3.0 FINDINGS

The literature review raised issues of land legislation and AIDS policy and the extent to which those are likely to impact on households affected by HIV/AIDS. This section pursues those issues through an analysis of findings from interviews with institutions, communities and affected households. It also examines the relationship between land tenure and livelihoods. Peoples' perceptions of HIV/AIDS are used as a framework to analyse why certain actions are adopted and others avoided.

3.1 PERCEPTIONS OF HIV/AIDS IN THE STUDY AREA

Perceptions are important for understanding why people take certain actions and avoid others. People's perceptions of HIV/AIDS partly explain why there is stigmatisation, how the disease affects institutional and community support systems and why the laws are sometimes sympathetic or indifferent to the plight of widows and orphans. The same perceptions also determine why some provisions of the land tenure system may represent opportunities or limitations for people affected by HIV/AIDS.

In the study areas perceptions have contributed to shaping responses to the disease and the impacts that were observed. For example, the fact that the community of Ha Poli has acknowledged HIV/AIDS as a major problem and recognised it as a killer disease has helped greatly in taking certain measures. These include reporting unusual diseases and sexually transmitted diseases, registering HIV/AIDS orphans, and getting some of the victims to attend counselling sessions. For example, women at Ha Poli reported body rashes to health officers, allowing them to take the necessary steps to alleviate the problem and provide advice.

In contrast, people in Matsatsaneng do not consider HIV/AIDS a problem and as a result they are reluctant to take the steps necessary to curb the problem. They are defensive and as a result they are ignorant about the disease. Ultimately this impacts negatively on efforts to curb the spread of the disease, take care of the sick, and make the necessary institutional arrangements to address land issues and other social needs.

Likewise, perceptions on the factors that contribute to HIV/AIDS will determine whether certain programmes to alleviate the problem and minimise its impact can be implemented. For example, even in Ha Poli, where awareness was relatively high, the health workers reported that they could not successfully implement community support groups since infected people would not willingly come forward and identify themselves as HIV positive. This was because HIV/AIDS was associated with prostitution and promiscuity. Thus the success of the rural support system will largely depend on what people consider to be the causes of the disease, and whether victims are deemed to deserve sympathy or stigmatisation.

Therefore, to some extent the impacts observed reflect people's perceptions of the disease. For example, taking care of orphans has traditionally been the duty of the extended family. Although it can be argued that the extended family cannot cope with the increasing number of orphans, there were reports of orphans being rejected due to the stigma attached to HIV/AIDS. At Ha Poli one extended family would not accept an HIV/AIDS orphan for fear of infection and because they considered that her mother had inflicted the disease upon herself through her behaviour.

It can be argued that where perceptions are correct and positive, progressive preventive measures against the disease can be implemented minimising negative impacts. Also with the correct positive perceptions new institutional arrangements in communities to take care of the victims and devise new livelihood strategies can be realised. The analytical framework adopted by this study therefore

examined the impacts of HIV/AIDS on land issues while linking land tenure with livelihoods and the way they are shaped by perceptions of HIV/AIDS.

3.2 IMPACTS OF HIV/AIDS

3.2.1 Land Issues

This section examines the impacts of HIV/AIDS on land issues in order to determine the extent to which the 1979 Land Act provides for HIV/AIDS affected households.

3.2.1.1. Postponement of Land Revocation

One of the major challenges likely to face people affected by HIV/AIDS in Lesotho is deprivation of agricultural land left fallow for an extended period due to continued illness. This situation is likely to be aggravated by the impending replacement of traditional land administration authorities by land boards that are likely to lack on-site knowledge of the status of people affected by the epidemic.

In both study areas, Matsatsaneng and Ha Poli, land administration and management is still under the control of the chiefs. The chiefs have not been observing the legislation on deprivation of land left fallow. Instead, to avoid revocation, HIV/AIDS affected households have been reporting their problems to the chiefs who grant them informal concessions, indefinitely postponing deprivation.

By invoking compassion to relax the binding force of the law in the face of the prevalence of HIV/AIDS, the chiefs have not only strengthened their authority but also ensured that land management at the community level provides a relatively secure means of livelihood for the HIV/AIDS affected households.

> One widow in Ha Poli reported that before her husband was diagnosed HIV positive, they went from one traditional doctor to another since they believed that her husband was bewitched. Later when her husband was seriously ill, the woman had to abandon both her field and garden and devote all her time to nursing him. Legally, that meant their land could be revoked and reallocated to other people able to use it more efficiently. However, the neighbours reported her situation to the chief who reassured the widow that her land would not be taken.
>
> *…this incident has made me recognise and appreciate the role of our chiefs in our lives. HIV/AIDS has given the land administration a human face*

Admittedly, the manner in which traditional land administrators have responded to this crisis might be partly due to general ignorance of present and proposed land acts. This raises the question of whether knowledge of the land law would bring about compliance resulting in transfer of land from HIV positive people to healthier members of the community.

