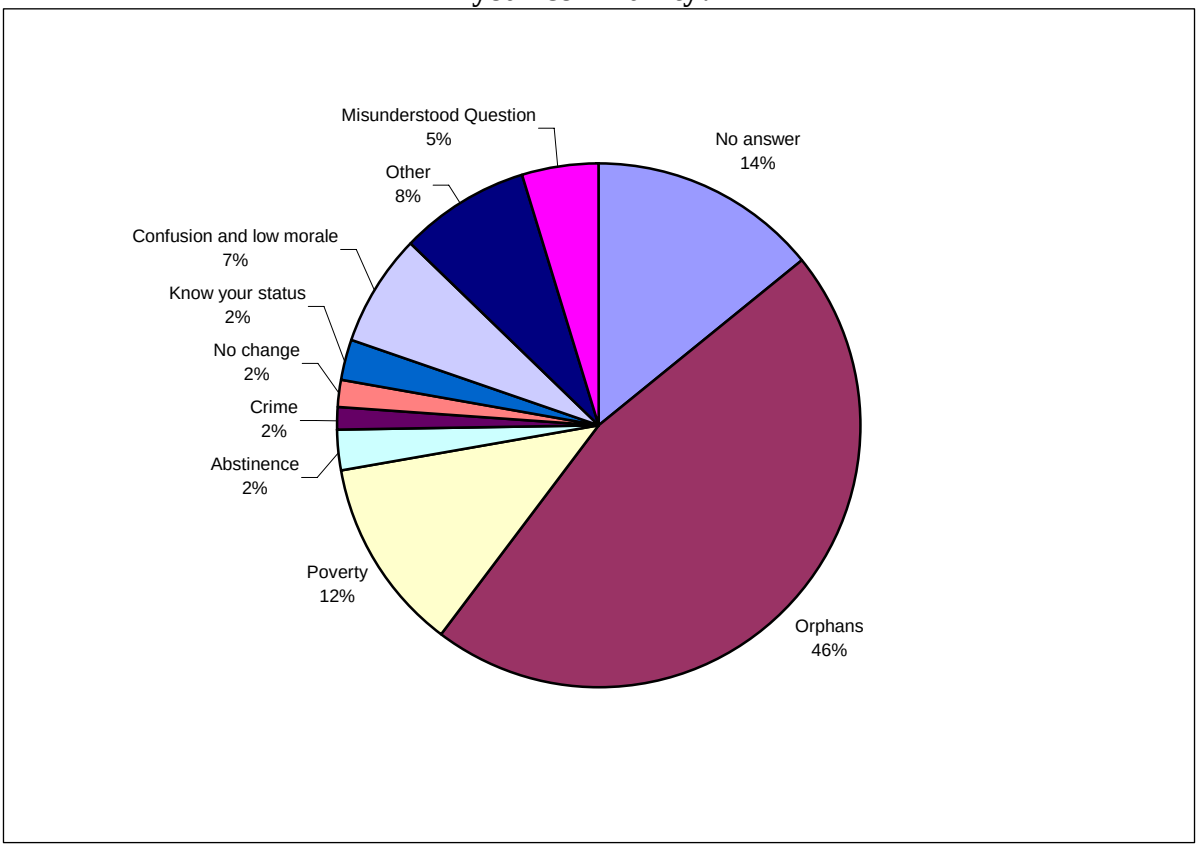
Figure 7. Learners' responses to: 'What did they die from?'



The impact of these deaths on the community was captured in question four (graphically represented in Figure 8). The biggest impact, according to 46 percent of learners, is the increasing number of orphans. The distinction between single and double orphans was not made and only one male learner (Survey 0027) mentioned 'double orphans'. The rising number of orphans leads to an increase in poverty (12 percent of responses) and a couple of respondents mentioned that often these children turn to the streets and engage in criminal activities. One learner commented that because more young people are affected by HIV/AIDS, no one is left to take care of the elderly (Survey 0040). Seven percent of learners indicated that these deaths brought about a feeling of low moral and confusion in the Quthing community, supported by statements such as "We are scared" (Survey 0108). A small percentage of learners feel that these deaths have had a positive impact on the community, as more people are encouraged to get tested and treated (two percent of responses) and are abstaining from sexual intercourse (two percent of responses). Another positive effect cited is that community members now share opinions with each other. Answers such as "The youth is dying and only adults are left" (Survey

0052) were grouped under ‘other responses’ (8 percent of learner responses). Two percent of learners indicated that there had been no changes in the community as a result of these deaths. Nineteen percent of respondents did not answer this question.

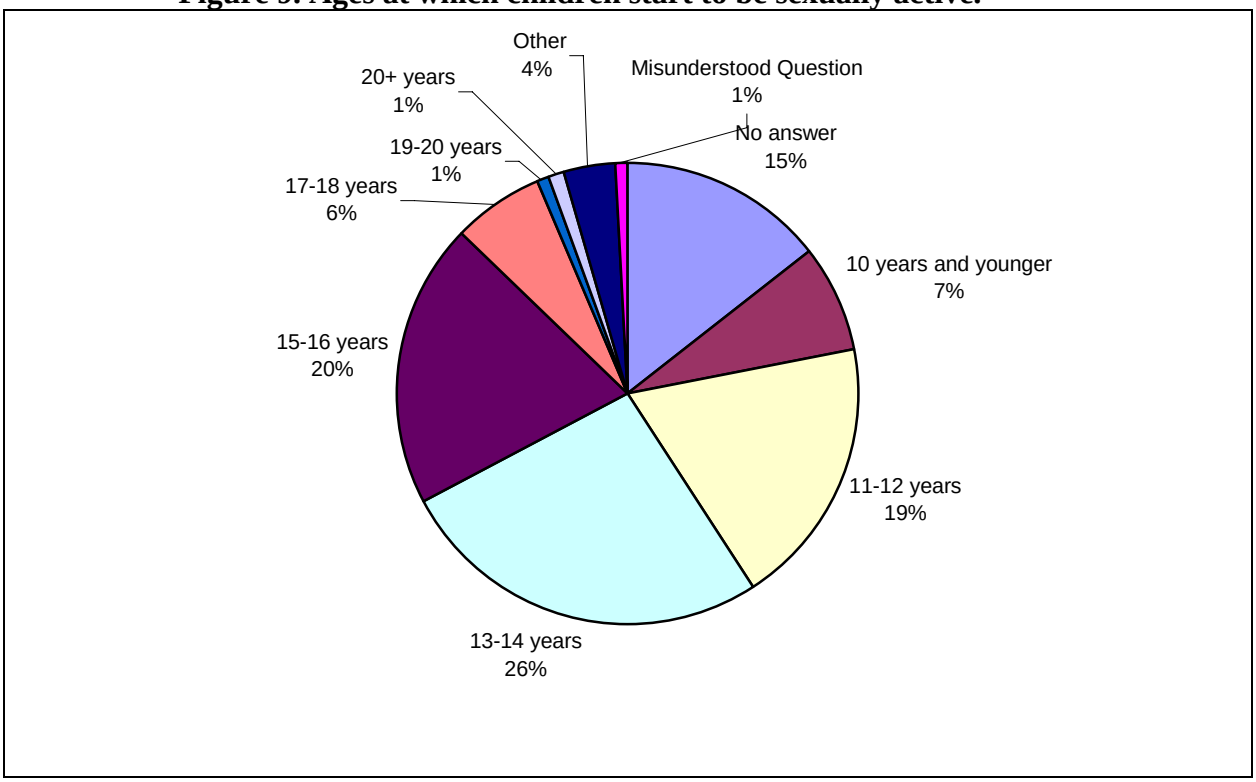
Figure 8. Learners’ responses to: ‘What impact has this death and others had on your community?’



Question five extracted information on the sexual behaviour of Quthing youth. Eighty-one percent answered that some or many of their friends are having sexual intercourse. Only 12 percent did not have any friends engaged in sexual intercourse and 5 percent did not know whether their friends were having sex. The second part of the question revealed the ages at which these children start being sexually active or, in other words, the personal sexual history. Figure 9 shows that the most common occurrence is within the 13-14 year group (26 percent), followed by the 15-16 year group (20 percent) and 11-12 year group (19 percent). The age group 10 years and younger as well as the age group 17-18 years are more or less equally represented, at 7 percent and 6 percent respectively.

Only one percent of learners have friends who started engaging in sexual activities at the age of 19 years and above. Answers such as ‘after marriage’ and ‘from their teens’ make up 8 percent. Fifteen percent of learners did not answer the question, which could indicate they were either too embarrassed to admit having had sex or it was not a pleasurable experience, such as in the case of rape, and they were ashamed to admit it.

Figure 9. Ages at which children start to be sexually active.



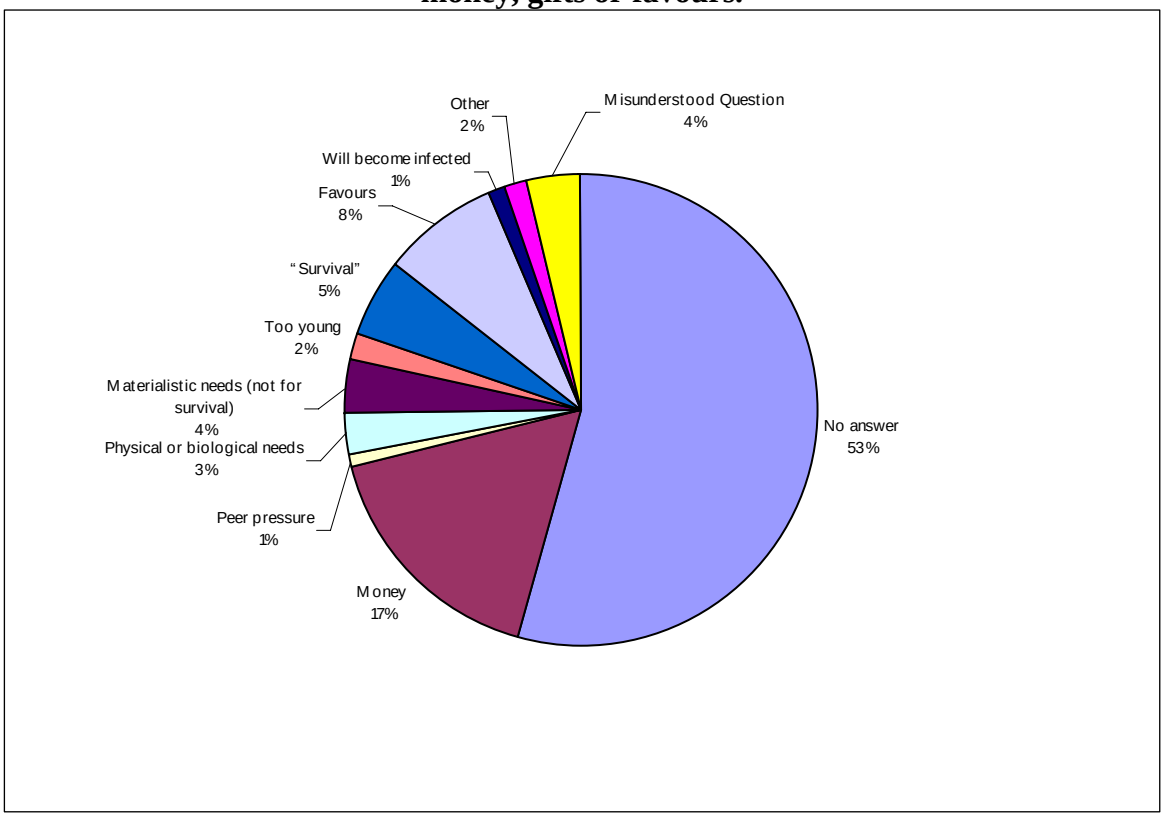
Learners were asked to indicate whether their friends ever have sexual intercourse for money, gifts or favours, and to elaborate. More than 50 percent do not have friends who engage in such activities, while 42 percent do. Three percent of the respondents either did not know the answer or chose not to respond. Fifty-three percent did not provide a reason why their friends were accepting money, gifts or favours for sex. However, of the 43 percent who did respond, 17 percent clearly indicated financial need as the main reason (Figure 10). Sex for favours make up 8 percent, but not enough data is available to comment on the nature of these favours. Five percent felt that their friends did not have any other income and had to satisfy their basic needs through this means (i.e. survival).

Physical or biological needs (3 percent) and peer pressure (1 percent) are given as reasons to engage in sexual activities for compensation.

One example of peer pressure came from an 18-year-old girl who said that her friends have sex in order to "…[entertain] friends and to prevent insults such as being called 'chickens'" (Survey 0052). Having sex for gifts did not seem to feature very prominently; however, a 20-year-old boy did mention that his friends "…have sex for gifts as we are growing up without any idea. We thought that its (sic) a good way" (Survey 0050). This learner admitted that he would have sex for money and gifts, "just to satisfy my feelings".

Only a small number of learners who answered No to the first section of the question provided a reason for their answer (and these were mostly female). Those who did, listed, among others, the fear of HIV/AIDS infection (1 percent) and being too young to have sexual intercourse (2 percent). One learner (Survey 0003) said that it was mostly girls who would have sexual intercourse for compensation; in addition, even though none of his friends were involved in such activities yet, their circumstances would soon force them to be. Four percent did not answer the question. When one scrutinises the responses according to age, clearly more learners aged 15 and younger have fewer friends who have sexual intercourse for money, etc. For those 18 years and older, the opposite is true. Sixteen-year-old learners have more friends who are doing this than those who are 17. Male learners have more friends who are having sex for favours and they are more likely to blame peer pressure and sex drive. Both sexes agree that their friends are primarily doing this for money (both for materialistic and survival reasons).

Figure 10. Learners' responses to why their friend are, or are not, having sex for money, gifts or favours.



The focus of Question 7 was on the learners themselves; the question asks whether they would have sexual intercourse for money, gifts or favours (Figure 11). Figure 11 illustrates that more than 80 percent would not, and they give mainly health risks, including HIV/AIDS, as the reason. Moral issues (13 percent) such as keeping their virginity, religious convictions (4 percent) and being too young to be sexually active were also stated. Four percent of learners wanted to avoid an unwanted pregnancy and 2 percent said they were responsible people and that sex would not solve their problems. One 15-year-old girl responded that she would not involve herself in these activities as "…boys cheat as by [tearing] condoms" (Survey 0015). The 14 percent of learners who would have sexual intercourse for money, gifts or favours would do so because of financial gain (4 percent), social issues such as poverty (13 percent) and to satisfy their physical needs (i.e. sex drive – 5 percent). This last point is explained by comments such as "to satisfy the needs of the body and exercising the body and [mind]" (Survey 0029). More learners aged 15, 16, 17 and 19 indicated that they would not have sexual

intercourse for rewards (money or other) while those aged 18 and 20+ would. Learners in the 14-year group were fairly equally distributed between the Yes and No response category. The majority of female learners would not engage in such activities because of moral and religious issues, being under-aged, fear of unwanted pregnancy and a general sense of responsibility (male learners did not consider the last two reasons). Male learners were more concerned about their sex drive and financial gain. They were also more likely than females to engage in such activities (Figure 12). Both sexes felt that a health risk was involved in having sex for money, gifts or favours.

Figure 11. Responses to: 'Would you consider having sex for money, gifts or favours?'

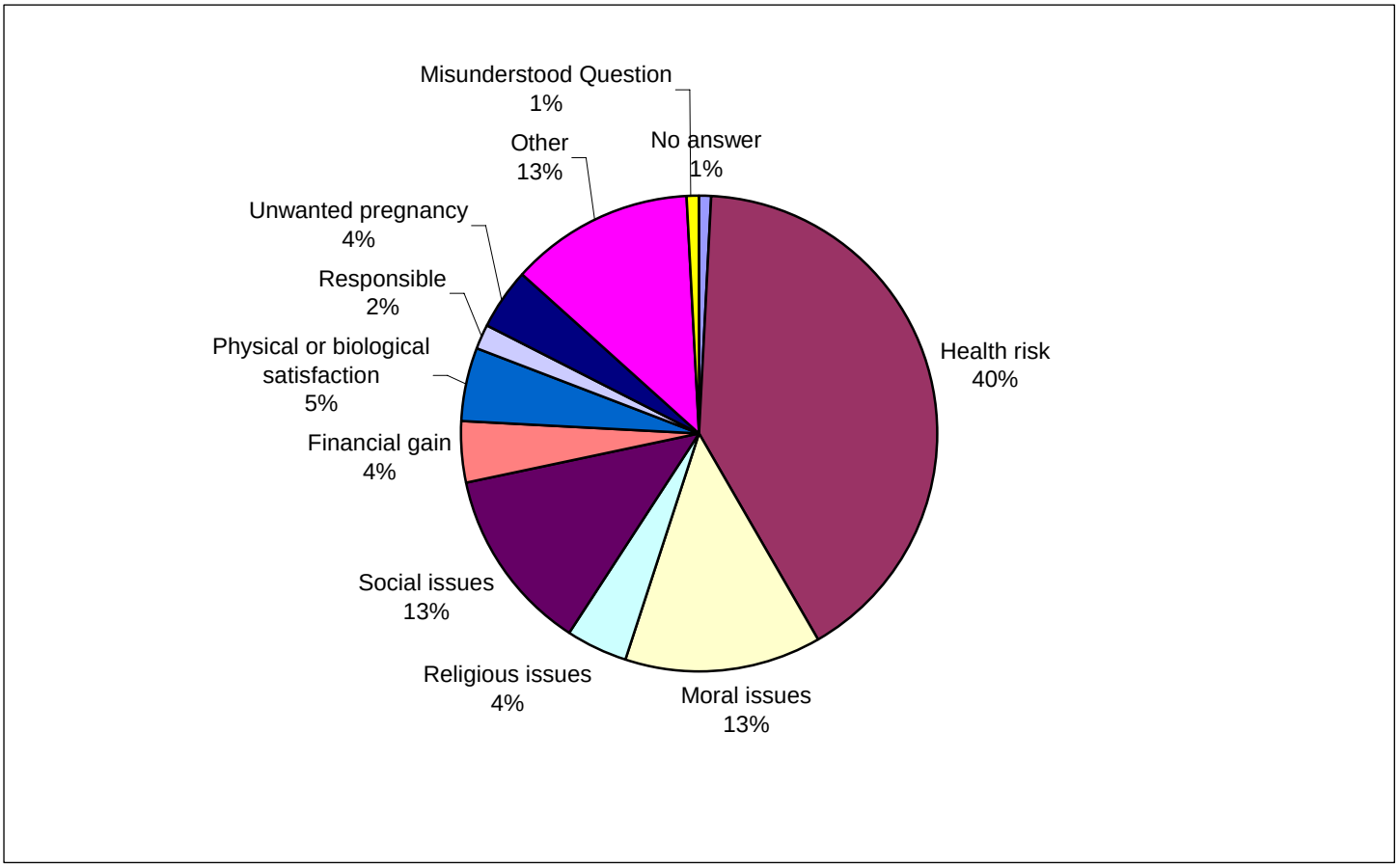
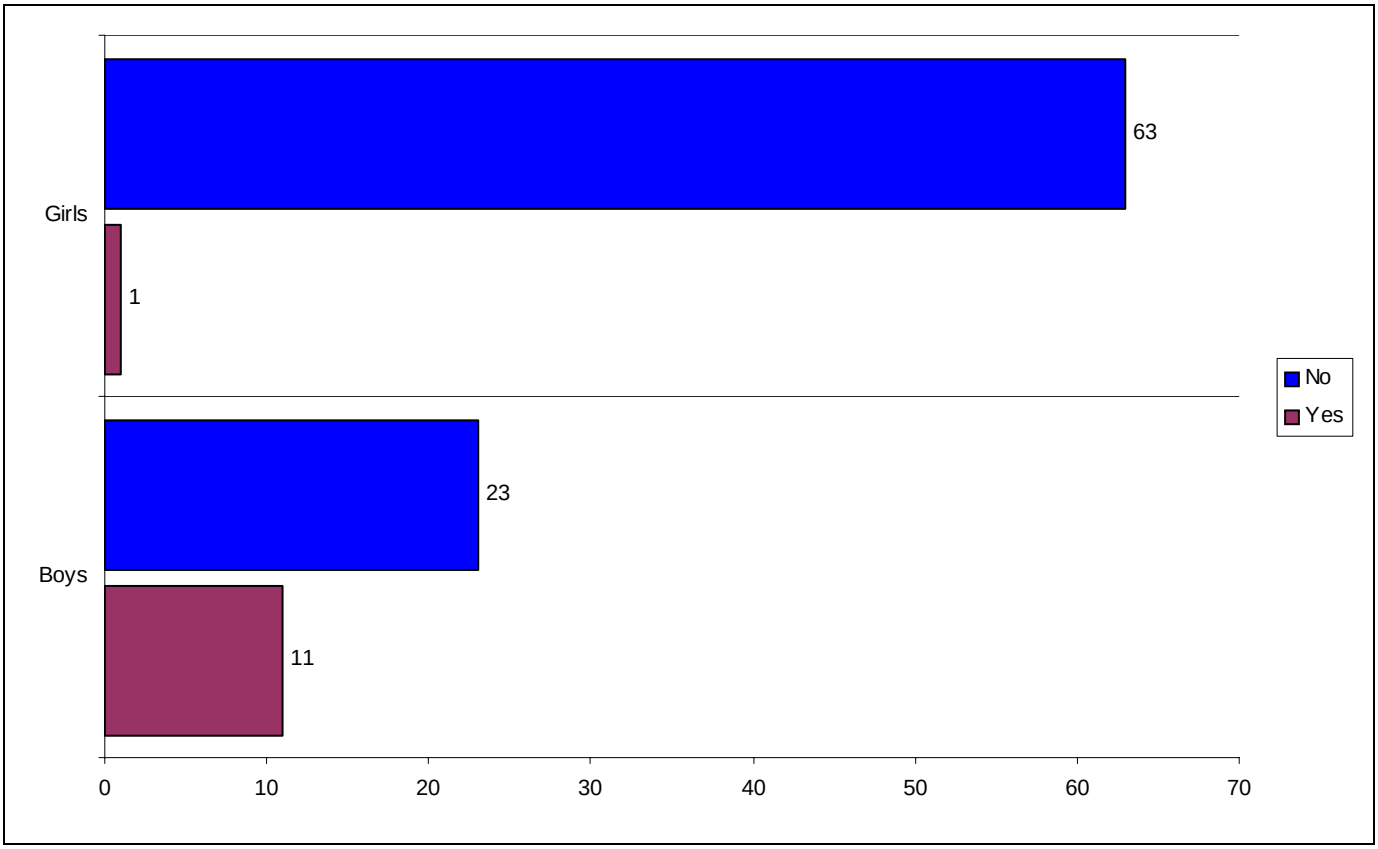


Figure 12. Girls' and boys' responses to: 'Would you consider having sex for money, gifts or favours?'



Question eight asked learners under what circumstances they would perform sexual acts for compensation. Almost 30 percent said that they would not under any circumstances perform sexual acts for compensation (Figure 13). Taking into consideration the fact that there are missing values for 15 percent of the respondents, financial need dominates the remaining 55 percent of answers. Thirty-two percent of learners said that they would consider having sex for compensation only when they are starving or because of poverty. One can also add to this figure the 8 percent of those who would only consider this in an orphan situation (i.e. having no one to provide basic needs). Peer pressure (7 percent), addiction to drugs or alcohol (3 percent), fear (2 percent) and other reasons such as needing money to travel (5 percent) were also added.

Figure 13. Learners' responses to: 'Under which circumstances would you consider having sex for money or gifts?'

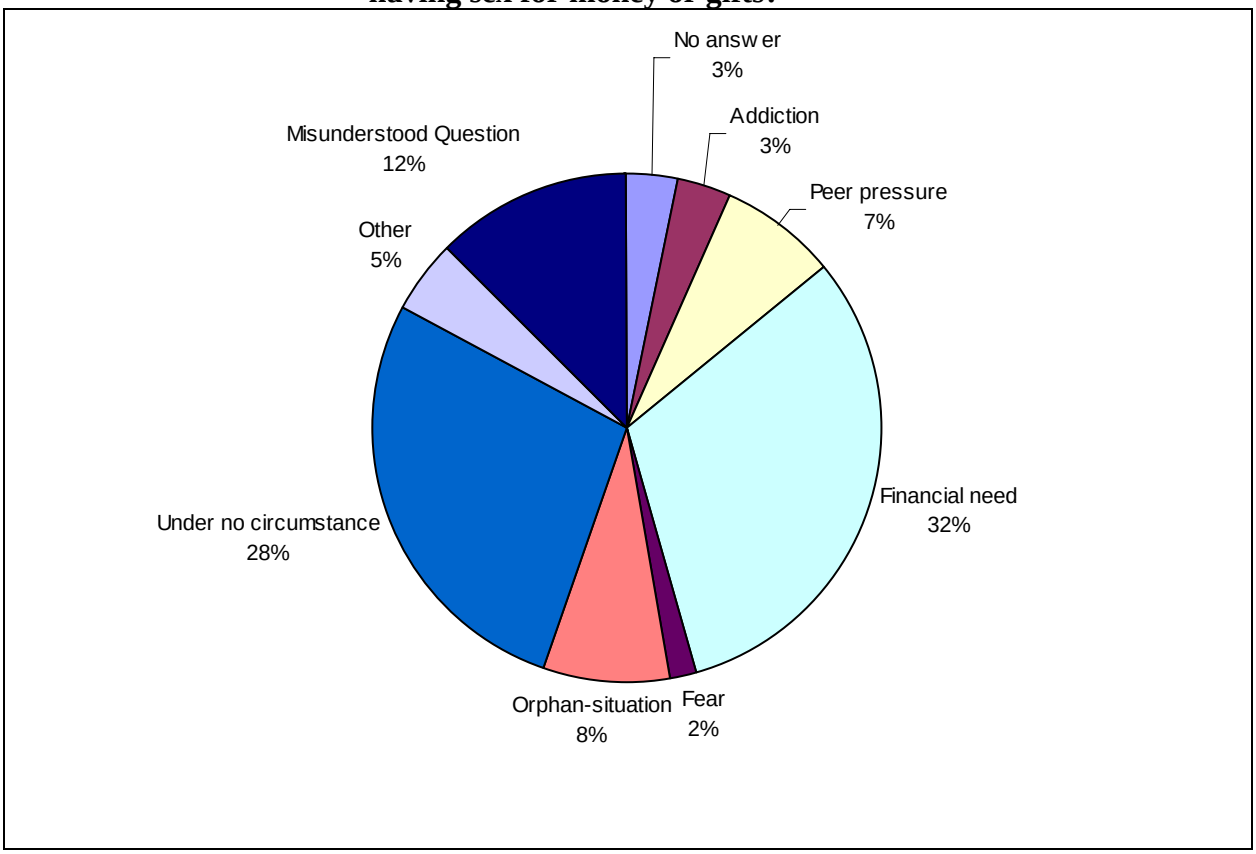
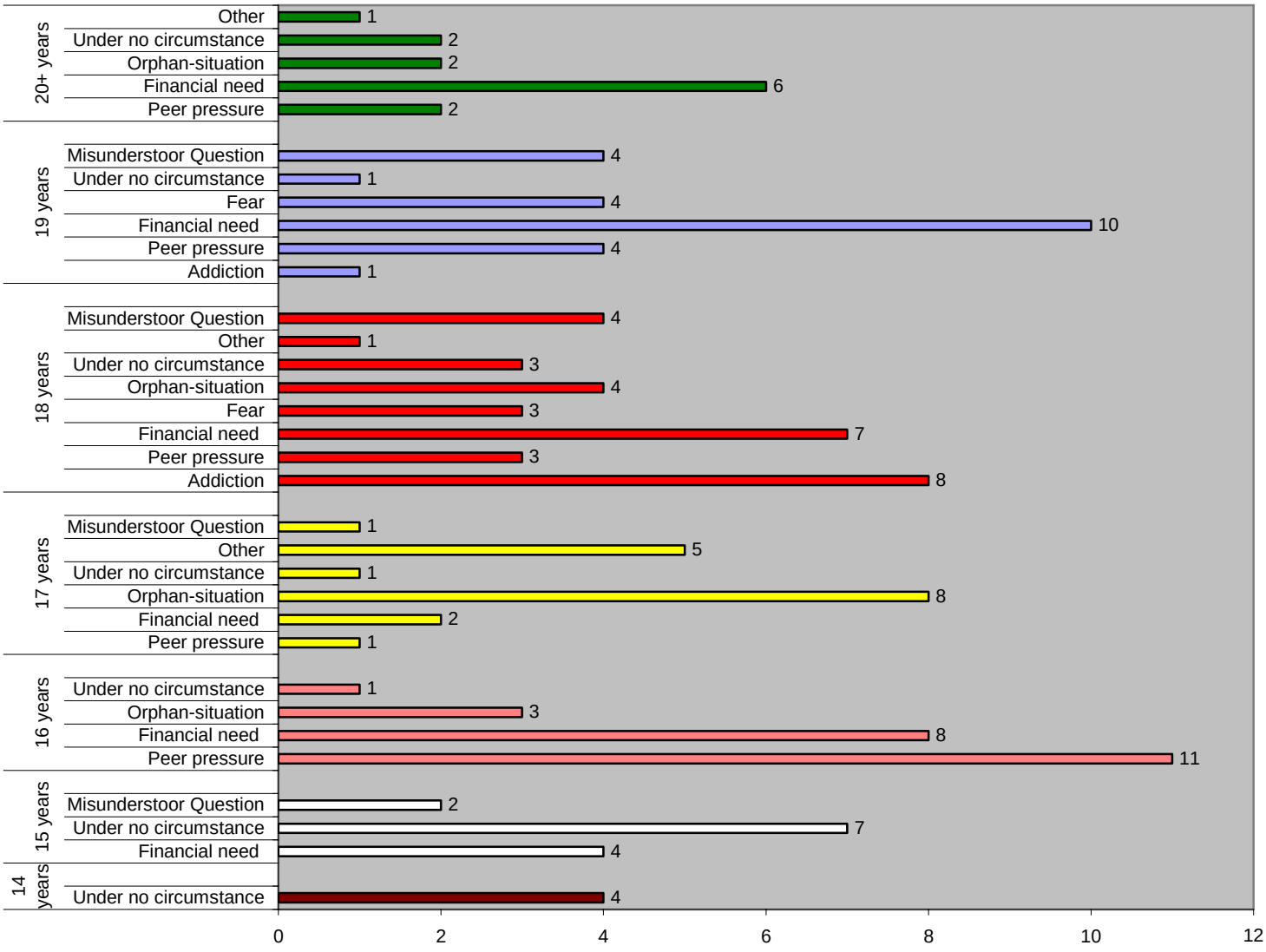


Figure 14 shows learners' responses in relation to their age groups. It is interesting to note that both 14- and 15-year-old learners would not have sexual intercourse for compensation for any apparent reason, while the older age groups would. Sixteen-year-old learners were more likely to choose peer pressure as a possible circumstance, while 17-year-olds said they would do so only when in an orphan situation. Addiction is the biggest factor for those aged 18, and the 19+ group said financial need. Male and female learners both regard the need to relieve poverty and hunger as the major factor (irrespective of age). More female than male learners indicated peer pressure, fear and having no one to provide basic needs. Male learners more readily chose addiction and were less likely to do it not at all (irrespective of age).

Figure 14. Learners' responses to: 'Under which circumstances would you consider having sex for money or gifts?' related to age groups.



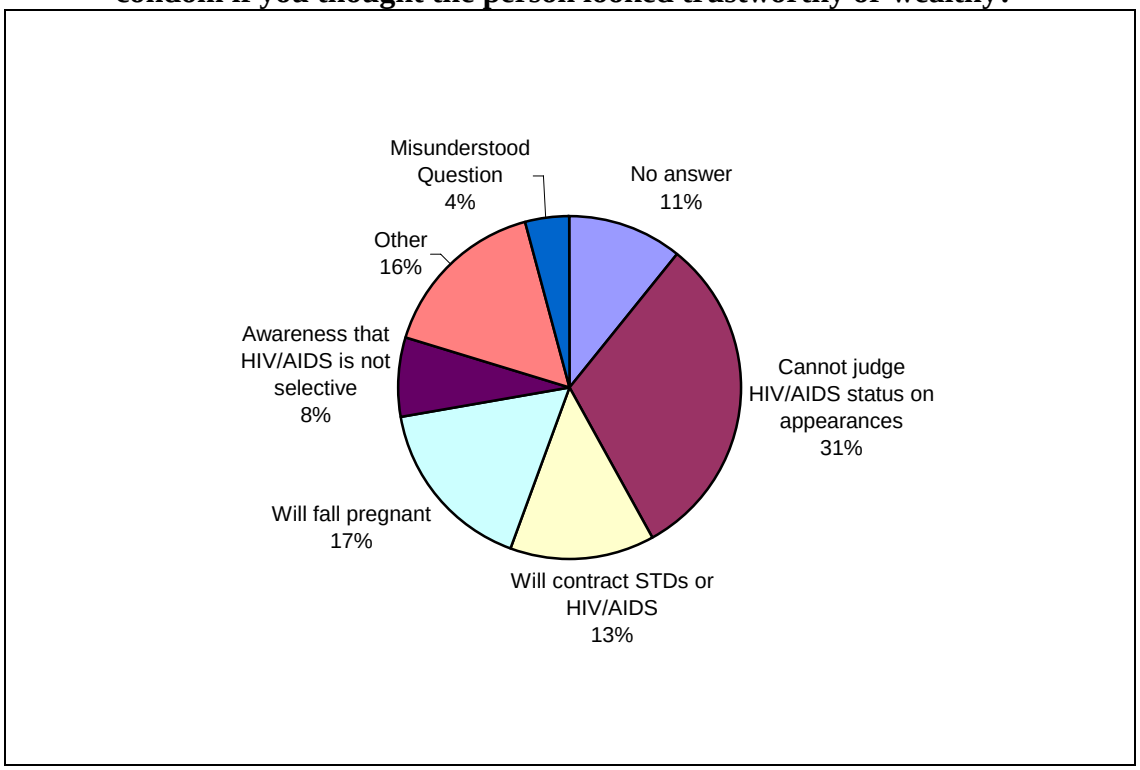
Learners were asked what they thought of people who did have sex for compensation. Answers were broadly grouped into positive, negative and indifferent responses. Most learners (59 percent) expressed a negative feeling towards people who did perform sexual acts for compensation, calling them "prostitutes" and "stupits". Only 8 percent responded positively, saying that those who have sex for compensation avoid committing crime (i.e. theft), among other things. Another learner commented that it is "'…good because they have nothing to do"' (Survey 0097). The 30 percent indifferent responses included that

people are poor and have no other means of providing for their families, and that sometimes people just do it because their friends do.

In Question Ten, learners first had to say whether they would have sexual intercourse without a condom if the person looked wealthy or trustworthy (Figure 15). They then had to provide a reason for their choice. The majority of learners (85 percent, both males and females) would not, and the most common response was that one could not judge a person's HIV/AIDS status on appearances alone. The second largest concern was unwanted pregnancy (17 percent), followed by a fear of contracting STIs and HIV/AIDS (13 percent). Eight percent of learners were aware that HIV/AIDS is not selective, and that even wealthy and trustworthy people might be infected.

Those who would have unprotected sex with a wealthy- or trustworthy-looking person made up 9 percent and were represented only by learners aged 17 years and older. Some of their reasons include that "He will be longing for a child" (Survey 0055), "If I'm pregnant, he might marry me and if he is trustworthy he won't leave me" (Survey 0036 and 0037) and "Wealthy people don't have diseases" (Survey 0097). Fifteen percent did not answer the question. What is clear from both this question and the one on whether the learner would have sex for compensation (Question 7) is that those who pay for sex do not want to use condoms. When one considers how the different age groups answered, it is clear that learners aged 16 and younger were definitely more concerned about contracting HIV/AIDS and STIs as well as unplanned pregnancy. This was also the case among female learners. Learners aged 17 and above were more worried about the fact that one cannot judge a person's status based on appearances alone. Male learners showed the same trend. In terms of HIV/AIDS, both male and female learners were equally aware.

Figure 15. Learners' responses to: 'Why would/wouldn't you have sex without a condom if you thought the person looked trustworthy or wealthy?'



When asked about the possible risk that HIV/AIDS may have on young people, a large number of learners answered that the most apparent risk is that of dying (27 percent). Another response was expressed in words such as, "They will have no future". Learners are also concerned about general health issues (4 percent), the effect that the disease may have on their sexual habits (4 percent), population decrease (3 percent) and the abandonment of studies (2 percent). A further 22 percent did not specifically indicate the risks that the disease may have but they agreed on the severity of the situation.

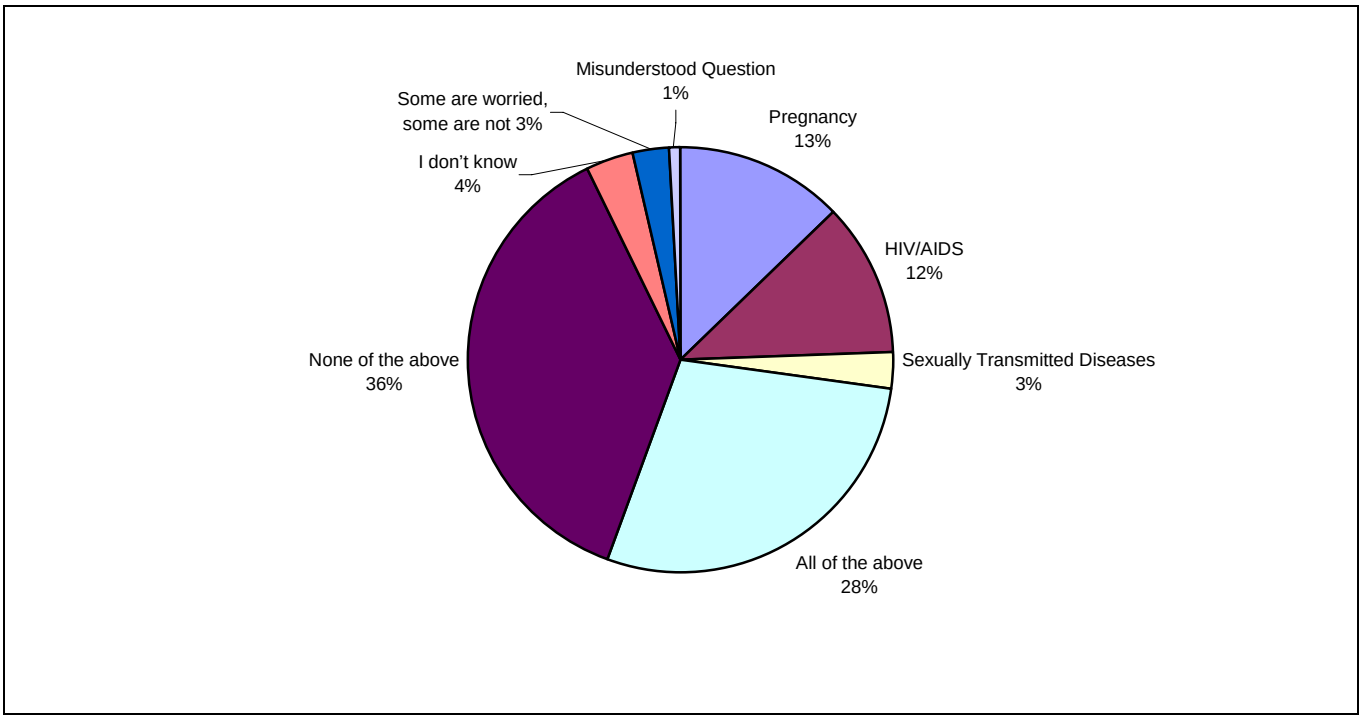
Learners seem to notice that HIV/AIDS is affecting and killing more young people rather than older ones. It is interesting to note that learners are concerned about their own possible death and the general well being of the larger population. It is also noteworthy that some learners do not regard death as the prime risk related to HIV/AIDS, but consider the influence of HIV/AIDS on their sexual habits as being more significant. As one learner put it, "We are unable to enjoy sex" (Survey 0068). Twenty-six percent of the

responses did not provide insight into the issue. Two percent of learners did not answer this question. Both male and female learners (38 percent each) thought death was the biggest threat. Male learners were more concerned about an unfulfilled future (15 percent vs. 9 percent) and health issues (6 percent vs. 1 percent). Male learners were also more worried than females about HIV/AIDS affecting their sexual habits; females did not consider this at all (9 percent vs. 0 percent).

Looking at the issue of general concern among community members, the majority of learners (36 percent) did not feel that HIV/AIDS, pregnancy or STIs were primary concerns; however, they did not specify any alternatives. Twenty-eight percent of learners felt that all three of these diseases created major concerns in the community. Pregnancy is a concern (13 percent) but HIV/AIDS (12 percent) is not far behind. A total of 3 percent of learners expressed general concerns in terms of STIs.

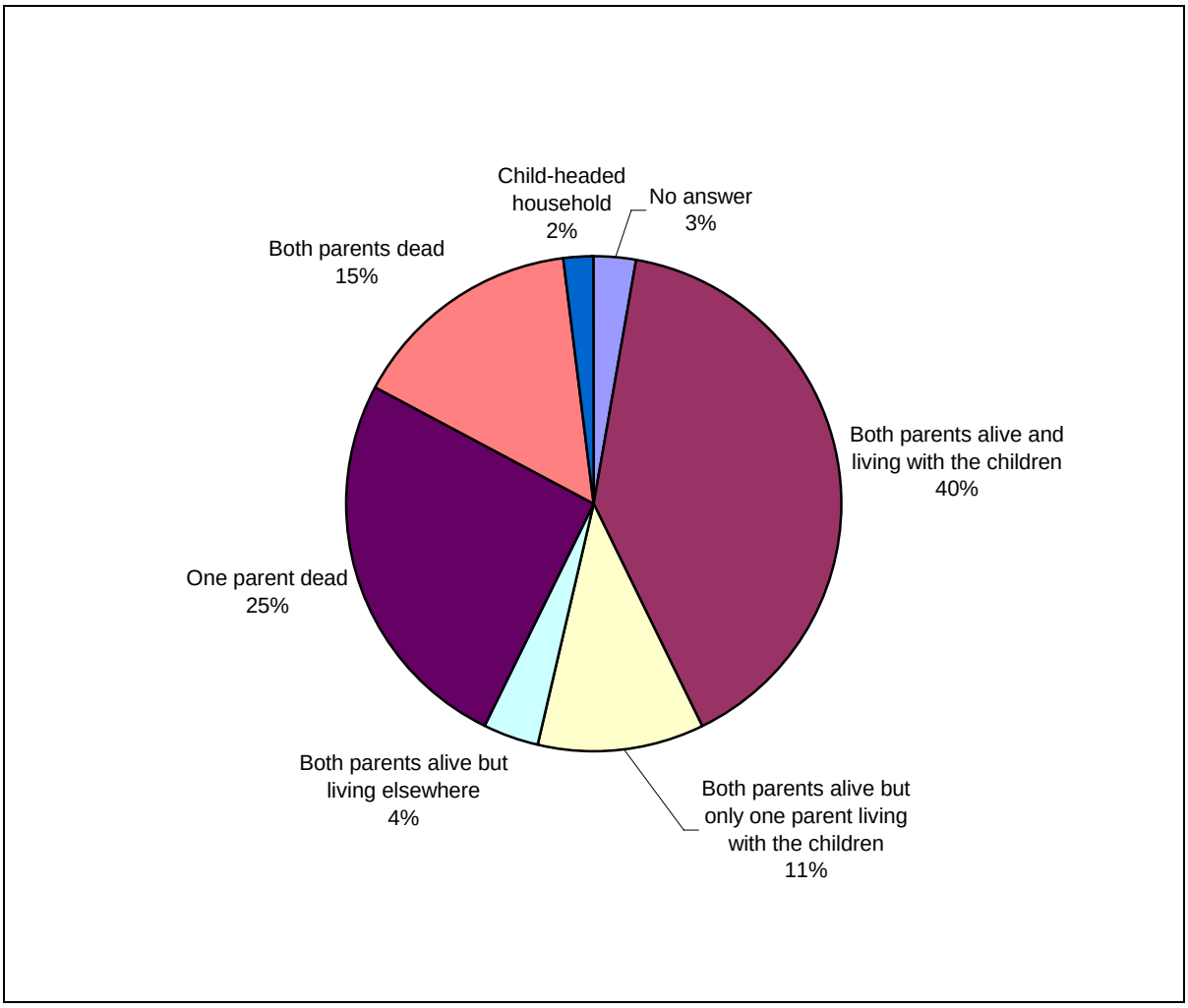
Four percent of learners did not know the answer to the question and 3 percent answered that in general, some people are worried and others seem to be indifferent. One percent of learners did not respond (Figure 16). There were no real differences in answers between age groups or between male and female learners.

Figure 16. Learners' responses to: Are young people more worried about pregnancy or HIV or other STIs?'



Question 13 explored learner family demography. The majority of learners (40 percent) live in a family where both father and mother are alive and reside in the household. Twenty five percent of learners have lost one parent to death; 11 percent have both parents living, even though only one is involved in the household and lives with the children. Fifteen percent of learners are orphans and 4 percent have parents who are alive but living away from the children. In 2 percent of cases, respondents head the households – in other words, they preside over child-headed households. Three percent did not answer this question.

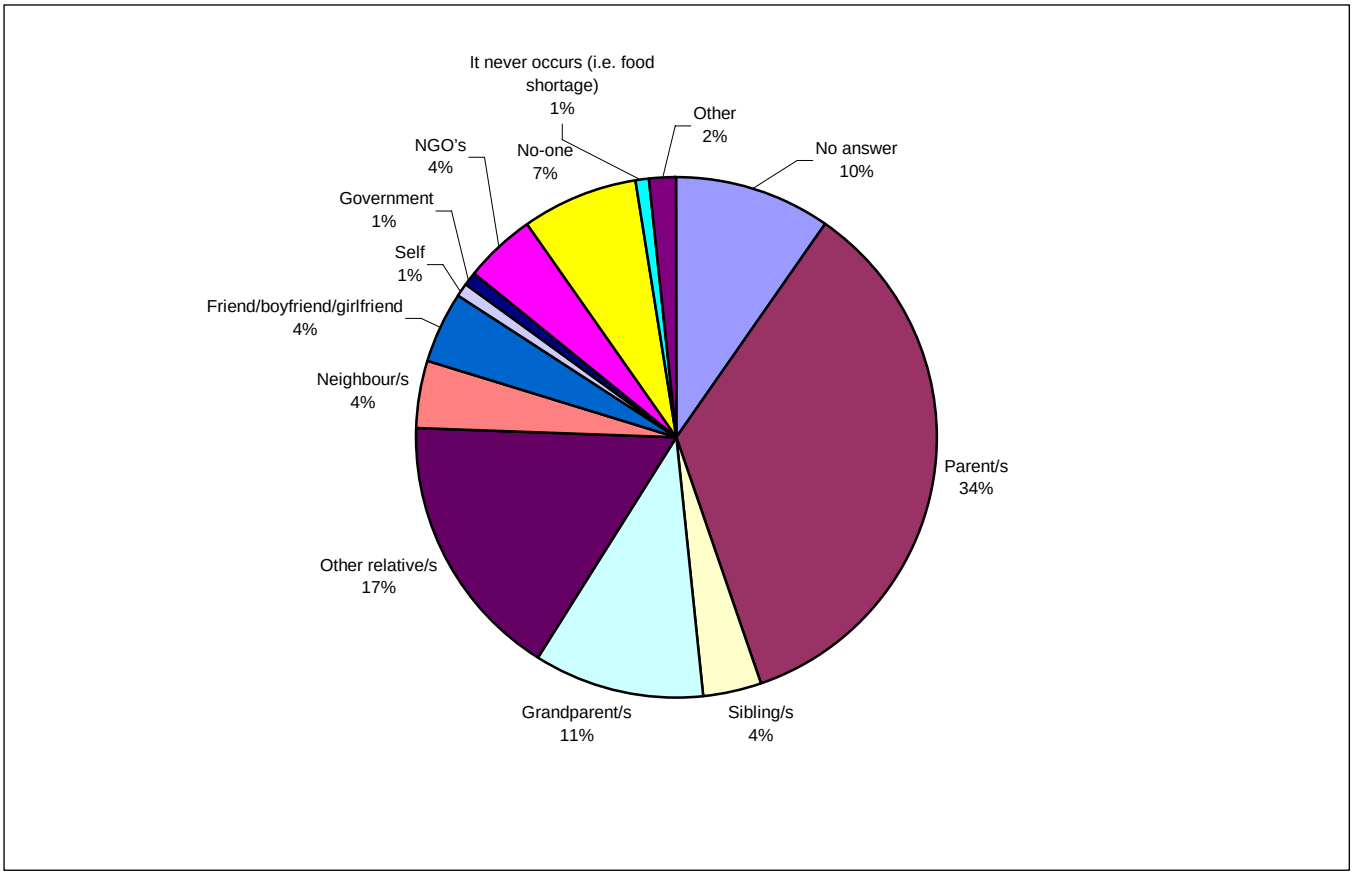
Figure 17. Learners' responses to: 'What best describes your family?'