In Matsatsaneng it is difficult to discern the impacts of HIV/AIDS on land issues since the general community is adamant that AIDS is not a problem. They even go to the extent of claiming that, apart from the elderly, there are no chronically ill people in their community.

The foregoing analysis raises the question of how long the chiefs can realistically postpone the inevitable. Another issue to be addressed is whether legislation is needed to assure the nation of food security and sustainable livelihoods while at the same time considering the plight of affected households.

3.2.1.2 Sharecropping Arrangements

Sharecropping arrangements have a long history. They have enabled households to gain access to land and to ensure food security within communities. For example, households that have no land but have remittances they can use to buy agricultural inputs often sharecrop other peoples' land. By the same token, households with land but no income and/or labour use sharecropping to gain access to farming inputs and labour from those who do not have land.

This study found that infected households are increasingly using sharecropping, as they are often too sick to work in their fields and gardens. Sharecropping allows them to avoid the risk of revocation and assures them of continued access to agricultural land and food. Fortunately in the Katse study area, where some community members have lost land to the Lesotho Highlands Water Project, there are always willing sharecroppers when needed.

A 27-year-old man from Ha 'Mikia had no land until 2001 when he inherited his parents' fields. However, by then he and his wife were too ill to farm. To cope with the lack of labour and avoid revocation they entered a sharecropping arrangement with a nephew who had no fields. That way, they were able to keep their land and share part of the produce with the nephew.

Other incidences were reported where infected households have used sharecropping to gain access to draught power after they had sold their livestock to cover medical expenses.

A widow in Vuka Mosotho narrated how she entered into sharecropping arrangements due to lack of draught power after her husband's death.

> *After we discovered that my husband was HIV positive we used all the savings earned from the mines and money earned from the livestock sales on medical bills and hospitalisation. When he died we had only two cattle left. I slaughtered one for his funeral and another one was sold and part of the money was used to buy a sheep to perform a cleansing ritual and cut the black mourning cloth. Then for the first time I faced the problem of lack of draught power during the ploughing season. My greatest fear was that my children would starve and my fields would be taken away. Therefore I arranged to sharecrop with one of my late husband's friends.*

The chief and the elderly group in Ha Poli confirmed these incidences by stating that sharecropping has decreased the incidence of land left fallow, especially amongst chronically ill individuals. They explained that the few reported cases of land left fallow were more a result of natural factors such as prolonged rains or drought that delayed farming operations than chronic illness. The men's group in Matsatsaneng expressed similar views.

3.2.1.3 Women's Land Rights

The customary land tenure system entitled a widow to retain two out of three fields following her husband's death. These fields became available for reallocation after her death. Similarly the Land Act of 1979 recognises widows as legal heirs to land provided they do not remarry. The proposed land policy on the other hand suggests more secure, unconditional titles for women. During the study questions on women's land rights were raised in this context to determine the impacts of HIV/AIDS on these rights.

All the widows interviewed reported that they had been allowed to retain their late husbands' agricultural land. They were also empowered to make arrangements such as sharecropping or hiring people to work on their land when necessary. However, the men's group in Matsatsaneng explained that widows lost title to the land if they remarried, since land could not be transferred from one

community to another, and by remarrying a widow gains access to her new husband's land. Interestingly, interviewed widows were aware of this and were quite clear that they would not consider remarriage since they would lose their social status within the community. Those who had commenced counselling sessions and whose HIV status had been confirmed were also totally against remarriage since they did not want to infect prospective husbands.

At Ha Poli the women's group strongly contradicted the view that widows are always guaranteed their husband's land.

Women in Ha Poli narrated a case where a man died and shortly thereafter the woman fell sick. It became known in the village that she was HIV positive and her in-laws accused her of having infected and killed their son. They claimed that she had had an affair with an LHWP construction worker. The woman was then expelled and sent back to her parents' village with her children – thus serving her a double blow of losing a beloved husband and breadwinner as well as his land – the principal means of livelihood for the widow and her children.

These contrasting views on women's land rights make it clear that what is stipulated in law is not always practised and that the manner in which land rights are interpreted varies with circumstances, the level of understanding of HIV/AIDS, and the fairness and strength of the chief's authority.

Community perceptions of factors contributing to HIV/AIDS, most of which place the entire blame on women, worsen the situation of widows. For instance in Ha Poli, the elderly women blamed younger women for having introduced and spread AIDS in the community as a result of affairs with LHWP construction workers. At Matsatsaneng the women's group argued that there was no way AIDS would infect their community because women were doing handicrafts in the community and did not loiter in town. Health workers, on the other hand, reported that lack of employment opportunities in the study area compelled women to engage in sexual transactions.