Linking up with the previous question, 34 percent of learners are cared for and given food by their parents. Figure 18 shows that close relatives also play an important role in the subsistence of learners (17 percent) and specifically grandparents (11 percent) care for youngsters. It seems that NGOs, friends/girlfriend or boyfriends, neighbours and siblings equally provide in the event of food shortages (4 percent each) and in isolated cases (1 percent) the government will provide food, or the learner will come up with a solution him/herself (1 percent). Only 1 percent of learners indicated that they do not experience food shortages and 10 percent did not answer this question. When asked to specify about the types of food consumed, half of the learners either did not provide an answer to the question (31 percent) or did not understand what was being asked (26 percent).

Nevertheless, learners indicated that the main foodstuffs consumed in their communities are milk (15 percent), vegetables (9 percent), maize meal or *papa* (7 percent), bread (5 percent) and meat (3 percent). Other foodstuffs make up 4 percent of consumed food.

Figure 18. Learners' responses to: 'Who gives you food if there is none?'

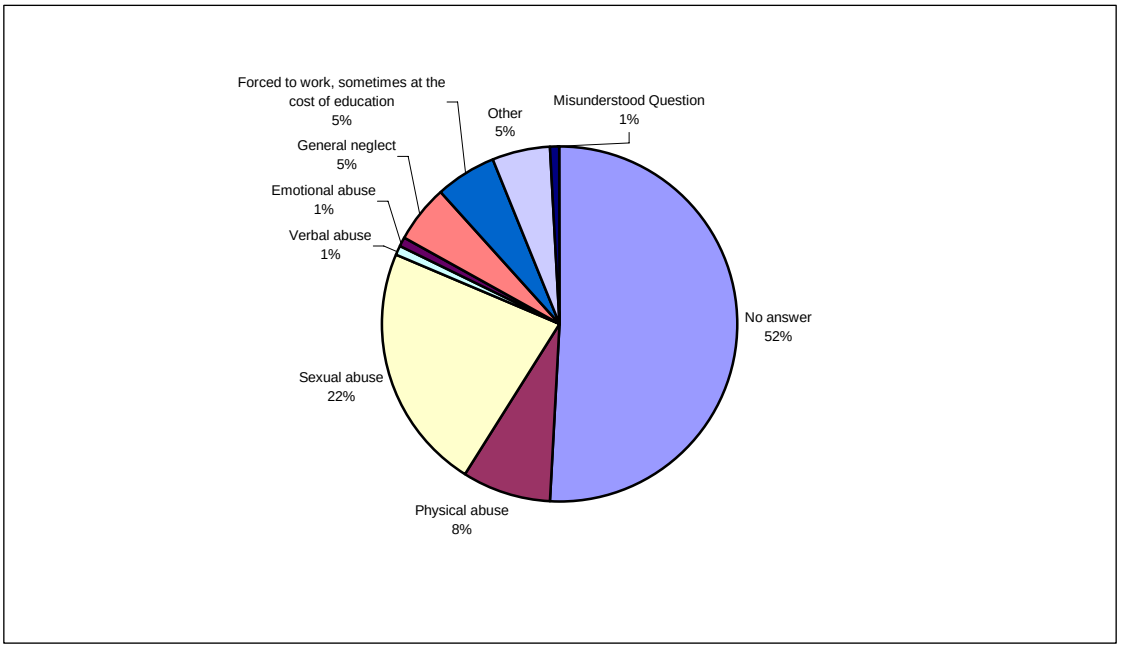


The next question asked how learners get money when they need it. For the highest percentage (66 percent), parents provide for these individuals. Learners also get money from their friends or boyfriends/girlfriends (3 percent), informal employment (i.e. 'piece' jobs, 11 percent) and entrepreneurial enterprises (3 percent). In some cases learners will resort to begging (3 percent), borrowing (3 percent) or stealing money (1 percent). Prostitution accounts for 2 percent of income generated by learners. As some of the answers were outside of what could be interpreted as an appropriate answer to the question, five percent of learners are thought to have misunderstood the question.

Figure 19 reflects issues around abuse. When asked if learners have any knowledge of friends who are treated badly at home in some way, a high of 59 percent replied that they did and 36 percent did not know of such instances. Five percent did not answer this question. In the event that learners knew who the perpetrators were, 13 percent identified the parents and another 13 percent specified the father as the abuser. The mother is apparently in the wrong in 5 percent of replies and 4 percent of learners identified a relative. Five percent indicated that a guardian of some sort was guilty.

It is perturbing that more than half the learners (56 percent) did not answer this question at all and it may be that the responses were suppressed. Sadly, sexual abuse accounts for the largest number of incidents (22 percent), with physical abuse also pertinent (8 percent). Learners also refer to general neglect (5 percent), forced labour (5 percent) and emotional and verbal abuse (1 percent each). Although only 1 percent misunderstood the question, a high proportion of 52 percent abstained from responding.

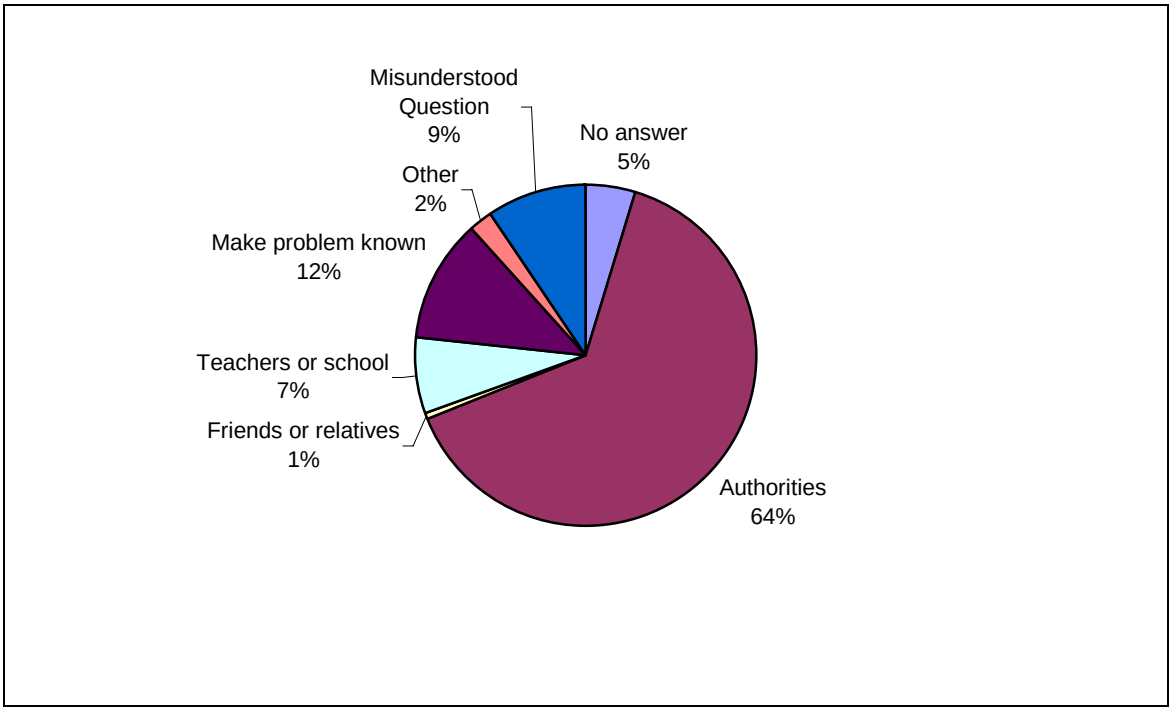
Figure 19. Learners' responses to: 'What kind of treatment are they [abused friends] experiencing?'



In Question 17, learners were asked to give recommendations to victims of abuse. According to 64 percent of learners, victims of abuse should report this problem and seek help from the authorities, and 12 percent felt that victims should make the problem known in some way or another.

Others suggested seeking help from the school (7 percent) or from friends and relatives (1 percent). Nine percent did not understand the question and 1 percent suggested other alternatives to this question (Figure 20).

Figure 20. Learners' responses to: 'What would you recommend someone do who is a victim of abuse?'

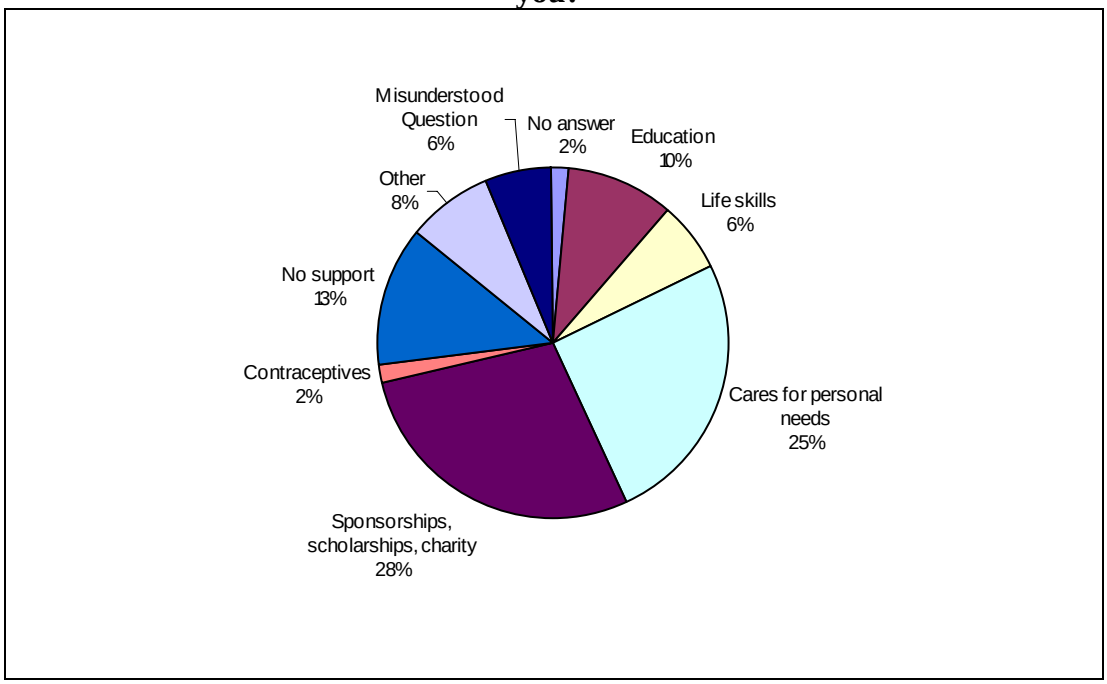


Question 18 required learners to say whether they had any knowledge of an orphan's inheritance being taken away by relatives. Forty-five percent of learners have no knowledge of orphans' inheritance being taken by others (i.e. relatives) but 39 percent have heard of such incidences. Missing data constitutes 16 percent.

When asked, “Are orphans treated differently by the community or friends at school, and in what way?” 70 percent of learners did not feel that orphans are treated differently but 21 percent agreed that there is differential treatment. Five percent did not answer the question and 4 percent did not understand what was being asked. Of the 31 percent who felt that orphans are treated differently, they felt that this is mostly positive for the orphans. Orphans often receive scholarships and donations through fund raising events at school and sometimes they even get better treatment than those learners with parents. Nonetheless, thirteen percent felt that these individuals are treated negatively. One learner remarked that the community abuses them and that they are discriminated against (Survey 0105). Eight percent indicated that a feeling of indifference exists towards orphans. Interestingly, the majority (43 percent) did not answer this question and 5 percent misunderstood what was being asked.

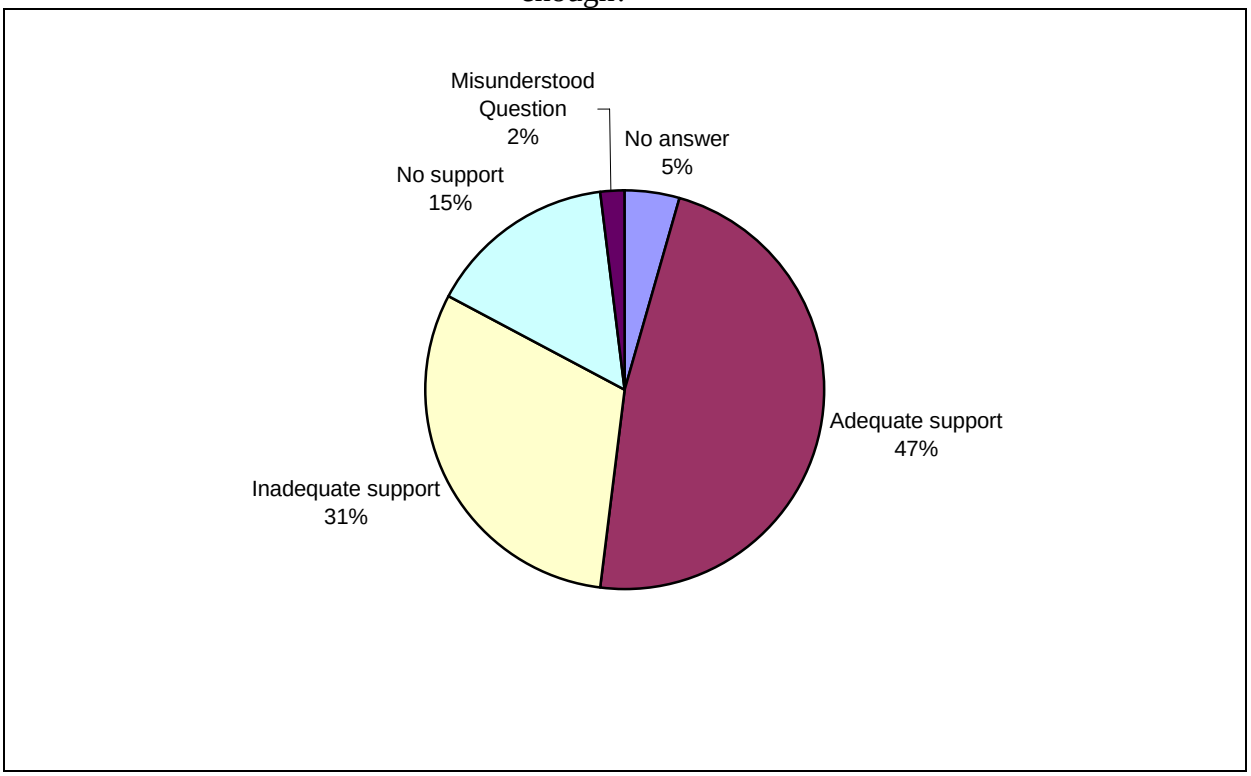
When asked to assess school support (Figure 21), learners said that catering for personal needs such as food, clothes and toiletries (25 percent) and scholarships (28 percent) are the primary means of support. The school also provides education (10 percent), contraceptives (2 percent) and life skills (6 percent). Eight percent of learners indicated other support, such as gifts, and 13 percent said that the school did not support them in any way. Five percent misunderstood the question.

Figure 21. Learners' response to: 'What kind of support does your school give to you?'



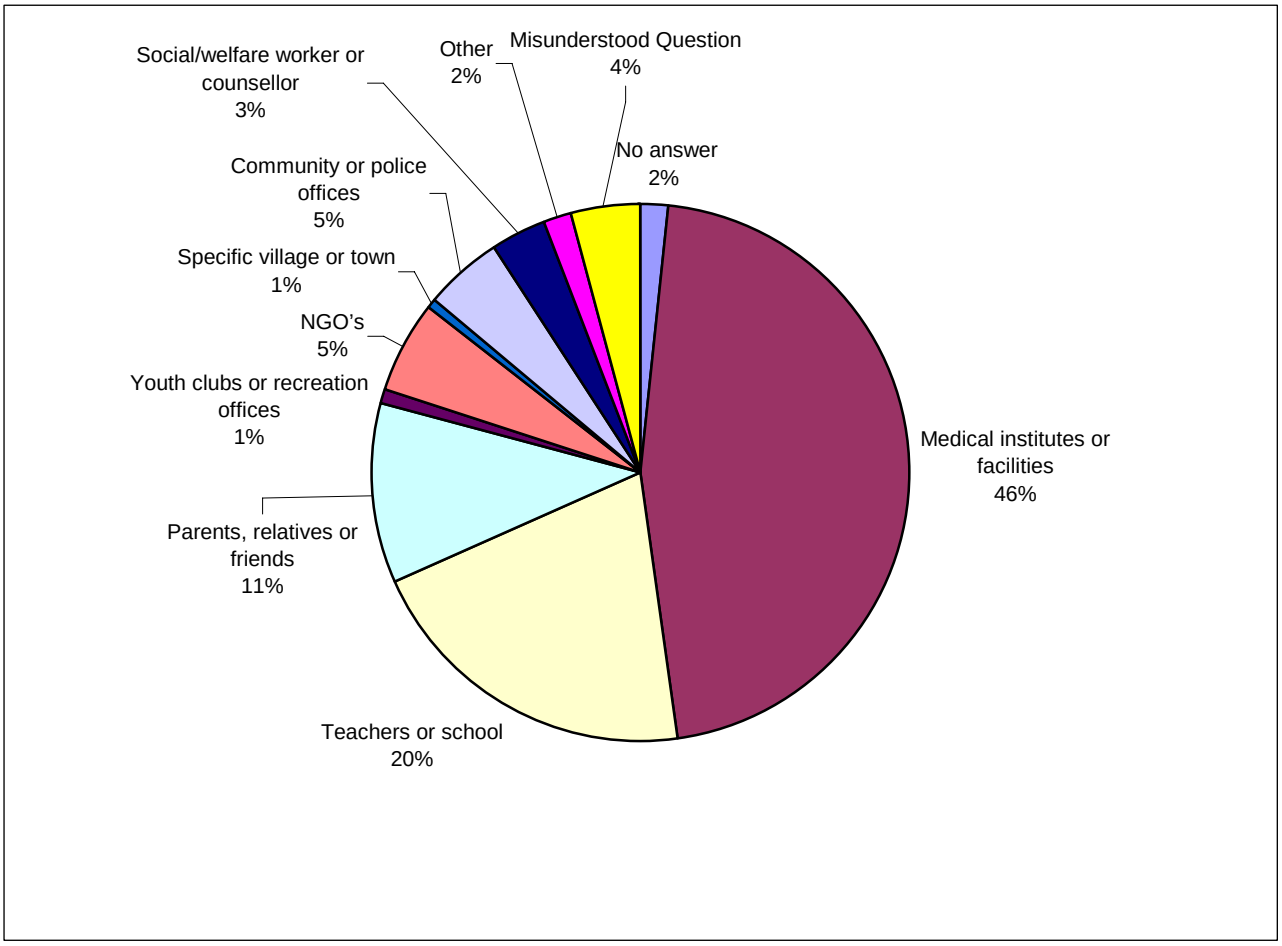
When asked about the support given by the government, as Figure 22 indicates, 47 percent of learners believe that the government provides adequate support. This is mainly in the form of scholarships and sponsorships, food and books. Thirty-one percent disagreed and felt that support is inadequate. According to 15 percent of learners, the government gives no support at all. Five percent did not answer and 2 percent of learners did not understand the question. When asked about community support, an overwhelming majority (80 percent) did not answer. This might be due to unclear phrasing of the question. Of the 20 percent who did answer, 4 percent were unsatisfied, while 3 percent were satisfied with the community's support. According to 13 percent of learners, no support comes from the community at all.

Figure 22. Learners' response to: 'What is the government doing to help you and is it enough?'



Finally, Question 22 asked learners to list all the places they can visit or people they can talk to about sex, STIs and contraceptives (Figure 23). A large number of learners (46 percent) feel that they can talk about sex, STIs and contraceptives to medical institutions and facilities (including the Lesotho Planned Parenthood Association, or LPPA). Twenty percent prefer to discuss these issues with teachers or counsellors at school and 11 percent would rather speak to their parents or relatives. Other alternatives for dialogue on sex, STIs, contraceptives, etc are NGOs (5 percent), community and police offices, including CGPU offices (5 percent), youth clubs and recreational offices (1 percent), and social workers and welfare agencies (3 percent). Some learners (1 percent) will also go to a specific town or village where they can engage in these discussions.

Figure 23. Learners' responses to: 'Can you list all the places and people you can visit or talk to fond out about sex, contraception and STIs?'



Analysis

Even though the results of the questionnaire reflect the behaviour and sexual practices of learners at only one high school, they give an important insight into attitudes towards HIV/AIDS among young adolescents in Quthing. Many of the respondents are within the most vulnerable age cohort (UNAIDS: 2006) or will move into this category in the next few years. As there is an expectation that some of the respondents will take up positions of power and authority in the future, either at the community, district or even the national level, there is a growing parallel concern that many of the respondents will die of AIDS before they get this opportunity (Cohen: 2002).

This hypothesis is enhanced by the fact that a gap is being created of people between the age of 25 and 49 (ibid), and many of the people who already hold these positions can be expected to die prematurely. A great deal of research has been conducted on projections of AIDS and the spectrum of issues facing human capacity in virus-affected countries, particularly southern Africa (Whiteside & Barnett: 2002, O'Grady: 2005, De Wall: 2003). Some of these issues are outlined in the introduction and literature review of this dissertation; they include difficulties experienced by the state in delivering services to weakened populations and the 'brain drain' of trained personnel increasingly looking abroad for higher salaries and better work opportunities (ibid).

As communities grapple with the impact of the epidemic, systems for service provision, democratic institutions, law and order, and political stability are becoming increasingly strained (Manning: 2003), raising the possibility that today's young people may be forced to take positions of power and authority before they are academically qualified or have gained broad experience and a deep understanding of what the position entails. However, there is also a high probability that many of the respondents will not reach an educational level beyond secondary school[38], and many will become infected with the virus unless preventative measures are adopted.

> "Young adults tend to imagine that they have immunity to HIV infection and so continue to practise unsafe sex, irrespective of their educational background and specific knowledge about HIV/AIDS." Levine and Ross (2002:1)

It is hypothesised that if an adolescent has gone through the various educational levels and then succumbs to AIDS, the impact on the state, which has invested in that individual through subsided education, and the loss to society is far greater than what has been calculated in macroeconomic formulas. Levine and Ross (2001) recommend an urgent reassessment of the efficacy of education as a means of disease prevention, as well as more examination of young adults' knowledge, attitudes and practices. In other words,

[38] The LDHS survey, 2004, revealed that 2.9 percent of women and 11.8 percent of men aged 45-49 had gone beyond secondary education, which does not necessarily mean they completed a higher degree. The results are even starker at the district level with 0.7 percent of female and 0.5 percent of male respondents in Quthing having gone beyond secondary education. The survey polled 7,095 women and 2,797 men across the country, and 461 women and 167 men in Quthing.

people know enough but do not act. The need for these recommendations to be followed through is even more recognisable at the district level in Quthing, where about 90 percent of high school respondents acknowledged some understanding about HIV/AIDS[39], even if it was on the periphery of fact[40], but only 31 percent of respondents[41] cited protected sex, (in other words, using a condom) as a means of halting the spread of the virus. Interestingly, nearly half of respondents (48 percent) cited abstinence as a preventative, but as Mihailovic and Olupot-Olupot (2006) point out, abstinence can be based on a flawed assumption, because it does not address underlying factors that make people vulnerable to HIV/AIDS, such as the social, political and economic causes of the epidemic.

While Uganda is lauded as a success story for following the 'ABC' of prevention – Abstinence, Being faithful to your partner, and using Condoms – condoms were not promoted as a preventative measure in that country's campaign against the virus, as it did not 'fit' with the ideology of one of its major donors[42], which prefers the promotion of abstaining from sex until marriage, and then staying monogamous (ibid).

The ABC approach, synonymous with the promotion of abstinence-only sex education programmes for youth (Murphy & Greene: 2006), is not relevant in the context of the high school in Quthing, because the learners demonstrated from their responses to the survey that they are not following any of the steps outlined in this approach. The ABC approach also neglects the role of women and unequal gender relations of power, as women have little control over their sex lives and are often unable to negotiate faithfulness and condom use (Nattrass: 2002). Mihailovic and Olupot-Olupout (2006) argue that by encouraging abstinence while neglecting sexual education and condoms as preventative measures against HIV infection, adolescents and particularly girls are put at greater danger of exploitation and ignorance and, ultimately, an increased risk of becoming infected. This concurs with Gomo et al (2005), who argue that that the "one

[39] Question one of the questionnaire
[40] Some respondents acknowledged only blood transmission as a means to contracting the virus rather than unprotected sexual intercourse and blood.
[41] Question two of the questionnaire
[42] The Government of the United States' Presidential Emergency Plan for AIDS Relief

size fits all" approach to prevention using the ABC principles alone is unlikely to yield the desired results.

Condom use is seen by many as the only way to control the spread of the virus, even if it is not openly advocated in national programmes. Murphy & Greene (2006) attribute Uganda's success in achieving a reduction in HIV prevalence to condom-related programming in the early years of battling the pandemic.

Indeed, 85 percent of respondents in Quthing said they would not have sex without a condom (Question 10a). Despite this, attitudes towards condoms around the world are largely negative, expressed in sayings such as: "You can't eat a banana without removing its cover" and "Having sex with a condom is like having a sucker with a wrapper on it" (Levine & Ross: 2002, p5). In Lesotho there are similar expressions. However, UNAIDS (2004) lists condom programming as an integral component in a range of prevention strategies, including informed, responsible and safer sexual behaviour, exemplified by delaying the age of the onset of sexual activity, abstinence, condom use and a reduction in the number of sexual partners. Gomo et al (2005) noted that condoms were used inconsistently or that use started after infection had occurred, with prevalence being recorded at 1.5 times higher among people reporting selective use of condoms with multiple partners.

The promotion of condom use has proved particularly successful in Thailand, where health workers embarked on a core advocacy strategy of "100 percent Condom Use" but incorporated supporting roles for health education, STI control, HIV testing and healthcare for those affected by the virus. It also received strong political commitment and support at all levels, including from brothel owners. According to UNAIDS (2004), two major behavioural changes took place: condom use increased in the sex work setting, which was anticipated; and the frequency of visits by men to sex workers fell sharply, which was not expected.

> "The proportion of 21-year-old men who indicated visiting a sex worker in the past year fell from nearly 60 percent in 1991 to 8 percent in 1998, while condom use during commercial sex transactions rose to more than 95 percent of all acts in 1995. These changes were the result of greater awareness of risk generated by the 100 percent Condom Use Programme." (UNAIDS: 2004, p9)

Condoms within the preventative strategy are also widely available in Lesotho, although attitudes towards them as a mitigating method may not be as successful as in Thailand, where prophylactics led the way in containing the spread of the virus. This discussion on condoms as a preventative strategy is important and will be further explored in Chapter Four, where ethnographic evidence suggests they people may not be using them despite their availability.

Although a significant number of boys and girls (38 percent each) in the survey are concerned about dying from the virus (Question 11), disturbingly, more than 60 percent have no clear concern. Instead many respondents do not view death as a prime risk of HIV/AIDS but rather see the virus as infringing upon their sexual habits, restricting them in some way from freely engaging in unprotected intercourse. This message was also carried forward by 36 percent of respondents (Question 12) who said HIV/AIDS, STIs and unwanted pregnancies were not their primary concerns in life. This could reflect either a carefree attitude towards sex and the virus, or the possibility that they are facing greater challenges in their day-to-day existence than those posed by the HIV/AIDS epidemic, such as the pressing need for food, clothing, shelter, school books or social status. Clearly learners are confronted with an unprecedented frequency of death and HIV/AIDS is the most commonly cited cause of death. The fact that learners know people are dying of HIV/AIDS[43] in their communities does not appear to be a deterrent from having unprotected sex,, and death is apparently accepted as an everyday occurrence.

Although this thesis cannot enter into psychological notions that would explain the behaviour patterns that are emerging in the face of death (and knowledge of its causes) it is worth noting that Freud (1920) provided one possible hypothesis that might throw

[43] 46 percent of respondents in the high school survey said that they know someone who had died of AIDS in the last year

some light on the anomalies around behaviour that emerge from the data and on the apparent contradiction between awareness and patterns of reckless behaviour that emerge. Freud posits that there is a link between the death force and the life force and that during experiences of death the individual has a tendency to counteract – or push away death – through erotic behaviour, or what he calls Eros. Freud's concepts emphasise the constant fusion of the death drive with that of a life force. The reverse is also true, of course, for Freud notes that erotic experiences also link with experiences of death. While this research project is not aware of theoretical work that has been applied to explain the relationship – or lack thereof – between knowledge acquisition and behaviour within the HIV/AIDS paradigm, Freud's research is enlightening and it does merit consideration and further inquiry within the HIV/AIDS context.

HIV/AIDS fatigue (Levine & Ross: 2002) must be considered when examining the evidence that is presented in this dissertation. A type of recklessness in sexual behaviour is mentioned by Freudenthal (2001) because death by HIV/AIDS has become such a common occurrence. It should also be remembered that nine percent of respondents in Quthing (Question 10a) said they would have unprotected sex if the person looked wealthy and, by inference, was able to grant material favours in return for sex. This was also reflected in respondent answers (Questions 6, 7, 8 and 10b) to attitudes surrounding having sex for money, gifts, or favours, with 42 percent of respondents saying they have friends who engage in sex for these returns, while 55 percent of respondents said they would engage in sex if there was a financial incentive. Another 32 percent said they would have sex for returns if they were starving or affected by poverty. With such a large number of people living below the poverty line in Lesotho and a good number of people affected by chronic food insecurity, it is reasonable to assume that the overwhelming majority of adolescents would have sex for gains if the timing of the transaction coincided with a particular need. This would also confirm the likelihood of the disease spreading more quickly in areas hit by poverty, food insecurity and vulnerability. The link between wanting to provide for basic needs and engaging in risky sexual practices is also highlighted by Nattrass (2002), although she adds that sexual behaviour on its own cannot account for the spread of HIV/AIDS. In addition, as cited in the introduction to

this dissertation, there is broad acceptance of the idea that poverty and vulnerability are increasing as countries struggle under massive debt burdens, poor governance and the impact of HIV/AIDS. Many of the academic and policy papers relating to southern Africa reviewed for this dissertation cited falling life expectancy, rising unemployment, elusive food security, and the decline of institutions that provide healthcare, education, and social services as key areas that need to be addressed to mitigate the impact of the pandemic (Nattrass: 2004, Barnett & Whiteside: 2002, Gulaid: 2004, Salaam: 2005, Richter et al: 2004).

It was also revealed in the questionnaire that more male learners had (male) friends having sex for favours than did the (female) friends of female learners. This could equate to bravado between men eager to exert their prowess because:

> 'For a man to qualify as a man, he must possess a certain (or worse, uncertain) number of demonstrable characteristics that make it clear that he is not a woman… which include…(hetero)sexual prowess, sexual conquest of women , heading a nuclear family, siring children, physical and material competition with other men, independence, behavioural autonomy, rationality, strict emotional control, aggressiveness, obsession with success and status, a certain way of walking, a certain way of talking, having buddies rather than intimate friends, etc.' (Comets: 2004, p 12)

The predominance of male learners and their friends having sex for rewards could also be a reflection of the prevalence of the 'sugar mummy' phenomenon in Quthing, as discussed in the introduction to this dissertation. It is also possible that fewer women are prepared to admit that they know people who have sex for favours, due to the shame of being associated with someone deemed to have low moral standards, and therefore the data could be skewed. This is a further reflection of the unequal relations of power between men and women and the highly gendered nature of society in Lesotho.
As men are the 'sexual drivers' of the pandemic (Kometsi: 2004) it is worth briefly exploring the sexuality of men in relation to the spread of HIV/AIDS. Murphy and Greene (2006) show that in Uganda, the turning point in the fight against HIV/AIDS first started with empowering women to protect themselves from infection. Only then did men begin to start questioning the 'dimensions of their masculinity' (ibid: 6) and engaging in behaviour change, such as being faithful or wearing condoms. Murphy and Greene also

argue that programmes must be adopted to transform gender roles for men and women separately as well as together. This is an important thrust for programming in Lesotho. In Quthing the programming approach has developed only along generic lines, rather than targeting the two sexes separately with carefully designed messaging that is appropriate for each case.

With a changing social landscape on the horizon in Lesotho, men will have significant adjustments to make in the way they deal with women and children in the future, particularly once the Capacity Married Persons Bill enters into force. In addition, the erosion of the traditional system of chiefs as power and knowledge brokers, discussed in some detail in the introduction to this dissertation, will further undermine the patriarchal structure of the Basotho. According to Silberschmidt (2005), who breaks from the conventional theorists who promote women's empowerment to tackle the virus, men in East Africa became aware that they were in the process of losing control over women when women started becoming empowered and aware of their rights, including their sexual and reproductive rights (Silberschmidt: 2005). Most men did not welcome this change or the messages of safe sex and being faithful, as proscribed by the often cited ABC of prevention discussed above.

> "This resulted in men's lack of social value and self-esteem. With unemployment and incapable of fulfilling social roles and expectations, male identity and self-esteem have become increasingly linked to sexuality and sexual manifestations. Multi-partnered sexual relationships and sexually aggressive behaviour seem to have become essential to strengthen masculinity and self-esteem." (ibid, p1)

Silberschmidt (2005) goes on to argue that women's rights and empowerment must be balanced against efforts to recognise and respond to the increasing frustration faced by men. She concludes that it is therefore necessary to locate men and women within the complex and changing social, political and economic systems. Disempowering men, she warns, is a mistake that will have major development consequences. The extent of the male role and studies of masculinity within the traditional family structure are only just beginning to be examined and understood. Laurie (2005) remarks that more than two decades of gender mainstreaming in development research and policy have failed to

encompass men, and although the male bias has been examined exhaustively, masculine identities remain largely unexamined.

Gender politics also play a role in domestic violence and child abuse in Quthing, with 52 percent of respondents (Question 16) saying they are aware of friends being badly treated at home, with an alarming 22 percent of respondents citing sexual abuse as the type of abuse and eight percent citing physical abuse. One reason for sexual assault cited by Earl-Taylor (2002) is the (groundless) belief that by having sex with a virgin, an HIV-positive man can cure himself.[44] The phenomenon is refuted by Jewkes (2002), who claims that after many years of working as a medical practitioner in South Africa she has never come across this myth being promoted as a cure for AIDS.

The discussion so far has been around some of the key issues that have been raised in the primary research, for example condoms and their role in prevention, the relationship between behaviour and knowledge/awareness, as well as sexuality and the need to address the complex set of gender relationships that go beyond the standard application of generic programmatic response. These are all critical discussion points that bear directly on the evidence around the consequences of not being able to arrest this virus, which is ravaging family and community structures.

The stark reality of a growing number of orphans and vulnerable children is pertinent, with 46 percent of respondents (Question 4) citing orphans as the main impact of deaths in their community and 25 percent saying one of their parents had died, or, in other words, they are orphans according to the definition contained in this dissertation. Those who have lost a parent may not view themselves as orphans, as their family support structure may function as a safety net, keeping them sustained with one parent. However, 15 percent of respondents did acknowledge being an orphan and two percent acknowledged living in a child-headed household. Further research would be needed to correlate the proportion of those who answered positively to having lost a parent with the

[44] Although this theory is often discussed at a community level in many countries visited by the researcher of this dissertation, there is no evidence to suggest this practice exists, nor has anyone interviewed acknowledged following this practice.

number of respondents who acknowledged being orphaned. Issues facing orphans and vulnerable children are examined exhaustively in this dissertation and therefore will not be discussed further in this chapter.

Conclusion

This chapter discussed the results of a survey conducted at a self-selected high school to gain information on Quthing school children's experiences with sexual intercourse, related diseases (including HIV/AIDS), attitudes towards orphans and issues of institutional support. There were different age cohorts and some discussion follows on the variations between ages. In general, the levels of awareness of HIV/AIDS, its causes and its effects are high. Nonetheless, learners are engaging in sexual behaviour at an early age. Clearly, from the data and results above, the linkages between HIV/AIDS and poverty are evident, for instance, learners engage in sexual relations as an alternative income generation potential. Although there is a reasonably high level of awareness of risk of HIV/AIDS, a greater reported risk is unwanted pregnancy.

The data reflect trends that are both positive and negative. The most serious overall concern, reflected above, is that 25 percent of the population would engage in unprotected sex and at an early age. The data on domestic violence or abuse also raises several questions. The first is about the high level of non-response (52 percent) to this question. Non-response could be because the respondents are not willing to disclose matters that rest in the private domain, or that they fear retribution if they disclose incidents of abuse. Non-response could also mean that respondents are unable to decide whether the incidences they experience can be classified as abuse, because these incidences form part of their everyday living. It is also possible that the order of the questions affects the response to this question, as this is one of the last questions on the survey and perhaps there was respondent fatigue. Whatever the reason, the question merits further investigation. This is particularly true because the responses provided do not coincide with national level statistics of high HIV/AIDS prevalence. If so many children are having (unprotected) sexual intercourse, why would the levels of HIV/AIDS in the age cohorts that correspond to the respondent population group be so much lower than the national level statistics? The reasons for this could, of course, be an atypical target population and once again, this merits further inquiry. Gomo et al (2005) also noted during research in Zimbabwe that HIV prevalence among 15-24 year olds rose

rapidly, more than doubling, especially among adolescents between the ages of 19 and 24 years, despite the fact that general knowledge of HIV/AIDS was above 85 percent.

Stigma-related matters seemed to be relatively unimportant and most learners felt that orphans were not discriminated against at the school. In fact, orphans were often beneficiaries of handouts or subsidies that were supportive rather than undermining. The school plays an important role here, in that it facilitates fundraising events and provides additional support to orphans as well as to non-orphans. The school also acts as a support in other domains, for instance the classroom curriculum provides information on issues such as sex, contraception and STIs. The school is stepping in and filling gaps where the state is not adequately responding – or able to respond – to these needs.

As noted above, knowledge or awareness of HIV/AIDS is not lacking and learners had a good sense of what the disease constitutes: that it is a virus, that it affects the immune system and so forth, and the majority knew that it was spread through sexual intercourse. A small percentage thought it was spread only through the blood and not through sexual intercourse. Almost half the learners said that abstinence was the best way to curtail the spread of HIV/AIDS or that they should use a condom, be faithful and so forth. These responses demonstrate a high level of awareness around socially sanctioned behaviour to prevent the spread of the virus.

Almost all learners knew someone who had recently died and it was mostly HIV/AIDS that was considered to be the cause of death. The biggest impact of death is the increasing number of orphans and the effects of this on both the economic and social well-being of the relevant communities. It is disconcerting to note that despite these high levels of awareness, some of the responses indicated that knowledge does not curtail behaviour: almost half responded that children between the age of 11 and 14 are engaging in sexual activities and 10 percent of the respondents said that children 10 years and younger were engaged in sex. The links between poverty and engagement in sexual intercourse are explicit, playing an even larger role than peer pressure, and more than 55 percent of respondents consider this as a means to gain income. There is some indication

that those who are older – and are therefore either more responsible for assuring household income or experiencing greater material needs – are more likely to consider exchanging sex for money or gifts.

These answers are particularly perturbing considering the fact that the target population of learners appears to be cared for by adults – either their own parents or close relatives. It would not be erroneous to presume that these incidences would be even higher in cases where learners are themselves responsible for the family or where they act as prime caregivers themselves. A high number of learners said that they knew of peers who were being treated badly at home and a considerable percentage also referred to other forms of abuse, for instance an orphan's inheritance being taken away by relatives.

This study was undertaken in a school environment and learners are aware of the ravages of HIV/AIDS as they regularly experience incidences of death. The responses to the questionnaire raise a number of questions. On the one hand, children and young adults have been exposed to the risks related to HIV/AIDS and this is a concern for a number of reasons, which include infection or pregnancy. But the ravages of HIV/AIDS and its association with death and/or disease appear to be accepted as reality, and exposure to or awareness of HIV/AIDS does not always impact on behaviour patterns. Although there were many areas not covered in the questionnaire (for instance, the survey did not go into depth about the number of partners or sexual relationships over the past 12 months) it extracted enough information to validate much of the qualitative interview material and it complements the findings in other parts of this dissertation.

One of the key points raised in this chapter is that if there is to be a turning point in the spread and impact of the virus, education programmes would need to be thought through very carefully so that they target the different realities facing men and women and ensure that theoretical or cognitive notions of HIV/AIDS are put into practice. Programmatic responses that include men and masculinity in their rapidly changing environment are recommended for future consideration. It is unlikely that in a staunchly patriarchal society such as Lesotho men will accept being left out of the development process, and as

they are considered to be the gender driving the epidemic they must be included in all facets of the dialogue associated with HIV/AIDS. In particular, prevention strategies need to be specifically targeted to them.

Analysis from the research findings touched on prevention methods such as the ABC doctrine and reflected flaws within the ABC method where there is, for instance, a deliberate exclusion of the promotion of condoms because of the perception that their availability increases the likelihood of sexual experimentation, implicitly encourages children to have sex at a younger age rather than wait until marriage, and opposes religious procreation beliefs (Levine & Ross: 2002).

An important finding of this chapter is the realisation of the extent of vulnerability of the future labour market given the current epidemiological projections of the virus's impact. As the focus of this survey was on learners, it is worth noting that there could be negative consequences in terms of education and future employment opportunities, with far fewer students continuing education past secondary school. [45] Lesotho may soon find itself relying even more heavily than it already does on international contributions to human capital in order to maintain a functioning state. The alternative scenario could mean that undereducated, underexperienced, young personnel are put prematurely into positions of power where they are asked to take on governance roles they are not equipped to occupy.

Whatever the scenario, HIV/AIDS has already taken its toll on the economic and social fabric of Lesotho and evidence from this survey – and elsewhere in the research – confirms that the situation is precarious and that the stability of the society is at threat.

[45] Due to financial, personal, or academic reasons

Chapter 4

Voices From the Frontlines: the War on HIV/AIDS

Introduction

In a speech to the heads of state of the African Union during the Special Summit of the African Union on HIV/AIDS, Tuberculosis and Malaria in April 2006, UNAIDS Executive Director Peter Piot likened the continent's battle to control HIV/AIDS to a war. President Yoweri Museveni of Uganda has also used this metaphor in his country's campaign, as has former Zambian leader Kenneth Kaunda[46]. Therefore it is fitting that this metaphor be used to describe the grassroots response to the pandemic in Lesotho as coming from the frontlines of the war zone.

This chapter discusses the issues faced by institutions, organisations, citizens, and orphans and vulnerable children in the struggle to deal with the impact of HIV/AIDS in Quthing. It will also examine what is and is not being done at the district level, as well as societal and cultural attitudes towards these vulnerable groups, some of which exacerbate the poor living conditions and ill treatment of minors, intentionally as well as unintentionally. The discussion draws on evidence provided through semi-structured interviews and direct observation with state and non-state actors in the district, as well as people directly and indirectly affected by HIV/AIDS and the rising orphan population. A matrix of the ethnographic data is included in the annex, as well as a detailed coding of informants who participated in this chapter.

The administrative capital of Quthing sits on an outcrop, with the peri-urban spread along the steep road that leads to the town centre . Dotted along the ascent are supermarkets, bars and stores selling everything from blankets and car parts to fast food. At night, as in many African cities, sex with mostly young women is on offer for a price. As outlined in Chapter 3, nearly 40 percent of surveyed adolescents at a local high school said they would have sex for money or gifts, either to meet their financial needs or because of peer

[46] http://www.un.org/ecosocdev/geninfo/afrec/vol14no4/htm/adf.htm

pressure. Most certainly the majority of girls found in the bars are of school-going age and their existence and behaviour is acknowledged by a wide cross-section of people interviewed for this chapter.

> "Girls from this school are sometimes found in bars selling themselves for luxury items like makeup, perfume and shoes. Sex can be [sold] for as little as a Coke or transport. Children are becoming increasingly uncontrollable and the community is not playing its role in reinforcing messaging to young people about their sexual responsibilities." High school principal.

Although evidence is provided from the interviews, a pivotal resource for this chapter is data taken from the 2004 Lesotho Demographic Health Survey (LDHS). The foundation of this survey was structured interviews with a nationally representative sample of residents from more than 9,000 households. It dealt with health status, attitudes and behaviour.

This chapter will draw upon both sources of information to examine the role played by gender (in particular, women's rights and exploitation, child rights and the abuse of children), social safety nets (in particular the role played by the elderly, traditional and cultural structures, the community, the state) and the education system. The findings will provide an in-depth understanding of how communities are responding to the impact of HIV/AIDS as well as examine the fragility of coping structures.

Gender

Until very recently in Lesotho, women have had no legal basis from which to negotiate sexual partners and terms, inheritance rights, land tenure, or rights to invest. This may now have changed through a landmark victory for women's rights following the passing by Parliament of the Legal Capacity Married Persons Bill in November 2006. It was first drafted in 2000. The bill received royal approval in December, making it a new law. It is yet to be gazetted and, most importantly, it is yet to be implemented, but it could bring sweeping changes to the legal and cultural framework affecting women. Up until this historic event, Lesotho's culture was based on patriarchal ideology whereby one's

identity is traced through paternal lineage and descent. While this is unlikely to change in real terms, some aspects of the culture could be affected, primarily the area of customary law that places women under the perpetual custody and protection of men, treating them as minors.

But gender issues go beyond just the maltreatment of women. The disparity of gender is reflected in statistics kept by the Registrar of Births and Deaths in Quthing. Statistics taken between January 2002 and September 2006 show an average life expectancy of 46.7 years of age: 48.5 years for men, and 44.8 years for women[47]. Alarmingly, the average mortality rate for married people in Quthing, which is dominated by the Basotho ethnic group, is 31.7 years: 34.1 years for men and 29.3 years for women. This is supported by national statistics from UNAIDS, which show that fewer than 10 percent of women aged 18-19 years are HIV positive, but three times as many are infected with the virus by the time they reach 22 years of age and nearly 40 percent will be HIV positive by the time they reach age 24 (UNAIDS: 2006)[48]. As discussed in Chapter 3, knowledge of HIV/AIDS prevention does not necessarily influence sexual practice. Medical practitioners in the district have no hesitation in attributing the majority of deaths of young sexually active people to AIDS or secondary illnesses associated with HIV.

As the mortality statistics are taken from official records, it is fair to assume that the majority of recorded deaths are of people living in urban centres. (Deaths in rural areas often go unrecorded by officials due to the complexities of reporting the incident, such as providing proof of death, finding transport, and then having the perseverance to undertake the bureaucratic process.) An explanation for the disproportionate high death rate among young women is that they are often forced into sex because they are culturally unable to refuse it, particularly if the man has provided some kind of service to the woman that she cannot afford to repay by other means. As explained earlier in this

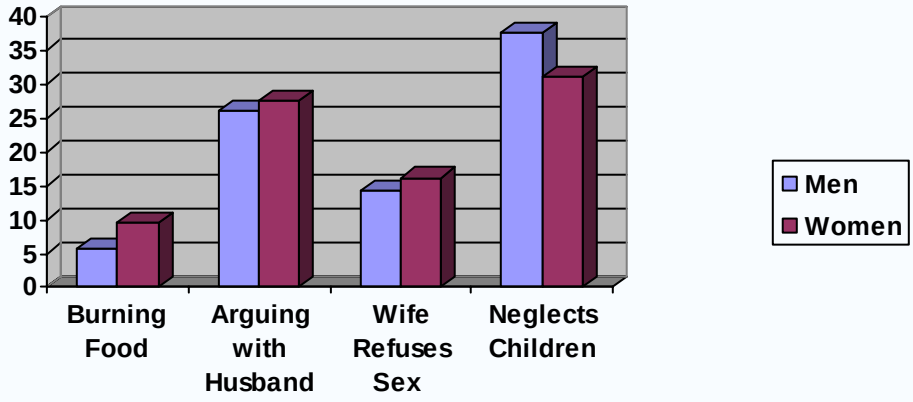
[47] As a random comparison, average life expectancy in Germany, one of the highest in the world, is 81.7 years for women and 75.9 years for men, according to UNDP Human Development Report, 2006.
[48] This also reveals the high level of intergenerational sex in Basotho society because young women are clearly not catching the virus from young men. It also reveals a possible increase in promiscuity from the age of 20 years.

dissertation, women carry a disproportionate burden of HIV/AIDS as well as the roles of household manager and main caregiver.

Abuse of women, sexual and domestic violence, and women's rights were all areas of deep concern in interviews, highlighted as expediting the erosion of coping strategies at the community level for orphans and vulnerable children. Data from the LDHS revealed that 56 percent of men in Lesotho think they have the right to get angry and reprimand their wives if they refused to have sex with them. Nearly one in five men nationally think they have the right to withhold money or financial support if their wives refuse sex, and an equal proportion of men think they have the right to have sex with another woman if their wives refuse to engage in intercourse. Disturbingly, 12 percent of men admitted to believing they have the right to use force to have sex with their wives.

This was corroborated by health practitioners and counsellors (interviews: 004, 005, 006, 010) familiar with the phenomenon. It should also be noted that in Quthing, in some instances, more women than men believe they deserve a beating from their husbands for failing in their wifely duties. Such shortcomings can include unintentionally burning food during cooking, arguing with their husbands, and refusing sex.

Figure 24: Acceptable reasons for wife beating in Quthing



Source: Lesotho Demographic and Health Survey, 2004. Values expressed in percentages.

This social conditioning of both men and women to accept sexual violence as 'normal' masculine behaviour along with the 'right' of men to control sexual encounters is explained by Nattrass (2004) (page number) as being part of the sexual culture which is 'socially constructed and reflect(s) unequal gender relations in the broader society.' The government plans to ensure that by 2008 legislation, policies and programmes are in place to address issues of education for girls, violence against women, property and inheritance rights, allocating value to women's involvement in household and community work, and access to HIV and AIDS treatment and care. The gazetting of the Legal Capacity Married Persons Bill should help achieve this end.

Children, Households and Vulnerability

In almost every community interviewed, respondents cited knowledge of some form of abuse of orphans and vulnerable children. This was also reflected in Chapter 3's discussion of the responses of learners to questions on this topic. Abuse in many communities is so systematic that it is perceived as the normal way to treat minors. While none of these activities fell into the illegal category, district officials acknowledged that more serious incidents of child abuse do occur on a fairly regular basis, prompting the state to create the Child Protection Unit (CPU) in 2003 under the auspices of the district police departments. Between January 2004 and August 2006, the CPU in Quthing received a total of 77 reported cases of sexual abuse towards children and 25 cases of child abduction.

> "Many orphans and vulnerable children face sexual harassment. Rape is also common, while others have their assets seized by greedy relatives as soon as their parents die." Police officer, Quthing

However, while administrative officials are quick to praise the efforts of this unit, some community leaders claim the officers are undertrained and underresourced and, to some extent, disinterested in the subject matter.

One of the commonest forms of orphan abuse recorded by district officials is theft by relatives of land and other assets left in the deceased parents' estate. This has been

particularly acute in cases where there were no boys in the family. Until recently Basotho law forbade wives the right to inherit assets left by their husbands. As discussed in the Literature Review, this might now have changed with the Legal Capacity Married Persons Bill, which is expected to be gazetted in early 2007 to make it legally binding. Girls are not covered by the Bill and as such are still inherently discriminated against.

Working against the process that allows children to inherit land is a law that stipulates that if land lies fallow for five years it can be confiscated by the state. Some children may never legally control land bequeathed by their parents because they do not come of age within the five-year limit and it is taken away from them. According to information provided by the district administrator in Quthing, who is a powerful advocate for children and child rights, efforts are under way to devise an initiative to support such children, by legally assigning land inherited by minors to the community to work until the child is able to take control.

In one example cited by a respondent (interview 019), a grandfather seized the assets, took in his grandson to make him tend the appropriated goat herd (thereby following Basotho culture and law), but left the two sisters to fend for themselves in the deceased parents' house. The girls brew beer to try to make ends meet, but their lives have been one of extreme hardship. While the younger girl managed to continue going to school, walking 1.5 hours every day each way to Quthing, the other stayed at home to take care of her baby and maintain beer production. In the evening the younger girl would return from her tiring trip to help market the beer and do other chores before doing her homework. Despite many months of requesting assistance from the chief of the village, they had not received a response, primarily because a girl child is deemed less worthy of having a voice than a boy child, and children as a group have little or few rights in village life. A female-dominated support group in the village is the only support structure available to monitor the girls' livelihood and offer ad hoc assistance.

Luckily this is not the case for all orphans and vulnerable children in Lesotho, with a significant proportion of people interviewed citing extended family as the main nurturer

and protector of such children, although children born outside the nucleus family are often not treated the same as their adoptive brothers and sisters. In some cases, the extended family tries so hard to make ends meet that it puts the entire family at risk by adopting adverse coping strategies, such as selling meagre assets, pulling children out of school, eating less well or irregularly, and in some cases turning to prostitution.

One alarming interview (interview 013) conducted for this dissertation revealed that people in a community wanted to become HIV positive so that they could partake in some of the benefits on offer from NGOs and the state. The respondent of this interview was a community leader and claimed she was reflecting on attitudes of a broad cross section of the people living in her area. While this view is not thought to be widespread, as this viewpoint was not raised again during the interviews, it does underline the disparity between the very poor who are not directly affected by HIV, who receive little or no poverty-alleviation assistance, and other very poor households that receive a variety of assistance linked to being affected by the virus. While this cannot be said to represent all communities, it does raise extreme concern that there may be individuals intentionally considering becoming infected to 'improve' their livelihoods. It also demonstrates what Basu (1997) describes as the 'vicious circle of poverty', whereby poor people are never able to break free from the shackles of poverty because they never have an opportunity to improve their situation. This phenomenon raises many moral and ethical issues about welfare and foreign assistance to vulnerable groups and begs further in-depth research.

Another form of illegal abuse perpetrated by not-so-benevolent relatives cited by respondents (interviews 001, 002, 005, 009, 014, 017, 030, 037) is the seizure of pensions, insurance schemes and bank accounts left by the deceased. Insurance schemes that pay out to surviving relatives are common for people in the education and health sectors or those who worked in South African mines. Law enforcement officials are routinely called by agencies such as TEBA to act against such relatives but often it is too late to stop the squandering.

> "We have had our successes. The Lesotho Mounted Police arrested the uncle who had seized the sheep and cattle bequeathed to a 16-year-old boy by his father. The uncle is now paying restitution while he awaits trial." District administration official for Quthing.

Another form of abuse includes theft of assets by relatives who claim to be 'managing' them in return for taking care of the orphans. This form of theft is often more palatable to other villagers and, if presented the right way, the authorities usually endorse this 'management'. In some cases, when the assets are exhausted, orphans are ejected from the family unit that has taken them in, invoking even more pain and suffering and effectively rendering them orphans for a second time. This behaviour is not often reported to the authorities, primarily for reasons outlined earlier in this subsection as well as the procedural cumbersomeness of building a case.

> "I am angry because relatives seize banks accounts and then withdraw the funds to enrich themselves rather than pass them on to the children left behind. Some relatives only take the in the children on the pretence of wanting to take care of their welfare, only to drop them as soon as the money runs out." TEBA official, Quthing

Aggravating the plight of orphans in Lesotho is the lack of state orphanages. The few NGO-funded orphanages primarily take in toddlers and under fives, but rarely children older than 12 years of age. This might also be explained by the fact that older children require less care and are therefore more easily farmed out to relatives or used in labour settings. The lack of an orphanage in Quthing was one of the weaknesses highlighted in the district's HIV/AIDS Strategic Plan for 2006-2011, as it leads to its most vulnerable and youngest having to leave the district to find care and support. Again, this underscores the role of relatives, who are key to maintaining the welfare of children affected by this type of abuse. Increasingly children are beginning to opt for a family constellation headed by the eldest child. Child-headed households, once an anomaly in African communities, are becoming a common phenomenon and are changing the societal landscape.

The central government has set the following specific objectives[49] for addressing the challenges faced by orphans and vulnerable children in Lesotho. Following each is the current state of play (in parentheses) as highlighted by respondents[50] during research for the dissertation: ensure that legislation and policies to protect the rights of orphans and vulnerable children are implemented by 2007 (on track); increase the proportion of orphan and vulnerable child households receiving free basic external support in caring for the child to 80 percent by 2010 (civil society is making some headway but given the scale of the problem and all of its machinations, it will require a bigger input than has been presented to date)**; e**nsure that 80 percent of orphans and vulnerable children have access to care and psychosocial support by 2010 (not a lot has been done to achieve this); ensure that 80 percent of people living with HIV/AIDS have access to care and psychosocial support by 2010 (on track through health clinics); provide support to alleviate deterioration of living conditions of 80 percent of people affected by HIV/AIDS by 2010 (not a lot has been done to achieve this).

The matron at Quthing Hospital, a sprightly woman who learned how to respond to the HIV/AIDS crisis in Uganda, says the biggest challenge facing paediatric response is 'education, education, and education'. Parents, healthcare workers and the children themselves all need to be better informed about all aspects of HIV/AIDS. Not only do many parents not realise their children can contract the virus, they are also not aware that children can be tested.

> "People are beginning to accept that HIV/AIDS is an illness like any other, which is helping to reduce stigma, but we still have a long way to go to convince some people that HIV/AIDS is not caught through bewitchment and that traditional healers and herbal remedies are probably not going to help them." Healthcare worker at Quthing Hospital.

The welfare of children concerns not only the child but also the unborn and newly born infant. The availability, awareness and acceptance of Nevirapine, a drug that can prevent transmission of HIV from mother to child, is limited. The mother can pass the virus to the

[49] Lesotho National Strategic HIV/AIDS Plan 2006-2011 – 2nd Draft
[50] Therefore this might reflect perception rather than actual progress

child during pregnancy, at the time of birth, or through breastfeeding. Nevirapine is administered to the mother once labour commences. If the labour is prolonged, the child is also given drops of the drug once it is born.

Complicating usage of the drug are cultural issues that confront women. For the drug to be effective, women must only breastfeed for a maximum six months after birth or, optimally, they must give the child milk formula to prevent or minimise the risk of post-natal re-infection. As few women can afford formula, most opt for breastfeeding. This is problematic as it is customary to breastfeed babies for several years and to supplement the infant's diet with other foodstuffs by the time they are a few months old. However, as breast milk contains the HIV virus, regardless of the drug regime given at birth, mixing the baby's food exposes it to intestinal and stomach upsets, which can lead to minor internal bleeding, making the child susceptible to the virus.

In addition, as was evident from the interviews, women often have little or no say in how their child is fed or raised during this critical period, as they are culturally at the scrutiny and mercy of their in-laws. A mother cannot even take her child to the clinic without the permission of her mother-in-law. If the child dies within the first few months of life, it is considered a poor reflection on the mother. Therefore, women with HIV who wish to keep their status secret risk exposure if they challenge traditions and culture by changing the regime of their child.

It is clear from this research, and attendance numbers at the Prevention from Mother to Child Transmission (PMTCT) centre at Quthing hospital, that few women are taking advantage of this service due to an overriding fear of stigma, putting the welfare of their child, and themselves, at risk. In August 2006, an estimated 140 pregnant women at the seven-month gestation period were referred to the centre , but only 58 of them agreed to take home the medication, presumably because of fear that someone in their community will realise they are HIV positive. Of those that took the drugs home, a good many of them may not take the drug at the right time. Furthermore, risk of transmission during birth and breastfeeding are high. Infants cannot be tested until they are 18 months old,

and even then the tests must be sent to South Africa as the state does not have the facilities to conduct the procedure.

> "Most women come when they are six months pregnant, which is around the time they are showing. Many do not realise they are pregnant before this." Healthcare worker at Quthing Hospital.

PMTCT, a relatively new phenomenon in Lesotho, requires further examination to determine the most appropriate way to communicate the importance of PMTCT and the required regime, as well as to remove the stigma of the virus from mothers and its impact on infants. This is supported by LDHS data, which show that nationally only 42 percent of women and 32 percent of men know HIV can be transmitted through breastfeeding and that the risk can be reduced with drugs. However, the data is skewed in favour of people who have received some education, which may be less in rural areas where 80 percent of the population lives.

Women with no education or who have not completed primary education are less likely to know about this type of transmission. Data at the district level is even more pronounced. Those with no education at all have the least knowledge and men with no education are even less likely to know about the connection between PMTCT and HIV transmission (LDHS, 2004). Therefore, ensuring a child receives an education is an extremely important step to ensuring people are informed about all facets of the virus, even though, as shown in Chapter 3, it does not always lead to appropriate behavioural responses.

Child labour is another common form of abuse of minors. Lesotho's Labour Code is the principal law governing employment-related matters. This law defines a child as a person under the age of 15, and a young person as someone over the age of 15 but under the age of 18. At particular risk of this kind of labour are child orphans, vulnerable children and to some extent young people in general. Boys are often forced to become livestock herders for food and sometimes shelter or a pittance of a salary. Boys are also engaged in seasonal agricultural work in South Africa but no data on the extent of this phenomenon is available, although research has been conducted on borderline farming and labour

issues (Crush:2003). Girls are often forced to become domestic helpers or child-care providers, sometimes for children barely younger than themselves.

An area in which children are totally neglected by family, state and advocacy campaigns is HIV/AIDS awareness and support. As mentioned earlier, children are excluded from HIV/AIDS campaigns because there is a steadfast belief that minors cannot contract the disease as they are not sexually active. This underlines the lack of understanding of the virus's breadth of contamination. This was also found to be the case in Zimbabwe (Gomo et al, 2005) where it was noted that government campaigns lack an emphasis on children.

Many people in rural areas believe HIV originates from witchcraft or that it is divine intervention for sins (Interviews 004, 006, 010, 016). Few can comprehend how a child could contract a virus that is ostensibly sexually transmitted or be cursed by witchcraft at such a young age, especially when children play such a pivotal role in Basotho society. Although no research is available on transmission rates to children, they are expected to be significant, either from mother to child or from sexual abuse.[51]

Hindering any proof of this theory is the very real prospect that many children die from 'normal' childhood illnesses, such as diarrhoea, colds, or other illnesses, before they reach the age of five. Health practitioners (interviews 004, 005, 010, 011, 037) believe many children experience a hastened death due to HIV/AIDS and their cause of death is in fact a secondary illness stemming from a weakened immune system attributed to HIV. Their death diagnosis would not be further challenged. The Baylor medical facility on the outskirts of Maseru, which treats mostly children affected by HIV/AIDS and TB, collects pathology data of this type but declined to share this information. This theory is also supported by an upward trend in childhood mortality (LDHS: 2004) which shows that one in nine children dies before reaching the age of five; and that eight in ten of these deaths occur in the first year of life (infant mortality is 91 deaths per 1,000 live births and child mortality is 24 deaths per 1,000 children aged one). Neonatal and postnatal periods account for 81 percent of all deaths under the age of five. One of the explanations for

[51] Quthing Hospital notes the youngest victim of rape in the 12-month period was two years old, while the oldest was 71.

such a high mortality rate among young children could be that they are succumbing to infections associated with HIV/AIDS. More research on this topic is recommended.

The government's much lauded Know your Status campaign does not address children. At the time of research, 850 people had been tested for HIV at Quthing Hospital, of which just over 400 people had been given ART. Only 20 children were receiving such drugs. Health workers at the hospital (interviews 004, 005, 006, 037) feel extremely frustrated by the lack of attention paid to children in national campaigns.

> "Medical assistance is lacking an holistic approach, there's no transport and the while the government-introduced Know Your Status campaign is good for adults, it neglects children. Parents just don't believe their kids can have the virus so they are rarely tested." Healthcare worker at a hospital in Lesotho.

At the same time, adolescents seem to destroy their own chances of avoiding the virus by engaging in risky sexual practices. Despite having full knowledge of HIV/AIDS and how it is transmitted and the availability of condoms on almost every street corner, they still engage in unprotected sex, particularly when they are away from school and back in their communities. Educationalists (interviews 007, 037) believe this has more to do with 'gushing hormones, peer pressure and sheer boredom' than willfully wanting to catch the virus or create an unwanted pregnancy.

Social Safety Nets

The Elderly: Elderly women remain the single largest support structure for orphans and vulnerable children within the extended family structure, even though they often live in chronic poverty themselves. Many grandparents inherit their grandchildren when their children die from AIDS or other illnesses or go abroad to work.[52] In addition to remittances that can be sent home, nearly 5,000 people in Quthing receive a non-contributory pension of 150 maluti[53] per month as an old age pension, according to the Post Office, which administers payments. The pension scheme, which has been running for only a couple of years in Lesotho, is not given in relation to a person's accumulated

[52] The new employment region appears to be Ceres in South Africa, where Basotho migrate year-round to work in the fruit and juice industry.
[53] The Lesotho maluti is pegged to the South African rand

assets, but is instead given to all people once they reach 70 years of age regardless of their wealth position. Given the high prevalence rate of AIDS, fewer people are making it to this age than before and therefore this coping strategy is slowly being eroded. Also, for this to be an effective safety net, the welfare of the child hinges on the extent of the pension receiver's benevolence. This can often be stretched to breaking point when the pensioner has already taken in several children and does not have enough land, agricultural inputs or remittances.

Evidence from other parts of the continent (UNICEF: 2006) provide an insight into elderly care of orphans and vulnerable children, with 40 percent of all orphans in Tanzania being cared for by grandparents, 45 percent in Uganda, 50 percent in Kenya and about 60 percent in Namibia and Zimbabwe. No statistics are available for Lesotho but it is reasonable to estimate the number would be significant.

The elderly are among the most vulnerable and marginalised members in society. Poverty rates for households with elderly people are up to 29 percent higher than for households without them, according to the five-country UNICEF study. Elderly women in particular assume responsibility for family members affected by HIV/AIDS and are frequently forced to sell personal assets and household goods to pay for medicines, healthcare and funerals. They are also forced to work longer hours to provide this care. As Lesotho is one of the worst affected countries by HIV/AIDS in the world, it is reasonable to expect similar patterns.

Some countries have embraced programmes to support the elderly, particularly those who are responsible for orphans and vulnerable children as a result of HIV/AIDS. In Zambia a pilot cash transfer scheme for older people caring for orphans and vulnerable children resulted in improved school attendance rates, while in South Africa it has been shown that girls who live with older women in receipt of a pension are up to four centimetres taller than girls in households with older women who do not receive a pension (UNICEF 2006). While such positive evidence is not available to support the pension system in Lesotho, it is reasonable to expect that a significant proportion of children living with

grandparents receiving a pension are better nourished and cared for than they would be if they lived in a non-pensioned household.

The important support role played by the elderly is acknowledged in numerous government documents. In almost all of them the state vows to strengthen support and assistance to mitigate deepening the impoverishment of the elderly[54], particularly in terms of their food security. Yet, besides the pension for the very few who make it to 70 years of age, the state provides very little direct support and instead relies on aid agencies to channel resources into poverty alleviation strategies for the elderly, particularly those caring for orphans and vulnerable children. In most cases this is not a sustainable long-term option, because all aid agencies are at the mercy of donor budgets, which are increasingly scaled back to focus more on emergency scenarios than social welfare schemes, especially when there is little hope of government being able to take over a scheme once it is up and running.

Traditional Structures and Change: In some villages the impact of HIV/AIDS, food insecurity and a weakened capacity for government to respond (De Wall, 2003) has become so severe that communities are resurrecting traditional coping structures that have not been employed on such a wide scale for many years. The practices of *matsema* and *mafisa* were the most commonly cited by respondents. No one could remember when both were last employed, and in some communities they have always been in place although not to the extent as they are currently be used.

Matsema occurs when a village shares resources such as land, inputs and labour to boost agricultural production. The output of the combined effort is then shared with all those who participated, including orphans and vulnerable regardless of whether they contributed. WFP (2006) notes that sharing of labour and food from communal plots is fundamental to households affected by HIV/AIDS.

Mafisa occurs when a poor person will offer to feed and care for surplus-to-need livestock owned by wealthier people in the village. In return, the borrower is allowed to

[54] Lesotho's National Policy on Orphans and Vulnerable Children, April 2005

use the animals' bi-products and any offspring are split with the owner. The borrowed animals remain the property of the owner. *Mafisa* was also cited by Mphale & Rwambali (2003) as a key coping strategy during Lesotho's drought years.

Both these methods are helping to ease the burden on struggling communities but given the four-year drought that has also affected the Senqu River Valley, where Quthing is one of the largest cities, the extent to which communities are able to draw upon these coping strategies in the long-term is questionable. These strategies might be adequate as a response to drought alone, but when an overwhelming crisis like HIV/AIDS is exacting a toll on social safety nets, these strategies cannot operate at optimal levels and may become redundant in lifting people out of their poverty trap.

> "We are encouraging communities to share resources to bolster agricultural production levels, which will also hopefully help benefit orphans and vulnerable children who don't receive enough food. Cultural values are changing and now when visitors come, people pretend they are not home or they run away from the house." District administration official

While some customs are seeing a revival, others are dying out. Traditionally Basotho make impromptu visits to friends and relatives over the weekend. During such a visit, the host is expected to provide food to the guests and then make a token gift, usually a chicken. However, since the rise of HIV/AIDS and orphans, combined with four successive droughts, this practice is threatened because it has become more of a coping strategy than a social occasion. The abuse of this custom means that many richer families have become so distrustful of their poorer relatives and friends that several respondents interviewed admitted to hiding when visitors arrive, to pretend they are not at home.

In the past families would send children to better-off relatives for long periods of time, if they could no longer fend for them. Culturally, the onus is on the relatives to accept the children and ensure they are taken care of. However, under the current socio-economic climate interviewees spoke of children who, after arriving at the relatives' home, are forced to work for their food and board, practically becoming slaves. Basotho farm out their children only as a last resort, but increasingly this seems to have become another coping strategy employed by poor families struggling to survive. The practice not only

puts the child in potential danger of exploitation, it also threatens the family nucleus, which once broken is difficult to recover.

Other more drastic cultural practices, while frowned upon by the upper echelons of Basotho society, are marrying off girls to wealthier suitors, or to anyone who may be able to fend for them. While the legal minimum age for marriage is 16 years, some interviewees spoke of girls as young as 13 being forced into marriage or even being abducted, usually by the male's relative. If the girl is younger than the legal marriageable age, then the police can be called to arrest the abductors, but this seldom happens in remote areas because chronically poor families often view the abduction as socially sanctioned behaviour as it results in one less mouth to feed.

During a focus group discussion (interview 029) with people affected by HIV/AIDS it became clear that some respondents also believe there is a broader deterioration of society taking place, attacking the moral fibre of customary and traditional laws. They cited modernisation, illness and religion as having equal impacts on age-old ways of being and behaving. Before the arrival of conventional religions, they say, young people respected their elders and did not engage in sexual activity before marriage, nor did girls roam the streets at night looking to make money or receive gifts from illicit sex. Such behavioural divergence was also cited by street children in Latin America (Scanlon et al: 1998) as a reason for being turned out from their families. Fortunately, social deterioration has not yet come to this in Quthing or the rest of Lesotho[55]. The focus group also claimed that HIV/AIDS had come about because of a disintegration of their cultural beliefs, family values, and customs, which started when Christianity was brought to Lesotho in the early 1800s by French missionaries. This view was strongly held by several of the older members of the focus group, all of whom were openly HIV positive. They said they felt disenfranchised by the modernisation of society, where young people now demand their own cellphone and car, whereas when they were young they had hoped for a stable marriage, numerous children, a roof over their heads and bountiful harvests.

[55] This could also mean that because sex is more accepted among some adolescent age groups, particularly boys aged 15-18, children may not be severely reprimanded for it. This would require more directed research.

This phenomenon of social divergence is widely discussed in literature (Kiragu: 2001, Barnett & Whiteside: 2004, Richter et al: 2004).

It also became clear during the research that the role of chiefs has been diminished since the introduction of community councils in May 2005. Council members are democratically elected rather than receiving their position through bequeathment or abdication, as in the case of chiefs. The move to create 128 community councils followed national government's decision in 2005 to decentralise functions to the districts and is seen as a central step in the country's need to deepen democracy and streamline service delivery.[56] An official from the Ministry of Local Government (interview 32) compared this policy to a "bloodless coup", in that it cedes power from central government and gives it to another more devolved entity.

To date, only eight out of 21 ministries have decentralised and not all departments have perceived this to be as desirable as others. For example, Health and Social Welfare is one of the ministries that have not fully embraced decentralisation. In particular, budget and decision-making powers at the ministry are still controlled by Maseru, in contrast with the Ministry of Agriculture, which has fully decentralised to the districts. According to officials and healthcare workers at the district level (interviews 001, 003, 005, 007), the slowness of the ministry to embrace change is a major obstacle to responding to the needs of orphans and vulnerable children.

Despite this, the move to create the community councils has been widely welcomed by the majority of institutions, NGOs, and community support structures. Traditionally chiefs were the most powerful and revered figures in their communities; their ruling was paramount on directives and dispute settlements, and often second only to national laws, of which the majority of rural people never had an understanding. Villagers consulted chiefs on business and all manner of problems such as: agricultural production, culture and traditions, births, deaths and marriages, inheritance practices, animal theft, etc.

[56] An example of this is the creation of the National Aids Council following the government's commitment to the principles of the Three Ones approach to combating HIV/AIDS, as outlined in Chapter One.

Respondents (interviews 005, 007, 016, 020, 023, 024, 039) noted that some chiefs were lethargic and unmotivated and unless 'an incentive' was offered to them, they were reluctant to help some people.

> "We survive because my cousin goes to work in South Africa for three months at a time. The community doesn't help us, and the chief doesn't help, but we're able to eat twice a day and my grandmother sends clothes." Double orphan who lives with his cousin along with his three siblings.

While chiefs serve on each community council, they no longer have final say in deciding a matter. Several chiefs interviewed (interviews 027, 029, 038) felt disenfranchised and bitter by the democratic changes that had swept away the greater part of their decision-making powers, while others admitted that modern times require modern solutions and were pleased that the burden of responsibility had shifted, particularly given the impact of the HIV/AIDS epidemic. Figure 25 demonstrates the divide between chiefs and councillors.

Figure 25: Division of Responsibilities between Chiefs and Councillors

Function of Chief	Duties of Councillors
1. Help people identify lost items, including livestock	1. Maintain close electorate contacts and consult with them on issues to be discussed in council meetings where necessary
2. Uphold the rule of law	2. Present views, opinions and proposals to the council
3. Prevent crime	3. Attend local council sessions and committee meetings as appropriate
4. Charge offenders	4. Meet regularly with constituents to discuss outcome of council meetings
5. Protect community development projects	5. Have due regard for national, district and voter interests
6. Work towards peace and tranquility	6. Mobilise constituents for development projects
7. Serve as first contact person for community in event of crimes	7. Act as community leader to whom voters will turn for guidance
8. Keep records for birth, death, marriages	8. Ensure sustainable use of the environment
9. Be custodians of Basotho culture and traditions	

Source: Decentralisation in the Kingdom of Lesotho, Trainer's Manual, Ministry of Local Government

Councillors and chiefs are expected work together to foster harmonious working relationships in local government; cultivate a culture of trust and respect for each other; show total commitment to the service of the council; \work as a team; protect the image of the council; and check the attitude of voters towards the way the council delivers services. In short, the implementation of this democratic institution, as the members of the focus group outlined, is changing the way Basotho culture operates and could eventually serve to shape adaptations to traditions that are required to face the evolving social landscape of Lesotho. It also holds public officials accountable for actions that affect community life, particularly if there is a perceived deterioration of societal values.

Given the problems faced by people affected by HIV/AIDS and in particular orphans and vulnerable children, having unbiased democratic institutions that provide a platform to debate issues and find equitable solutions to problems, may prove fortuitous in dealing with impact of HIV/AIDS, the legacy of orphans and vulnerable children, and other challenges that will arise in the 21st Century.

Food Security and Safety Nets: A perceived change in tradition has affected agricultural production. With the onset of drought in 2002, massive amounts of food aid arrived in the country. Food aid played an important role in saving countless lives at a time when the government was not able to respond. Since then food aid, has continued to support the people of Lesotho although to a lesser degree, to the point where it is now viewed by many households, parts of civil society and even some government departments, as a social safety net. Indeed, community support networks for orphans and vulnerable children view food aid as an essential component of assistance, while medical practitioners applaud food aid for impoverished households, particularly those receiving ART. (Food and nutrition play a critical role in helping the absorption process of ART as well as coating the stomach for the often caustic drugs to take effect.)

In lieu of longer-term development commitments from the international community and government, food aid helps people meet their immediate needs. The negative impact of this aid, according to respondents (interviews 014, 015, 016), has been that farmers in some communities have become ‘lazy’; instead of trying to grow their own food and

spending money on agricultural inputs like seeds and fertiliser each year, they sit back and wait for aid agencies to bring food, particularly during the lean season (December to April) when crops are scarcest.

> "Many people in this village, especially men, just loiter. People are used to receiving food aid but for the last three months supply has been erratic and they are now nervous of what will happen if the food aid stops." Healthcare worker, Quthing District.

WFP, the largest food aid provider in Lesotho, goes out of its way to programme food so it is not a free handout. In most cases recipients must be children in school, orphans or classified as vulnerable, people receiving ART, or people in hospital. Food distributions to the general population take place only during times of severe drought and crop failure, and even then it is targeted to the most vulnerable in the worst affected areas.

Therefore, while some interviewees cited food aid as a negative coping strategy because of its potential impact on farmers, it has in fact been a positive support structure, ensuring people do not starve. Adding to this negative perception is the climate of stigma. With so many people affected by HIV receiving assistance and so few willing to admit their status, people who receive food aid and do not grow food may in fact be too ill to plant or unable to afford the inputs due to mounting medical bills.[57]

Initiation Rites and Condoms: Other traditions are adapting to modern times. Initiation schools in Quthing, which are culturally a passage to manhood for many boys, have been incorporating information on HIV/AIDS, STIs, and unwanted pregnancies since 2004. The central role of the initiation school is to prepare a boy for life beyond the care of his parents, when he will be responsible for raising his own family. This could be of great importance for orphans and vulnerable children, who may have grown up without one or both parents and therefore lack appropriate gender role models.

The main event at an initiation school is a circumcision ceremony, an increasingly controversial act that, on the one hand, is blamed for the deaths of initiates when the circumcision is botched, and, on the other hand, could lower a man's susceptibility to

[57] Based on interview with WFP Deputy Country Director for Lesotho

contracting the HIV virus according to new research[58]. Some health practitioners are even calling for circumcision to be incorporated into HIV prevention campaigns.

> "Many still don't believe AIDS exists and that if someone is dying, they instead think they have been bewitched." Traditional ceremony coordinator, Quthing District.

Initiation schools are a little like the Freemason sect in other parts of the world, in that they serve as a fraternal network for all those who have been through it, dispensing "secret" information that is not supposed to be divulged to men who have not been circumcised. Circumcised men claim to work together, particularly for economic gain, more than with men who are not circumcised, who they say can be quickly identified (interview 018). Quthing was the first district in Lesotho to incorporate HIV/AIDS awareness into initiation schools and to use a new razor blade for each child for the circumcision. Quthing's HIV/AIDS Strategic Plan for 2006-2011 notes that education on HIV prevention needs to be strengthened, and HIV testing of boys and counselling should be incorporated into the initiation school curriculum. Boys also receive a stock of condoms once the initiation school is completed.

LDHS data suggests that Quthing has the highest proportion of circumcised men (69 percent) in Lesotho, nearly all of them circumcised in initiation ceremonies. The research shows that people who follow a Western religion are less likely to be circumcised, with an average of 48.4 percent of men in a Christian-based faith being circumcised compared with 64.1 percent of men who have no religion. This may reflect the possibility that men who follow a Western religion are less likely to believe in traditional cultural practices such as circumcision, but this would require further research to draw a conclusive link. In addition, LDHS data shows those who are better educated and wealthier are less likely to be circumcised: only 30 percent of men in the top wealth bracket are circumcised, compared with nearly 70 percent in the poorest wealth bracket. According to the local chief coordinator of initiation ceremonies in Quthing, 879 boys went to the school in 2005 with only five fatalities, a considerable reduction in deaths from previous years.

[58] Reported in the South African *Sunday Times* newspaper. Circumcision reduces Aids risk: study. December 15, 2006.

Given the fraternal bonding that takes place during the initiation school, boys who have been orphaned might gain a new sense of belonging and acceptance, and if nothing else, they will learn vital information about avoiding HIV/AIDS, unwanted pregnancies and STIs.

Initiation schools, in their new improved form, therefore could provide potential for an institutional setting that corresponds to the needs of orphans and vulnerable children. Acting as another social safety net, this could help reduce the transmission of AIDS among this vulnerably aged group.

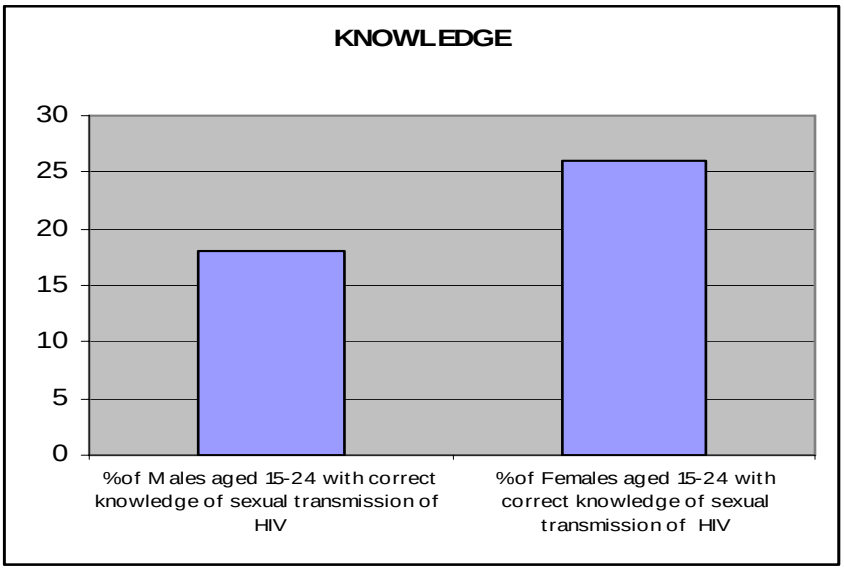
According to key informants and evidence from the LDHS, the arrival of condoms, now freely available in almost every village, police station, factory, community health clinic and government office, has also changed the social landscape in Lesotho. Before the advent of HIV/AIDS, families consisted of five, six or many more children, primarily because birth control was not easily accessible. Moreover, a family's wealth and, more importantly in Basotho culture, a man's prowess, were measured by the number of children. Although it has taken many years of campaigning, the availability of condoms and the possibility of their use on a wide scale indicate that traditional sexual values may be beginning to change.

This argument is strengthened by LDHS data, which show that nearly 80 percent of men and nearly 70 percent of women aged 15-24 in Quthing knew of a condom source. Fifty percent of surveyed men in Quthing said they approved of contraception in 2004, while 34.7 percent disapproved and 15.3 percent were unsure. Acceptance of family planning methods increased with the level of education and wealth bracket. In one community, about 100 condoms are distributed each month, primarily to youth. The Red Cross distributes between 2,000 and 3,000 condoms each month in Quthing.

As Figure 26 demonstrates, correct knowledge of HIV transmission is alarmingly low despite the years of campaigning to put the message out in communities. Condom distribution and usage are therefore critical to curtailing the spread of the virus while more fundamental information on HIV/AIDS is injected into the public arena. The

reverse trend was seen in Chapter 3, which described respondents to a survey at a high school in Quthing as showing a very high understanding of HIV transmission, but even in this case there were concerns over whether an appropriate behavioural response was undertaken.

Figure 26: Knowledge of sexual transmission of HIV



Source: Lesotho Demographic Health Survey, 2004

One of the most important aspects of communities taking the lead with condom distribution and HIV awareness is that it empowers the community to take action on its own problems, rather than wait for a directive from central government. The importance of community buy-in was emphasised during the SADC Regional Consultation on Social Change Communication for HIV Prevention, hosted by Swaziland in October 2006. Grassroots participation and leadership is considered critical because people's ideas and outlooks are shaped by what happens in the home, where socialisation occurs, and not, as many would assume, by the availability of factual information and advice from outside.

Despite such community involvement, HIV infection rates continue to rise unabated, particularly among young women. One reason cited by several healthcare and community respondents (interviews 004, 005, 012, 017), is the doubt that people, particularly those in the 15-24 age group, are actually using the condoms. Some believe adolescents, particularly males, are using condoms as more of a status symbol. By carrying a condom

in their pocket, they are demonstrating to their peers that they could be sexually active at any time because they are potently desirable to the opposite sex, even though they could be neglecting to use the condoms at the moment of intercourse. This concern was also raised by NGO workers who deal directly with condom distribution in communities.

According to LDHS data, the percentage of sexually active men and women aged 15-24 in Lesotho who said they engaged in higher-risk sex over a 12-month period was 89 percent for men, 42 percent for women. Alarmingly, only 48 percent of men and 50 percent of women who were surveyed admitted to using a condom. Although the sample size was very small in Quthing, (53 men and 124 women), 90.6 percent of men admitted having higher-risk sex in a 12-month period compared with 55.8 percent of women. However, 41.8 percent of men and 43.2 percent of women said they had used a condom the last time they had higher-risk sex.

The LDHS data was released in 2004, and if the data was truly representative of attitudes among both sexes, it could mean advocacy campaigns and awareness among the general population about HIV/AIDS and the way it is spread have been having an impact on those who are sexually active. Although the LDHS statistics are extremely high for men and women who do not use condoms, it must be remembered that a few years ago condoms barely existed in the country, let alone in rural areas and isolated communities. Further investigation is needed to determine whether informed behavioural change is responsible for this dramatic shift in use or if the sample size was too small to be reliable.

The possibility of behavioural change concurs with information supplied by key informants during the course of this research. In almost every interview, respondents responsible for distributing condoms or making them available to the community said they were often overwhelmed with requests for condoms, usually from young males. Quthing Hospital also makes them available to patients, although one senior health worker stated that some patients believe condoms are part of a conspiracy by the government of the United States to wipe out Africans. The sceptics believe the condoms that are made available by international organisations and NGOs are infected with HIV, because the arrival of condoms coincided with the rise in the virus's prevalence, and the

campaign for people to use them. This popular belief was voiced during a focus group discussion in 2005 in a neighbouring district of Lesotho where the writer was present.

These changing traditions are important for children growing up in Lesotho today, as many will feel the tensions between old beliefs and the new thinking with its many contradictions. Peer pressure has always played a prominent role in shaping a child's outlook but now, so too will the age of the caregiver responsible for the child's welfare.

These influences will be important when a boy is weighing up the decision to attend initiation school, if he has a say in it, or when children are considering having sex for the first time and deciding whether to use a condom. It is important to note that orphans and vulnerable children could be of particular risk to infection as the result of misinformation (UNICEF, 2005), although preliminary research from South Africa[59] suggests that children who are orphaned are not necessarily more vulnerable than their non-orphan counterparts. Instead, the research suggests poverty is the crippling factor in enabling the child to live a full and productive childhood.

As has been seen with LDHS data and information from interviews for this dissertation, the education level of the child and his/her caregiver plays a crucial role in shaping the kind of information that is processed by the child. South Africa, in stark contrast to Lesotho, has more developed social services structures and receives a higher level of international attention and funding for research and financial support for vulnerable groups -- perhaps even a disproportionate amount, given the number of people affected by HIV/AIDS in the two countries: 270,000 people out of a population of 1.8 million (1:66) in Lesotho, compared with 5.5 million out of a population of 47 million (1:8.5) in South Africa. What is clear, however, is that very little qualitative research exists on children and the impact of HIV/AIDS in Lesotho. This is one of the most critical areas for future research in this country, because today's children will have to deal with the complex fallout from the pandemic, and need to be equipped with knowledge to respond.

[59] University of KwaZulu-Natal's Health Economics and HIV/AIDS Research Division, as reported by the Irin news service, November 10, 2006.

Community Support Structures: From a number of interviews and LDHS, it is clear that community support structures act as social safety nets for people affected by HIV/AIDS. They also play a vital role in aiding and monitoring the welfare of orphans and vulnerable children and their care givers. Community safety nets play a particularly vital role for extremely poor households that receive insufficient support from relatives (WFP: 2006). Nearly every village has a community support structure made up of volunteers, most of whom have been affected by HIV/AIDS in some way. In all of the communities randomly visited for this dissertation, community support structures involved with home-based care[60] were active and thriving. These structures have been a benefit to those in need but have also served as a mechanism for uniting communities, giving them an opportunity to join forces and actively participate in tackling the crisis.

One aid worker remarked that forming these structures gave ownership of the problem to the people who are directly affected by the virus, which was crucial in starting the grassroots response.

> "Before the formalisation of HIV groups, community home-based care groups were sitting, praying, and discussing the disease sweeping the land. Once support structures began to be put in place, the community support structure changed. These groups took on new relevance to communities, a new raison d'être." NGO volunteer, Quthing

Although community responses provided a safety net, they are unable on their own to provide a comprehensive service without adequate resources. All groups complained of a lack of resources to enable adequate care to those in need. In cases where adequate resources are not made available to these groups, individuals are expected or obliged to use their personal resources to maintain vulnerable groups. The most common request is for food, soap and clothing.

[60] This is assistance given to someone who is critically ill and cannot receive institutional care for one reason or another so it is given in their homes.

It was evident from interviews with these groups (interviews 019, 029) that community support structures are under an extreme burden to perform their work in an environment of steadily increasing needs and stretched resources. This burden affects the willingness of volunteers to participate in a community support structure as they see their care-giver role being increasingly linked to their own meagre assets. In addition, some support group members interviewed were so demoralised by the lack of recognition and never ending workload that they admitted to unintentionally not giving the proper care to those assigned to them. A person who has AIDS and is receiving ART can require months of intensive care before showing any signs of recovery. Despite these frank confessions, care groups are effectively unpaid community healthcare workers. Support group members felt they should be paid for their time and commitment. Many thought a financial incentive would also help bolster service delivery.

It was noted during interviews with informants (interview 039) that in some cases there was an element of collusion between key personnel in some communities to exaggerate the number of people affected in their area of responsibility, in order to solicit more resources. In one community, the leader of the support structure informed me that she was assisting 300 orphans and vulnerable children through her network of nine caregivers. However, closer examination of her records revealed that she had under her care only about 100 children spread across 15 villages. She herself was responsible for 14 children.

It was later explained (interviews 012, 016) that with so few resources available and a lack of coordination to ensure even resource distribution, many felt compelled to inflate the impact of HIV to get a greater share of the scarce resources required to support the community. If such data inflation is as prevalent as some respondents and NGOs believe it may be, it could have major ramifications for the validity of current data as well as future data collection processes that rely on local extrapolations.[61]

[61] The Statistics Office in Quthing lacks computers, or computer information gathering tools. No records are kept in the office, but rather they are sent to Maseru to collate information from all districts in the country.

As there is no requirement for the head of a community support structure to be literate, have training in bookkeeping and data collection, or have even basic mathematics skills, the potential for data distortion is real. Leaders are usually elected by their peers, and often they are selected because of their influential social and political standing, rather than their intellect or their expertise in rallying the community.

To maintain these positions of power and respect, community leaders are under pressure to deliver resources to their constituents. Many of the caregivers interviewed (interviews 013, 014, 016, 038, 039) were impoverished themselves and it was revealed (interviews 002, 013, 016) that sometimes assistance given by NGOs for orphans and vulnerable children is used for the caregiver's personal gain. For example, a woman who had been given cloth to make school uniforms for orphans and vulnerable children in her village decided that as she had worked tirelessly to support these groups and had received no compensation, she would keep the material herself. She later admitted to making uniforms for her own children and selling the excess to other people in the village[62].

The role of community support structures is complicated and there is a lack of clarity on where assistance for this support is found or how it is accessed. Many community support group members who were interviewed expressed the perception that the lack of transparency starts at the top, with individuals in the district administration and Maseru controlling access to funding and resources. They claim that only a trickle of assistance filters down to the community level.

An example cited by one health practitioner is the large amount of finances from the Global Fund that support projects around Maseru rather than in outlying towns and rural districts. However, it is also clear from interviews that if this control and access were devolved to the community level, the problem might not be resolved, as the same hierarchical structures would quickly be formed and would probably be less effective in utilising the resources, due to a lack of programme expertise at the community level. If

[62] Cited in an interview with an aid worker

corruption exists among public officials, it is fair to assume that given an opportunity, equally corrupt networks could be formed at the community level as well.

This was also evident from examining civil society budgets for responding to the HIV/AIDS and orphans and vulnerable children paradigm. Large amounts of money, sometimes more than 50 percent of project budgets, are spent staging workshops, paying stipends, and covering travel costs for people to attend workshops that have little or no follow up. In some instances participation is refused if there is no 'donation'[63] to the individual or hosting community.

There is very little evidence that information transfers or meaningful debate among those who attend these workshops takes place at the community or district level. It would appear that attending workshops, in some cases, serves only to bolster the status of participants among their peers, because knowledge and power are so linked in a largely uneducated community struggling to cope with HIV/AIDS. It also shows a grave lack of planning, monitoring and evaluation among some NGOs, which are given healthy budgets by donors but do not have long-term strategic goals or knowledge on how to implement projects, and instead spend money on workshops to appear to be efficient.

Despite these problems, some community groups have made great strides and are efficient and effective in improving the lives of those affected by the virus. One of the ways this has manifested itself is through the creation of key-hole gardens, a vegetable patch of sorts that is built at waist level, resembling a round key-hole to enable sick people or children easy access to low-maintenance food production. Its design requires a minimal amount of water and offers a diversity of crops, so it is an appropriate technology for improving food security at the household level, particularly among vulnerable groups. C-SAFE, an NGO consortium[64], has helped communities across

[63] In a September 2006 bi-monthly report for the String Game, a village-level HIV/AIDS outreach programme, it was noted that the community of Sixondo refused to facilitate a meeting to hold the event without payment.

[64] Made up of the US arms of Save the Children, World Vision, and Catholic Relief Services, this consortium was formed in 2002 to respond to the humanitarian challenges in southern Africa by capitalising on strengths and offering a streamlined, cost-effective response.

Lesotho develop more than 9,000 of these key-hole gardens over the last couple of years.[65]

State Responses: Resources, when made available at the community level, can have a positive impact on the welfare of all habitants. Devereux (2002) NEED PAGE NUMBER points out 'tiny transfers equal tiny impacts, but moderate transfers can have major impact'. He argues that poverty-stricken households first satisfy immediate consumption needs; then they invest in human capital, such as education and healthcare; then in social capital, such as supporting others while establishing a basis of reciprocal clams; and then finally to directly invest in income-generating assets and livelihood activities. One of the arguments against social safety nets is that they are often too donor driven and thus may exclude or alienate the communities they were designed to assist because of a lack of ownership by the affected communities. [66]

Another safety net available to impoverished individuals in a community is a state-paid stipend of 100 Maluti for those who earn less than 150 Maluti per month or comparatively through agricultural production. The Office of Social Welfare in Quthing says 196 people receive this monthly payout, but at least 500 others are in need of it. People who receive this welfare are also entitled to a coffin should the need arise, as well as free medical services and, in some extreme cases, food parcels. Milk formula is provided to mothers who are too ill to breastfeed (i.e., not merely because they are HIV positive) but only five infants were receiving this benefit at the time of research.

To receive assistance from Social Welfare, a destitute person must come with a letter from the chief of the village, stating that assistance is required. Only then will Social Welfare visit a community to verify the claim. Given that women and children are often marginalised by the male-dominated patriarchal system, as well as being disproportionately illiterate and lacking access to funds to travel, some may find it difficult to traverse these barriers.

[65] Case study: "Key Hole Gardening Techniques", C-SAFE Newsletter, January - April 2005
[66] Noted in the Quthing HIV/AIDS Strategic Plan, 2006-2011

Education: The education sector is one of the most important pillars of support for orphans and vulnerable children. Lesotho has some of the highest illiteracy rates in sub-Saharan Africa, with only 26 percent of men and 10 percent of women able to read and write. Government expenditure on education accounts for almost one-fifth of total expenditure, one-third of which is allocated to primary schooling (WFP: 2006). Since 2000, the government has made considerable investment in making primary education free, which has boosted enrollment and attendance. Nevertheless, there are concerns about the quality of teaching, with an average teacher: student ratio of 1:44 (ibid). The government pays for some textbooks, paper supplies, maintenance and meals[67]. Since the state made primary education free in 2000, there is now a significant number of children eligible for secondary school in 2007. While the government has committed itself to universal and equitable access to completion of basic education[68] for all Basotho, no time frame for its introduction has yet been established. At this stage, no secondary school in Quthing would be able to take on a caseload of students beyond the usual annual intake, without a considerable supplement of financial and infrastructural resources.

> "Government really is trying to address the issues being faced by orphans but the sheer scale of the problem is immense.' Government official, Quthing.

If such a measure is implemented, there has been no discussion on how much general budgetary expenditure will need to be increased to expand facilities and increase the number of teachers required to cope with the influx, or even whether enough qualified teachers exist in the country to meet the expected demand. Without such a measure by the government, enrolment of secondary school students is expected to remain low, with as many as 70 percent of boys and 61 percent of girls opting out (LDHS: 2004).

The government has also committed itself to establishing a comprehensive early childhood care and development programme to promote functional literacy through non-

[67] WFP-provided food to schools is often the only meal a child will receive in a day.
[68] The SADC Protocol on Education and Training defines basic education as seven years of primary schooling and three years of secondary schooling.

formal education centres. Resources shortages for education were also discussed in Chapter 3.

Despite these shortcomings, schools offer one of the most important safety nets for orphans and vulnerable children, and indeed children in general. Even though the state provides the bulk of funding for operating expenses, most schools are under-resourced. Although primary education is free and the state pays bursaries for some secondary students, parents and guardians are expected to meet many of the hidden costs, including books, meals, boarding fees, and school uniforms that are not paid for by the state or supplied by NGOs such as the Red Cross, which supplies uniforms to the poorest children. Some respondents voiced concern that such services are not available to families above a certain wealth threshold and therefore these families, although poor, miss out on this NGO support.

> "The fact that the education system is free has helped improve the welfare of children, especially orphans and vulnerable children. Some people are getting pensions and using it to take care of orphans and as a result their lives have been changed although it's difficult for the elderly because they don't have many resources." Community care giver, Pokane, Quthing

Teaching staff hold regular events to raise funds for orphans and vulnerable children, as well as carry out building and maintenance requirements that are not met by the state. This assistance enables the school to extend boarding services to non-paying orphans and vulnerable children, and therefore reduces the burden on the community and affected families to feed and house them, as well as ensuring a more productive and safe environment for the child.

One secondary school visited during the course of this research funded several teachers' salaries from school fees paid by better-off learners. While this helps to ease some of the burden, most schools do not have enough teachers to educate the rising tide of eager students. As a consequence, some classes are in excess of 70 pupils and teachers are forced to repeat classes several times, to ensure every learner receives the information. While teachers complain that this is untenable in the long term, the efforts made by the

school and its teaching staff offer valuable institutional support to orphans and vulnerable children.

To underscore the importance of educational institutions to orphans and vulnerable children, the Ministry of Health and Social Welfare included this category in its 2004 sample for the LDHS. The data reflected that only 41 percent of children in Quthing live with both parents, while one or both parents of 30 percent have died. As a result of government support for orphans and vulnerable children, more than 80 percent of children with one or both parents dead still manage to attend school.

Educational institutions afford orphans and vulnerable children an opportunity to blend in with other children and not feel excluded, stigmatised or singled out because of their circumstances. The Education Sector Strategic Plan for 2005 to 2015 endorses comprehensive strategies for improving access and equity for orphans and vulnerable children, as well as other disadvantaged children.

Access and equity are two key themes in the Ministry of Education's strategic priorities. Access emphasises the commitment to the universal provision of educational opportunities, while equity emphasises the need to ensure that the distribution and utilisation of opportunities in education are done fairly to reach disadvantaged groups. When free primary education was introduced, there were instances of adults 40 years and older registering for school because they wanted to learn how to read and write. This underscores again the important and pivotal role played by the education system.

Conclusion

As outlined at the beginning of this chapter, all information contained in this section is based upon semi-structured interviews and direct observation with state and non-state actors in the district, as well as people directly and indirectly affected by HIV/AIDS and the rising orphan population. Data pivotal to the discussion was also taken from the LDHS. Evidence drawn in this conclusion is based on interviews with key informants. Nonetheless, it is hoped the points raised in the chapter, which affect institutions, organisations, citizens, and orphans and vulnerable children in the struggle to deal with

the impact of HIV/AIDS in Quthing, might be useful in discussions and research in this area.

On a positive note, it is important to underscore the commitment shown by government and civil society, which have clearly put the HIV/AIDS epidemic on the agenda of challenges for Lesotho and Quthing. There is evidence that officials of the state and particularly of the district are trying to move in step with the evolving impact of the crisis but are often hamstrung by bureaucracy, opposition to change and inadequate resources. It is widely recognised in these circles that poverty, gender inequity and sexual practices are driving the spread of the virus. This recognition has been reflected in the increase in the number of people coming forward to be tested for HIV[69] and the increase in the availability of condoms in rural areas.

Furthermore, there is recognition by a growing percentage of the population that HIV/AIDS is responsible for the growing death toll and is the reason why government has made a clear commitment to increase funding for education to make primary fees free. It also became clear in this chapter that education plays a critically important role, not only in supporting orphans and vulnerable children by creating a caring and 'normalising' environment in which to learn, but also making it possible for adults who have received an education to make better informed choices that lessen their exposure to the virus. This evidence was gathered from primary data and is also reflected in LDHS data for: knowledge of PMTCT; fewer sexual partners; and increased awareness about condoms and their possible use. However, as the responses to the survey show in Chapter 3, education does not guarantee a change in behaviour.

At the community level, the elderly are stepping into an intergenerational gap created by the overwhelming number of deaths of the most productive members of society, more often than not their own children. As the literature review of this dissertation revealed, the elderly are playing a fundamental role in keeping communities and family structures

[69] Which also suggests a decline in stigma

running and away from the 'breaking point'[70], although there is also an acknowledgement of abuse of some minors left in their care. Reported incidences of abuse might be a symptom that this particular coping strategy is beginning to fray. Given the age of many of the elderly, it is pertinent to ask whether this support structure can be sustained. Many of those acting as this safety net for orphans and vulnerable children are 70 years or older and often they themselves were impoverished even before taking on the additional burden of caring for minors. It must also be acknowledged that children growing up in the new family structure will be indoctrinated into a different set of cultural values, which belong to a generation older than their parents.

It is also evident from the chapter discussion that food aid has played a vital role in keeping vulnerable people alive since the drought of 2002. Although there is a strong perception that this external assistance has destroyed the incentive to plant crops at the household level, this concern may be unfounded, as food aid has been reduced in line with improvements in crop production and vulnerability over the years. What is clear is that regardless of the harvest, there is a growing vulnerable population due to HIV/AIDS who will require external assistance each year as the government is unable to meet their needs.

The pandemic in Lesotho has brought about changes in traditional and cultural systems, some of which are deemed for the better, such as the creation of democratically elected community councils that cede power from hereditary and often ill-equipped chiefs; as well as the incorporation of information on HIV/AIDS and STIs into the curriculum of initiation schools, which also offer the potential for providing behavioural role models to orphaned and vulnerable boys.

The chapter also reflected on important aspects of intervention that are not being provided at the district level, as well as societal and cultural attitudes towards orphans and vulnerable children, some of which exacerbate the poor living conditions and ill treatment of minors, intentionally as well as unintentionally. These include: exploitation

[70] Also discussed at great length in the literature review

by relatives of assets bequeathed to children; gender and domestic violence; maltreatment of minors by current standards; non-inclusion of minors in government HIV/AIDS campaigns; the low priority or poor understanding of child rights; the removal of children from school as a coping strategy; limited knowledge or usage of PMTCT treatment; the problem of access to healthcare (in the future the government must grapple with the critical shortage of affordable transport to take people medical clinics for earlier diagnosis and treatment of HIV before the onset of AIDS); the need for early diagnosis and treatment to help preserve the family unit for as long as possible; the need to reduce the level of mistrust among Quthing's three ethnic groups, by translating key documentation into the appropriate languages; the need to streamline government response, including all aspects of decentralisation; the need to increase transparency and accountability of all funding mechanisms to combat the impact of HIV/AIDS; and the need to increase advocacy programmes to reduce promiscuity and unprotected sex in general;

The research identified three alarming phenomena that merit further examination. The first is the growing wealth disparity between poor people unaffected by the virus and poor people affected by the virus, who receive assistance from the government and/or civil society. There is an increasing perception of discrimination by the 'have nots', to the point where some are asking whether their lives would not be enhanced if they deliberately became infected by the virus.

> 'People want to be HIV positive. People want to receive food aid and other benefits.' Caregiver to nine chronically ill adults and 15 orphans and vulnerable children in a community near Quthing

Programmers must consider this disparity when designing support mechanisms, otherwise healthy populations could wilfully start becoming infected to receive support.

The second phenomenon is the HIV transmission and infection rates of children. There was enough anecdotal evidence to suggest many children are dying of secondary illnesses before they have an opportunity to be tested and treated for HIV. The third phenomenon

is the possibility that communities are exaggerating the extent of the HIV/AIDS paradigm in order to receive more support from external players. This point alone, if substantiated by further research, could have sweeping repercussions for the entire humanitarian sector.

Chapter 5

Conclusion

At the outset of this dissertation, four research questions were raised: What is the status of social safety nets? How are communities surviving with the growing number of orphans and vulnerable children? What might be the early warning signs of community breaking points as a new category of child-headed household emerges? What are the human drivers of the pandemic in terms of behaviour and attitudes towards HIV/AIDS, orphans and vulnerable children, and sex; and in terms of reasons why people are not heeding the warning signs and adopting behaviour change?

To satisfy the first question – What is the status of social safety nets? – the thesis examined the social protection measures, also known as social safety nets or social assistance programmes, which are plentiful and on various scales in Quthing. Safety net mechanisms include the roles played by educational institutions; community support groups; remittances from relatives employed in South Africa: traditional coping strategies like *matsema, mafisa* and the extended family; the role played by elderly citizens; the state-funded pension scheme and destitute allowance; and the role played by civil society in delivering externally funded support.

The research presented in this dissertation demonstrates that these social safety nets are operational in various capacities to assist orphans and vulnerable children impacted by the HIV/AIDS epidemic. However, there is also evidence that these systems are overworked and under-resourced, and the strain from the burden of trying to cope with the rising number of parentless and destitute children is beginning to take its toll. There is also evidence that some of the systems, such as the extended family, community support groups, and education facilities, are heading towards breaking point – the moment when social safety nets become overwhelmed by the demands placed on them. It is also clear from this research that there is no clear systemic or holistic approach to coping with the

impact of HIV/AIDS on orphans and vulnerable children; instead, it would appear that a random mishmash of social and state responses form a fragile safety net that is knitted together to prevent individuals from falling into utter destitution. These coping mechanisms form an ad hoc safety net but it is unlikely that this system will be sustainable given the projections for orphans and vulnerable children over the medium term and the estimated scarcity of human and financial resources.

As established in this dissertation, communities in Lesotho are traditionally tight-knit cohesive entities but the strain of the orphan and vulnerable children crisis due to the HIV/AIDS epidemic is beginning to show signs of eroding the traditional structures of communities and in particular the primary family unit. As described in Chapter 4, examples of this are evident from: the disquiet from community support structures that admitted to ill-treating those affected by the virus because of being overburdened, underappreciated and under-resourced to do their work effectively; overworked teachers who see no increased resources on the horizon, despite the ever rising tide of orphans and vulnerable children arriving on their doorstep looking for support; and the number of elderly who make up the majority of caregivers for orphans and vulnerable children despite their own frailty and destitution and the likelihood that their own death will effectively leave children orphaned for a second time.

As outlined above, another finding of this research is the over-reliance of communities on the elderly, who act as the single most resilient safety net that is operational today. This is an unsustainable coping strategy, as fewer and fewer people are becoming elderly or grandparents because of the intergenerational gap created by the epidemic, which is claiming the greatest number of its victims from the most productive age group, those between 15 and 49 years (UNAIDS: 2005). With average life expectancy already at an all-time low of 34 years and an estimated 60 percent of people infected with HIV coming from the general workforce (Kimarayo: 2004), it is difficult to ascertain how the government is planning to overcome the challenges that will arise as the inevitable mortality of the elderly population manifests. When this critical support structure collapses, the children in the care of the elderly not only lose emotional and physical

support but suffer the second ‘shock’ of losing the pension that is paid by the state to the elderly. Without the likelihood of an aging population to take over the financial gains that come with the pension entitlement, the impact on orphans and vulnerable children will only intensify, particularly in a state that has no kind of pension-equivalent for orphans and vulnerable children.

The recent fast-tracking of two pieces of legislation in late 2006/early 2007 may indicate that the government now recognises the urgency of these problems, although both documents have been pending for several years. By trying to anticipate the challenges to be faced in the years to come, there is another scenario that could evolve, given the fact that the most productive, and therefore most fertile, members of society are succumbing to the virus. This scenario involves a drop in child birth, and could mean a decline in the number of orphans and vulnerable children, relieving some of the strain on government to meet their needs. However, for now the government will still be faced with another significant challenge in trying to cope with a proportional decline in human capital that is both available and sufficiently educated to take on critical functions in government and industry. The lack of human capital could further weaken the institutions of state and industry, which are already struggling. It could also increase Lesotho’s reliance on external donors, particularly South Africa, to provide personnel to run essential services.

This dissertation illustrates that social safety nets are straining to keep up with the demand posed by an increasing number of orphans and vulnerable children. This strain is particularly apparent when examining social structures of support that are weakened as a consequence. The impact of HIV/AIDS on communities is most acute when put into a poverty and vulnerability context, because the way individuals respond is tightly linked to cultural belief, knowledge systems and behaviour. In communities where education levels are low and the impact of poverty has aggravated social behaviour and responses, this is particularly critical. The way societies respond to this crisis has everything to do with poverty and vulnerability, which is part and parcel of the everyday reality of affected and infected communities.

Freudenthal (2001), although writing of conditions on the African continent in general, could have been reciting findings from a Quthing case study where he describes the driving forces of the pandemic as: little or no condom use; an adult population with multiple partners; overlapping (as opposed to serial) sexual partnerships; wide sexual networks (often due to work migration); women's economic dependence on marriage or poverty driven commercial sex work and their lack of power in negotiating sexual relationships; age differences between sexual partners - typically older men and young women or girls; high rates of sexually transmitted infections, especially genital ulcers. The dissertation reflects on work by Freduenthal (2001) who, alarmingly, notes that most people have a good knowledge about AIDS. This paradox between inappropriate or 'bad' behaviour and knowledge is a theme that is scrutinised throughout the dissertation. It leads to a conclusion that advocacy campaigns carried out in educational institutions need to be carefully redesigned and applied.

The research findings presented in this thesis concur with the points raised by Freudenthal (2001). What is evident is the correlation between poverty and HIV transmission and this reality is vividly portrayed in the findings reflected in Chapters Three and Four, where it is noted, for instance, that some learners at the high school admit to being ready to engage in sexual relations as an alternative income generation measure. Although the numbers are small the survey findings were confirmed by key informants. These explicit linkages between financial and human capital and the prevalence of HIV are also cited in the data from LDHS resources which was discussed in Chapter 4. The LDHS shows that as wealth and education increase, so too does the decrease in prevalence rates and risky behaviour. While the paradox between knowledge of HIV/AIDS and taking protective measures has been examined to a great extent in this dissertation, the topic raises a complex set of research questions that beg further inquiry: What are the underlining factors that result in a limited correlation between knowledge of AIDS and behaviour related around sexual behaviour? Is the driver for improved citizen response and personal behaviour overridden by the everyday urgency to make money or satisfy a sexual need? Do individuals feel that there is hopelessness and that 'they will die

anyway' and that they therefore adopt a nonchalant behaviour despite evidence that this behaviour might lead to death?

Despite the lack of evidence that raised awareness leads to changed behaviour, the government of Lesotho is struggling to increase messaging to pre- and currently sexually-active people. These campaigns are important but as the empirical evidence presented in Chapters 3 and 4 shows, many people are ignoring the warning signs and may be engaging in unprotected sex despite the campaigns, workshops, advertisements, and improved school curriculum where there are school lessons that teach learners about the risks associated with the virus. Reckless behaviour is perpetuated also despite the fact that condoms are more readily and freely available in Quthing today than they have been at any other time. One point raised in the empirical data is that safe sex practices are not followed because, according to some respondents, there is a climate of deep mistrust[71] among the three ethnic groups, Basotho, Baxhosa, Baphuti in Quthing causing the different ethnic groups to distrust information that is not in their language or delivered by someone speaking their language. Government and civil society have not yet addressed this problem and therefore prevention and treatment campaigns remain ineffectual for the minority groups, the Baxhosa and Baphuti. This understanding is significant because it acknowledges the fact that problems might be aggravated – and therefore the crisis could be perpetuated – simply because there is no due recognition of ethnic disparities. Addressing the issue of ethnic disparity could reduce the ineffectiveness of coping strategies required for fighting the spread of the virus in Quthing.

The linkages between awareness, education and behaviour are an important area for continued inquiry and this has been tabled in Quthing's HIV/AIDS Strategic Plan 2006-2011. The district plans to incorporate messaging into public gatherings, community workshops, church sermons, youth groups and pamphlets. In addition, Quthing would like to broaden its programme of youth/life skills education as a coping strategy but its ambitions are limited by a lack of financial and human resources support. As noted in Chapter Four, the Ministry of Education complained of lack of resources and lack of

[71] Reflected in minutes from the 'String Game' operated by district officials, August 2006.

cross cutting HIV messaging in daily life. Embracing cross cutting messaging could serve as a pivotal weapon in combating HIV and could result in overall financial savings by fully exploiting programmatic and messaging synergies.

Throughout the dissertation, district and community structures complained that their efforts to respond to the crisis were faltering due to funding and resource shortages, and more often than not, bureaucratic bottlenecks and a lack of fiscal transparency. While it is clear central government is trying to speed up its responses to the HIV by decentralising ministries to the districts and thereby attempting to ensure more resources are funneled directly to affected communities, the speed of reform is slow and one reason is the resistance to decentralisation from reluctant ministries.

The conclusion has already outlined the way in which family and traditional coping mechanisms are being strained and it is of key concern that, with the spread of the virus in the district of Quthing, it is the extended family that is now showing signs of not coping with the impact of the virus. The strained relations between extended family members is manifesting itself in a number of ways, including: changing cultural values, such as wealthier families hiding when friends and relatives make traditionally impromptu calls on them as it requires not only entertaining them but providing them with a welcoming gift, usually in the form of a food offering such as a chicken. This once traditional and social norm is muting into something that is becoming almost a negative – rather than positive – cultural phenomenon; a marked and concerning increase in the number of relatives who exploit inheritance bequeathed to orphans; and, alarmingly a clear increase in the number of children being abused, physically, sexually and psychologically.

Under the current social landscape, the adult is now taking on the role of a social worker where, in a more robust social context, the social worker would be able to fulfill the function of care giver in a situation where state systems are more effective in providing safety nets. Today, because orphans are being cared for through informal social structures, they are less protected than they would be if they were receiving care through conventional state structures. Because of this changed emphasis on the informal

structures, rather than formal state institutions, caring for orphans, it is important that legislation should be put in place, or that existing legislation be enforced to ensure that minors are protected. Those families who have now taken on the role of care givers to orphans are not necessarily providing the same quality of care as they provide to their own biological offspring. It is critical that the human rights of orphans be safeguarded. Empirical evidence showed that this is a problem area but the true extent of child deprivation as well as the true extent of orphans and child-headed households could still be masked by community definition and interpretation of what constitutes an orphan. The problem of definition is perturbing because the real numbers might be less stable, for instance, the definition of what constitutes a child-headed household is not the same for everyone – some people believe that in cases where the community has appointed a care giver to keep an eye on the children, the household would not be seen to be a child-headed household.

Communities in the district of Quthing are struggling to survive. Support structures for orphans and vulnerable children are maintained solely by a web of amalgamated efforts, which are not necessarily coordinated resulting in unstable social safety nets. The current landscape is a volatile and highly fragile set of social and government coping mechanisms that together provide some sort of safety net for orphans and vulnerable children. The range of safety nets is discussed in the dissertation.

The response to the second research question - how are communities surviving with the growing number of orphans and vulnerable children? - has been given some answers already in the section above, but the discussion that follows here will examine some of the broader support structures for communities, orphans and vulnerable children and those affected by HIV/AIDS. Social Welfare provides some support through its pensions and through the distribution of its destitute allowance. The education system is an important institutional setting that today plays a pivotal role of support in providing a stable environment for orphans and vulnerable children to learn, be protected, and 'normalised.' It is interesting to note that in such a patriarchal society as Lesotho, girls are offered the opportunity to board at school rather than boys. This is clearly evidence of the nurturing and protective environment provided by the education system as girls are

recognised as being more at risk of exploitation and sexual predation. The schools, at least in Quthing, also hold regular fundraising events to supplement their own funding so as to be able to meet the gap in state funding for infrastructural support as well as to provide additional much needed support for orphans and vulnerable children.

NGOs such as the Red Cross, C-SAFE, and WFP bring critically needed external assistance and in Chapter Four the challenges and opportunities that food aid, for instance, present were discussed in some detail. It is the elderly who are also providing a vital but exhaustible resource of care and protection. Given this, it appears that community support groups although recalcitrant in some ways, probably offer the best possible long-term caregiving structure for orphans and vulnerable children and those infected with HIV/AIDS. Nonetheless, there are problems around this support system, including lack of resources and training and little or no sharing of information amongst community members from those who participate in workshops or training activities on behalf of their community. Nearly every village has a community support structure made up of volunteers, most of whom have been affected by HIV/AIDS in some way. These individuals have an affinity with those who are suffering the impact of the virus and could and should serve as catalysts to motivate and unite communities to respond collectively. As presented in Chapter 3, community support structures are under an extreme burden to perform their work amid an environment of steadily increasingly needs and stretched resources. This situation is putting a strain that is adversely impacting on the willingness of volunteers to participate in a community support structure. Volunteers who are willing are also stating that they are just unable to keep up with the demands placed on them by the sick. In effect, these volunteer care groups are effectively unpaid community healthcare workers. Volunteerism, under these circumstances merits more support.

At the community level, the renaissance of cultural practices such as Mafisa and Matsema as coping strategies shows the collective spirit of communities to join forces and tackle problems. Key informants were unable to remember when both practices had been last employed, and although in some communities these strategies have always been in place, they are being put into practice to a far greater extent today. These systems are

adequate as coping mechanisms to ensure people's immediate needs are met during times of crises or 'shocks' but they do not have the ability to lift households or communities out of poverty and they should not be seen as an answer to any long term development programme.

Migration and remittances continue to be a major supporter for all communities. Even though the workers often come home with AIDS and then draw upon savings to survive or be buried, their remittances act as a stop gap of support at least while they remain healthy.

Losing a pillar within the community, such as an elderly caregiver suddenly dying, or an external assistance source drying up, could have significant implications for 'breaking point' scenarios. The issue of 'breaking points' is the subject of the third question of the dissertation. As discussed in the introduction to this dissertation, for the purpose of this study 'breaking points' are considered to be those moments when coping strategies and social safety nets become overwhelmed by the demands placed on them.

As discussed by Nattrass: 2004, Barnett &Whiteside: 2002, Salaam: 2005, Richter et al: 2004, at the outset of this dissertation, the first coping strategy employed by a family or community as they edge towards 'breaking point' includes: removing children from school, selling assets, reducing meals and consuming a higher proportion of wild foods. The second stage is far more serious, and could be categorised as an actual 'breaking point' because these strategies involve much more drastic measures that are far less talked about and, in Chapter Two some of these measures included prostitution, migration, the sale of children for labour, chronic depression and anger, and the early marrying off of girls. The empirical evidence did not reflect these extreme coping measures and although not many respondents in the dissertation admitted to taking such drastic measures directly, many did say they "know of people" who had taken these steps. This reported proxy evidence implies that this is a reality that is taking place and that there is reason to belief that the respondent themselves might not find it socially desirable to report on these incidences and defer to 'the other' as being responsible for this type of anti-social behaviour. It is highly likely that there is underreporting in this area.

It was established in Chapter 4 that most respondents "knew of" children that had been removed from school to find piecemeal employment or to make savings on school fees and other costs[72]. Most impoverished families had already sold many of their assets during the harsh drought years and at the time of the research, it is likely that these respondents would have exhausted this coping strategy as they claimed to have nothing left to sell. Reducing meals was still common place and consuming a higher proportion of wild foods has become routine.

It was also apparent from research conducted for Chapter 4 that families are already engaging in 'breaking point' strategies to survive. Although the numbers are low, there are children/adolescents who are engaged in acts of prostitution. The research has not established whether this behaviour is in fact a survival strategy to satisfy an immediate need like food or a consumerable 'want' like makeup or a soft drink and it is not clear from this data whether there is a push factor coming from within the household. It also shows that in a few cases children have been farmed out to relatives and although the income flows might not exist, this is nonetheless a stage two coping strategy because it means that families are themselves no longer able to feed their children. Some young girls are being married off as a coping strategy so that they become the responsibility of their husbands and not their parents. It is unclear how many of these instances were a distress coping strategy and how many were a cultural action unlinked to deprivation.

Migration is a difficult concept in Lesotho, because of the complexities of its definition. People have been 'migrating' to South Africa for more than two hundred years for employment opportunities, so it is difficult to cite this as a 'breaking point' coping strategy although clearly remittances play a key factor in keeping household economies buoyant and prevent or retard the family from falling into a real 'breaking point' scenario. It is also clear that many people from rural areas have 'migrated' over time to urban centres, but there was no sudden significant influx of destitute people recorded by

[72] As primary school fees are free, there are still many 'hidden' costs for books uniforms, meals etc. Most secondary school students must pay fees and all other 'hidden' costs so, their removal from the system would represent a major cost saving.

government or civil society during the drought years. Population movements need to be studied over time and the correlation between migration and coping strategies or extreme measures of survival 'breaking point' is unclear. Migration might be the final straw in the 'breaking point' scenario but it is less easily measurable in the short term. Similarly in the case studies of Ethiopia, Zimbabwe and Latin America, cited in the introduction, migration was not as big a concern as the rise of the street child phenomenon. While the number of street children in Lesotho is minimal, this could be a phenomenon for civil society and government to monitor in the future. The fact that there are 'less' children on the street might be a result of 'keeping the problem at home' and does not necessarily imply that the children are not engaging in anti-social behaviour. It might mean that the families would be shamed to be seen to be ejecting their children.

Lack of resources is a recurrent theme throughout this dissertation, mentioned by nearly every civil society organisation, government agency, and community support structure as a major obstacle to effectively building better coping strategies to mitigate the impact of orphans and vulnerable children. However, as one healthcare professional pointed out during an interview, Quthing needs to lure trained professionals to the district to work in the "eye of the storm" of the AIDS pandemic. Currently, doctors come from around the world to work for six weeks at a time, but if the right marketing approach was taken this could be extended for longer periods. As was stated in the earlier chapters of this dissertation, doctors who have come to work in Lesotho say that 'they learn more in six weeks in Quthing than they would have learned in six months at another hospital in another part of the world' (Interview 006). The idea of requesting better human capital expertise from interested parties, given the unique opportunity Lesotho offers for outsiders to gain experience of HIV/AIDS, could be applied to other sectors as Cohen (2002) strongly suggests. Adopting this strategy is likely to put Lesotho into a far stronger proactive role that could replace the "we'll take what we can get" attitude, which makes Lesotho more dependent on donors and their demands, an issue that was discussed in Chapter Four.

Another area of concern raised throughout the dissertation and examined in more detail in Chapter 4 is the disconnection between research and policy on HIV/AIDS, as argued by Freudenthal (2001) and Court (2005). Court (2005) describes the gap as "devastating" because of its clear implications for human survival, quality of life, and national development. Policy makers should be encouraged to show commitment and willingness to listen to researchers and use independent research results in the design of projects and programmes. Freudenthal (2001) urges the establishment of stronger links between research, policy and implementation, including incorporating plans for dissemination of research results to policy makers in all research proposals. Better synergy between policy makers and research would certainly benefit the District of Quthing.

Greater effort is also needed by all parties to ensure deeper transparency in the decision-making process for programmatic response as well as during funding allocation from government and external resources. To this end, it might be useful to introduce a body independent of government and civil society that would have the function of allocating and monitoring resources and that could ensure transparency as well as equitable resource distribution through proposal application. This might be a useful strategy to further decentralise power from the central government and, because the body would be able to act independently from the state and donor agencies and it could go a long way to combating suggestions of corruption and collusion from community and district structures. Corruption at the community and district level is problematic because this is the frontlines of the epidemic and it is at this level that unity and trust is critical to ensuring communities survive.

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APPENDIX:

RESEARCH QUESTIONNAIRE

HIGH SCHOOL

This research questionnaire is designed to better understand how people in Quthing are coping with illness and poverty associated with HIV/AIDS, particularly orphans and vulnerable children. The information gained from answers will hopefully help to design better programmes to aid orphans and vulnerable children and their caregivers. It will also aid university work in Johannesburg.

I therefore wish to invite your participation into this study. However, you will not be penalised for not participating. You may withdraw from the study at any time since participation is voluntary. The study will be confidential. This means the information you give will be written down and will not be shared with anyone else.

Sex: Boy/Girl **Age: _____**

1. **What is HIV/AIDS and how do you catch it? _____**
   _____
   _____
   _____

2. **How can someone stop the spread of HIV/AIDS? _____**
   _____
   _____
   _____

3. **Do you know of people who have become ill and died in the last year? If so, what did they die from? _____**
   _____
   _____
   _____

4. **What impact has this death and others had on your community?**
   _____

_____
_____

5. **Are many of your friends having sex? From what age did they start having sex?**
_____
_____
_____
_____

6. **Do your friends ever have sex for money, gifts or favours? If so, specify?**
_____
_____
_____

7. **Would you consider doing this? Why or why not? _____**
_____
_____
_____

8. **Under what circumstances would you consider having sex for money or gifts?**
_____
_____
_____

9. **What do you think of people who have sex for money or gifts? _____**
_____
_____
_____

10. **Would you consider having sex without a condom if you thought the person looked trustworthy or wealthy? Why? _____**
_____
_____
_____

11. **To what extent do you think HIV/AIDS is a risk to young people of your age?**
_____
_____
_____

12. Are young people more worried about pregnancy or HIV or other sexually transmitted diseases? -

_____
_____
_____

13. Tick the one that best describes your family:

a) Both parents alive and living with the children
b) Both parents alive but only one parent living with the children
c) Both parents alive but living elsewhere
d) One parent dead
e) Both parents dead
f) Child-headed household
g) If you have lost both parents, who takes care of you? _____

14. Who gives you food if there is none at home and what kind of food is it?

_____
_____
_____

15. If you need money for something, how do you get it? _____

_____
_____
_____

16. Are you aware of friends who are badly treated at home? If so, who is doing the abuse and what kind of treatment are they experiencing?

_____
_____
_____

17. What would you recommend someone do who is a victim of abuse?

_____
_____
_____

18. Do you know of orphans who have had inheritance from their parents taken by relatives? Yes/No

19. Are orphans treated differently by the community or friends at school? Please elaborate. _____
_____
_____
_____

20. What kind of support does your school give to you?
_____
_____
_____

21. What is the government or community doing to help you and is it enough?
_____
_____
_____

22. Can you list all the places and people you can visit or talk to find out about sex, contraception and sexually transmitted diseases? -
_____
_____
_____
_____
_____

Ethnographic Data

GOVERNMENT AND STRUCTURE

Problem	Coping Strategy	Result	Problem
Education			
Inadequate accommodation at school for OVC	Schools hold fundraising events to build accommodation	Less orphans in need of accommodation	Not enough resources to keep up with demand for accommodation. Schools become quasi benefactors
Distorted OVC numbers in education system - 'disappeared children' who have been taken in by relatives in other districts		District numbers can fluctuate wildly, making planning and funding extremely difficult.	Resources for OVC in some areas might be strained while others are better resourced.
Orphans without food, school uniforms, school fees, books – which leads to exclusion	- WFP, Red Cross, other NGOs provide some assistance - Free education for primary school and bursaries for some secondary students	Many school kids, particularly, OVC, receive some help. School gives OVC an opportunity to blend in with other kids and be in a supportive environment.	Not enough resources for all kids in need – those without assistance face stigma and exclusion and an uncertain future
Lack of school capacity for all who need education	Classes double up	Quality of education suffers, teachers work under very stressful conditions	Many kids are unable to go to school because of limits on class-sizes
Free high school for double orphans could result in new student landslide (proposed for 2007)		Schools will be more overwhelmed than they are already unless government funding is increased	Expectations for OVC will be raised by State when resources are already stretched
Government			

No state funded orphanages	NGOs operate orphanages in lieu of government support	Abandoned or extremely vulnerable children are given care	State does not necessarily have a handle on treatment of children. Luckily, all NGO run orphanages have a good reputation
Lack of regulatory environment to support rapidly evolving Basotho society within an HIV/AIDS context, including inheritance rights for women, girls, and orphans	- Cooperatives are sometimes formed to work land until the child is able to take control. This also helps to reduce the burden placed on orphan caregivers	- Antiquated laws and regulations that do not address the real problems of the people but instead favour and enhance a patriarchal system	Women are consistently discriminated against eg: women need husband's or male relative's signature for a bank loan - Child may never regain full control over land
Bureaucratic grand standing on sharing resources, leading to obstructionist or hierarchical policies		Delayed services and inefficient use of systems and resources – eg: NAC car three year delay	People in need pay the ultimate price
Lack of transport infrastructure for people to get to hospital	People walk to clinics or seek local traditional healers	People often arrive at hospital too late to benefit from medication	They die or take much longer to recover
HIV/AIDS messaging is not cross cutting every policy and directive from central and local government		Messaging becomes piecemeal or fragmented and 'optional'. Leaving too much room for interpretation.	HIV/AIDS strategies are not effective because they are not properly delivered
High unemployment and low wages	-Social Welfare gives 100 maluti/ month to destitute families or people earning less than 150 maluti per month. - Social Welfare also funds micro enterprises, such as piggeries, Vaseline production, and chicken farming - People go to work in South Africa	- 196 people in the district receive destitute allowance. - Some people are able to rear animals from these projects and supplement their incomes and overall well being	- 500 need Social Welfare grant, but due to lack of resources they are unable to be helped - Too few people are able to benefit from the micro enterprise schemes and little transparency exists over their allocation - Work in South Africa is hard to find

Destitute old people who may have to support OVC	State pension	Nearly 5,000 people in Quthing receive a pension of 150 maluti/month	People have to be 70 years or older to qualify for the pension
Corrupt or incompetent village heads/officials or systems	People are forced to pay bribe to achieve goal; report incident to community council or police	Some people are helped by 'playing ball' with 'traditional' systems	Most people's efforts to improve their lot are thwarted by these factors
Children are neglected in HIV campaigns		Transmission to children, through rape, birth or abuse	Many kids die before age of five from 'other' causes.
Critical shortage of medicines (ARVs) and chemicals for testing CD4 count		- Demand far exceeds shortages of ARVs and trained medical - Some test results are sent to Maseru or South Africa – expensive and cumbersome	- Large numbers of people in rural areas on waiting list for testing - Difficult to determine type of ARV required before results come back from lab, therefore a delay to treatment
Shortage of trained medical staff and civil service due to brain drain or death – salary scales	International 'donations' of teachers, doctors, dentists, nurses	Some gaps in essential services are temporarily filled	Few stay longer than a few months or at most a year or two, some due to better salaries in SA
Shortage of psycho social care at the village level in rural areas		Many people face bleak prospects trying to deal with HIV in rural areas	- People find it difficult to cope with village pressures and HIV. - Many are afraid of being discovered to be HIV positive
Inflated statistics to increase allocation of aid (gov+ngo)	'He who shouts loudest wins' or is connected wins	Too many resources going to too few or being skimmed off	Reflects numeracy skills and literacy levels of some community leaders

Poor coordination in the response to HIV/AIDS crisis	National AIDS Council (NAC), the new coordinating body has taken over	Resources are beginning to be more evenly allocated	Not all bodies support NAC in practice – some see its advent as an erosion of authority
Confusion over mandate of district bodies		Duplication of work, resources wasted	Vitally needed work falls through the cracks
Caregivers are told to administer food three times a day with ARV. But when patients tell hospital healthcare workers they eat three times a day, they are cut off from food aid. Catch 22	Patients on ARV are forced to sell their assets to maintain the food/drug regime if they are cut off from assistance or they are forced to stop or erratically follow regime	Poor families end up becoming even more destitute as they struggle to maintain regime by selling their assets	If patients abandon treatment they are more likely to start a domino effect of deprivation leading to the disintegration of the family unit following the death of the breadwinner or main caregiver

CULTURE AND TRADITIONS

Problem	Coping Strategy	Result	Problem
Growing number of child abuse reports – girls tend to be sexually abused while boys tend to be physically abused		Some children are helped through the Child Protection Unit - unit within each district police force	Some suggest that the police have little interest in responding or have inadequate resources for effective response. Lesotho's remoteness means abuse occurs unchecked.
Rape of women and children		Adult and child rape occurs with near impunity	HIV infection through this means is common. Psycho-social support is near non-existent.
First-born boy inherits assets owned by his father – not the wife.		Wife or sisters receive nothing without consent of the boy	In child-headed households, older sisters may be at the mercy of a younger 'underage' brother.

Changing face of Basotho culture due to extended families adopting children impacted by HIV/AIDS		In past, Basotho gave surplus food to the poor, but since 2002 drought and increase in orphans, this has stopped	This could lead to long-term societal rifts that could impact on traditional Basotho culture
Girl orphans must get permission from village chief or male relative to attend school	Education acts as support system for orphaned girls if they are allowed to attend	Girl orphans are at the benevolence of their chief or male guardian	Girls, in general, take second place to boys and may not receive permission
Children prostitute themselves for items such as makeup, perfume and clothing despite the fact they are aware of dangers of HIV/AIDS. No shortage of 'sugar daddies/mummies'	Transactional sex for basic needs – sometimes for as little as a coke or transport to the next town	Spread of STIs, HIV, and unwanted pregnancies	Children can be competitive in their 'want' for material items, so more are egged on despite being fully aware of the dangers. Intergenerational sex is common and culturally accepted.
Not enough food or money in poor family	Mafisa – where poor will take care + feed livestock from rich in return for bi products. They then split the offspring, while the original animal always belongs to the rich	More food assets available to poorer households	Rarely occurs in post HIV scenario, especially after four years of poor harvests
Not enough food or money in poor family	Matsema – when village shares resources, inputs + labour to boost agricultural output	More food availability for all in villages	Successive years of poor harvests means fewer assets to buy inputs, so smaller yields and less food
Not enough food or money available in poor family	Poor family visits richer family – Visited family is culturally expected to give food and a present to the visitor	Richer family are becoming so tapped that they too can no longer cope and hide when visitor come	Cultural practices are being abandoned for self preservation
Not enough food or money available in poor family	Adults send one or two children to live with relatives	Family can cope better if there are less mouths to feed	Nucleus of family is split, welfare of children suffers

Exploitation of girls to improve family welfare	Girls are married off – some as young as 13 to reduce burden on rest of family. Usually marriageable age is 18 years old	While underage marriage is illegal, it is not often reported to the authorities. No welfare structure to protect girls. Rape is common	Girls are sometimes abducted from their villages– traditional - although if reported, the police will intervene if they have resources
Children engage in unprotected sex due to peer pressure and boredom		Unwanted pregnancies, transmission of STIs + HIV/AIDS	Some believe educating boys on condoms leads to more promiscuity so abstinence or faithfulness is advocated
Infection of boys with HIV during initiation ceremony	Initiation coordinator advises new razor blades for each boy. Boys are also taught to use condoms during the initiation process	Boys have better chance of not catching HIV during ceremony and know how to avoid catching it in the future	Exists only in Quthing, and is not mandatory. Numbers of boys being circumcised has also decreased in recent years
Loss of culture and traditions due to modernization, illness and religion		Perceived loss of traditions, values and culture, particularly among older people	Resentment and disenfranchised sentiment dividing community, against younger generation. Perceived increase in moral decent and criminality

NEW

Problem	Coping Strategy	Result	Problem
Orphans: single and double	- Government provides some assistance through several ministries for some double orphans at secondary school - NGOs and other agencies also assist	Uncoordinated response from government and aid agencies, some kids benefit, others fall through the cracks	No single institution takes care of orphans, instead it's left to multiple agencies and approaches

Burden on orphans to take care of siblings, particularly double orphans	- Government provides bursaries for some double orphans at secondary school - NGOs and other agencies also assist	Some orphans receive assistance	Not enough resources to help all children in need
Orphans leave care of relatives because of abuse or feeling of discomfort		Child-headed households struggle to survive and can place additional burden on community, particularly if there are no assets	OVC suffer deprivation – children may end up separated if they are minors and relatives refuse to release them
Child-headed households	Short term poverty alleviation – some inherit insurance policies or estates	Relatives can be more attracted to the assets than to the child	Children are unable to access assets until they are 'adults' due to lack of regulatory framework. Children can be abandoned after resources are squandered.
Extended families are at breaking point and are reluctant to take in orphans and families either abandon adopted children or adopt risky practices to support them		Family may survive but child may be re-orphaned or risky practices could result in further hardships at a later date. Families are also increasingly reluctant to take in orphans	Family may have eroded spare coping mechanisms to survive first 'shock'. Abandonment of an orphan could lead to long-term family rifts that impact on the very essence of Basotho culture
Stigma due to HIV/AIDS	People refuse to be tested or deny infection. Some hospitals use numbers instead of names to protect identities	As more people openly admit they have the virus, stigma is declining – see VCCT research	As more people demand ARVs due to low stigma, the greater the demand for supplies
Food shortages	Farming or food aid	More food availability	Many people do not have access to enough land and inputs to meet household needs

Food versus hospital – limited resources, survival for today		Resources are spent on food rather than medical	Illnesses are too progressed by time consultation occurs
Oversupply of food aid	Excess food is available at village level	Breeds dependency and inaction	People no longer plant or invest in inputs, and price of food that is available is dragged lower
Changing attitudes towards HIV/AIDS and testing	People are more prepared to be tested if they have had persistent illnesses	People are beginning to see HIV as any other illness	More advocacy must be conducted before people openly admit status
Abandonment of double orphans after parents die	Volunteers in some communities keep guard. Improves community spirit.	Some double orphans receive limited support from government	Quality of care is not always consistent and many are excluded from help
Ignorance of HIV child transmission	PMTCT for the very few who can be convinced of the treatment	Parental scepticism or prevention by cultural pressures to do only breast feeding after birth	Babies become infected at birth or during breast feeding in first six months
Poverty	Remittances from SA mineworkers, domestic workers, or farm workers, textile workers	More funds available to poor at the village level	SA mines have retrenched workers Textile industry has collapsed and many SA firms cut back
Death of workers abroad	TEBA Quthing pays out pensions from insurance schemes and workers comp to about 1300 families per month	Some funds still flow to poor households	Workers come home ill – payouts are exhausted paying for medical or funeral bills, leaving little for or nothing for a post death scenario.
Ignorance on how to respond to HIV	Formalization of HIV support groups and then training, sponsored by government, NGOs,	Groups stopped praying, weeping, and became active. Support groups took on new structures and took on new relevance to their communities.	Grossly under resourced groups still struggle to benefit from information – big disparity between the ‘have’ groups and the ‘have nots’.

Not enough OVC support from the international community	Global Fund gave 120,000 maluti each to 10 districts – including Quthing - to fund income generating projects for OVC	Some money is generated but very little filters back to OVC.	Little transparency over funds allocation and too little money dispersed to make a real difference to OVC on the ground
Overstretched support groups		Support groups are expected to dip into their own pockets to buys soap and Vaseline other supplies for sick + OVC	Support group members, many of whom themselves struggle to make ends meet, become exhausted and discouraged.
Sudden loss of parents, leaving OVC behind	Extended families step into help – sometimes children are divided among relatives	Often they have limited resources to deal with the new arrivals	Resentment builds against orphans and they can end up being abandoned for a second time

CODED INFORMANT DATA FROM RESEARCH INTERVIEWS

QUTHING AND MASERU
CHAPTER FOUR

001- District Administration Official
Interviewed: Monday September 11, 2006
09:00 – 13:30
Tuesday September 12, 2006
18:00 – 18:30
Friday September 15, 2006
10:15-10:45
Monday September 18, 2006
09:00-10:00

002- Non-Government Organistion Employee
Interviewed: Monday September 11, 2006
15:00 – 17:00
Thursday September 14, 2006
10:00-16:00

003- Educationalist
Interviewed: Tuesday September 12, 2006
09:00 – 10:00

004- District Administration Officer
Interviewed: Tuesday September 12, 2006
10:30-11:30

005- Healthcare worker, Quthing Hospital
Interviewed: Tuesday September 12, 2006
11:30-12:30
Wednesday September 13, 2006
08:15 – 08:45

006- Healthcare worker, Quthing Hospital
Interviewed: Tuesday September 12, 2006
14:30-15:30

007- Educationalist
Interviewed: Tuesday September 12, 2006
16:00 – 17:30
Monday September 18, 2006
14:30-15:30

008- District Administration Officer
Interviewed Wednesday September 13, 2006
08:45 – 09:30

009- TEBA Officer, Quthing
Interviewed Wednesday September 13, 2006
10:45-11:30

010- Healthcare worker, Quthing Hospital
Interviewed Wednesday September 13, 2006
11:30-12:30

011- Moipone Leteba, Sister in charge of PMTCT, Quthing Hospital
Interviewed Wednesday September 13, 2006
12:30 -13:15

012- Non-Government Organisation Employee
Interviewed Wednesday September 13, 2006
14:40 – 16:30
Thursday September 14, 2006
10:00-16:00
Saturday September 16, 2006
08:00- 17:30

Field Trip to Nkuebe, Thursday 14, 2006 - 10:00-17:30

013- Community Caregiver
Interviewed Thursday September 14, 2006
11:00 – 11:30

014- Community Caregiver
Interviewed Thursday September 14, 2006
13:00-14:15

015- Community Care Giver, Pokane Village
Interviewed Thursday September 14, 2006
15:30 – 16:30

016- District Administration Officer, Quthing
Interviewed Friday September 15, 2006
08:00-10:00
Saturday September 16, 2006
08:00- 17:30

017- Child Protection Unit, Quthing
Interviewed Friday September 15, 2006
11:00-12:00

018- Traditional Ceremony Coordinator, Quthing
Interviewed Friday September 15, 2006
14:00-15:00

Field Trip to Kuming Kumong, Saturday 16, 2006 - 08:00-12:45

019- Caregiver Coordinator + Support Group
Interviewed Saturday September 16, 2006
09:00-10:00

020- Double Orphan, aged 15, Kuming Kumong
Interviewed Saturday September 16, 2006
10:15-10:40

021- Guardian to Double Orphan and his siblings
Interviewed Saturday September 16, 2006
10:40 – 11:00

022- Caregiver and Guardian to two orphans
Interviewed Saturday September 16, 2006
11:10-11:30

023- Caregiver and Guardian to orphaned Grandson
Interviewed Saturday September 16, 2006
11:40 – 12:00

024- Child-headed household, Kuming Kumong
Interviewed Saturday September 16, 2006
12:10-12:30

Field Trip to Dilli Dilli, Saturday 16, 2006 – 14:00-16:30

025- Orphan Girl, aged 11
Interviewed Saturday September 16, 2006
14:30-14:50

026- Caregiver to two children
Interviewed Saturday September 16, 2006
15:00-15:20

027- Chief (since 1995)
Interviewed Saturday September 16, 2006
15:30 – 16:30

028- Anglican Church Coordinator for HIV/AIDS projects, Lesotho
Interviewed Sunday September 17, 2006 (Quthing)
14:00-15:30

029- Focus Group Discussion with People Living Opening with HIV/AIDS who represented five communities within Quthing
Interviewed Monday September 18, 2006
11:00-14:00

030- Healthcare Worker, Bophelong Paediatric Clinic, Maseru
Interviewed Tuesday September 19, 2006
10:00-10:45

031- UNICEF, Child Protection Officer
Interviewed Tuesday September 19, 2006
11:00-12:00
Interviewed Thursday January 11, 2006 (by phone)
10:00-11:00

032- Local Government Officer, Maseru
Interviewed Tuesday September 19, 2007
12:30-13:30

033- Coordinator for Women and Law, Maseru
Interviewed Tuesday September 19, 2006 (Maseru)
14:00-15:00
Interviewed Friday January 12, 2007 (by phone in Pretoria)
15:00-15:30

034- UNAIDS officer
Interviewed Tuesday September 19, 2006 (by phone in Maseru)
15:30-16:00

035- WFP Employee, Maseru
Interviewed repeatedly throughout stay in Lesotho by phone
Formally interviewed Tuesday September 19, 2006
16:10-18:00

036- WFP Employee, Maseru
Wednesday September 20, 2006
09:00-10:00

037- TEBA Official, Maseru
10:30-11:00

038- Confidential proxy for respondents who requested total anonymity or informal interviews with unscheduled respondents that were too brief to take notes immediately, such as a waitress in a restaurant, a parking guard, healthcare assistant.

039- Writer Observation