3.2.1.4 Inheritance and Succession

It has always been common practice in Lesotho to give mature elder sons preference when reallocating their parents' land. At the same time provisions were made for minor children, thus enabling orphans to retain possession of their late parents' land. Recently there have been proposals to entrust the land boards with the power to approve or reject heirs to land nominated by families. This proposal has been questioned on the basis of its fairness to both families and land boards in nominating and approving or rejecting land heirs and the risk of added insecurity for orphans on issues related to inheritance of land.

In both study areas AIDS orphans were found to be still very young and therefore could not be interviewed. However, the men's group in Ha Poli explained that orphans are always treated fairly and that if they are still young their uncles use their late parents' land to raise them until they are old enough to inherit the land. The women's group in the same area, however, pointed out that there are cases where orphans are cheated out of their heritage by the uncles. They also showed that in some cases the orphans are forced to seek refuge with their maternal grandparents because relatives on their father's side thought that by caring for them they would be infected by AIDS. In this case they lose their rights to their father's land. Some of the orphans in Ha Poli were being raised by the hospital because their relatives had abandoned them.

Health workers reported a case where parents had died leaving behind a very young child. The hospital continued to nurse the child hoping that after the funeral the relatives would come and claim it or make other arrangements with the hospital. However they never came forward and questions of the child's right to the parents' land have remained a closed subject.

It is unusual to abandon children in the rural areas and this might have stemmed from AIDS stigmatisation.

Based on this analysis it is clear that it is not only the probable replacement of the chiefs by land boards that is likely to increase insecurity around HIV/AIDS orphans' inheritance of land, but also the stigma attached to people who have died of the virus.

3.2.1.5 Land Sales/Land Conversions

Lack of land resulting in food shortage has been quoted as a possible factor that worsens the situation of households affected by the epidemic. Lack of land could result from sale of agricultural land or conversion of agricultural land to other uses. Leasehold makes this possible by allowing for the sale and transfer of land. Viewed positively leasehold can give HIV/AIDS affected households access to income from the sale of land, thus improving their means of livelihood. Also, during the terminal stage of illness, households might be able to sell their land to raise money for medication and hospitalisation.

This study has shown that land is a highly valued commodity that HIV/AIDS infected individuals and households see as the ultimate form of security for children if their parents die. The fact that the land is poor and its productivity is low does not diminish its value. Those without land who are affected by the virus are seen as the most destitute. Thus, despite their depressed financial situation, affected households reported that they have never considered sale of land as an option.

A 35-year-old man from Ha Poli pointed out that nobody in Lesotho would be eager to sell land, especially in the absence of other alternative means of income. He further explained that for people like him, who are already infected with the deadly virus, selling land was out of the question since it is the only precious thing that they can leave for their children to live on when they die.

This man reported a case in a neighbouring village where a man died of the virus leaving a sick wife and three children. A rich man, who owned a shop, offered to sharecrop with the widow and in return took care of her medical bills, fed the children and paid their school fees. When the woman died, the shop-owner paid for the coffin and continued to support the children.

A chronically ill woman in Matsatsaneng argued that part of the reason why she was reluctant to sell land was because she did not have other sources of income. She also said that unlike livestock, which follows you when you die, land always remain behind, even for your grandchildren.

It might be true that part of the reason why HIV/AIDS infected households are not selling their agricultural land is ignorance of the provisions of the current land act. This legislation allows them to obtain leases that they can sell and transfer. However, it is also clear that the security offered by the land is considered to be more valuable than satisfaction of other needs.

3.2.2 Livelihoods

This analysis takes a holistic look at the livelihoods of communities and tries to compare them with the livelihoods of households affected by the HIV/AIDS pandemic. The analysis of the sources of livelihoods and coping strategies of the households affected by the epidemic is based on interviews conducted at household level. This analysis paid attention to the apparent changes that have

occurred as a result of chronic illnesses and HIV/AIDS in order to establish how households cope and at what stage they become more vulnerable.

3.2.2.1 Changes in Household Structure

The households studied varied in structure, size and composition. Twelve were headed by males while the rest were headed by females. Household heads were aged between 24 years and 60 years. While most household heads (14) were married, four – all women, mostly in their late twenties and early thirties – were widowed. A couple of young household heads had been deserted by their spouses.

To a large extent the households resembled the traditional African household, which still predominates in rural settings, in size and composition. Most of the households consisted of both parents and their children while some consisted of a widowed adult female and her children. Some households included other members of the extended family such as nieces, nephews, younger siblings and herd boys. Households tended to be large with the majority having not less than seven members and an average household size of six. The majority of households studied had very young dependent children, many of them still of school-going age. Increased numbers of births was one of the factors that led to change in the household demographics after 1995. The few children aged above 15 years were still dependent on their parents as they lived with them and had no income of their own. In the African context therefore they are regarded as children despite their age. Four of the households studied had children aged above 15 years.

The above description of households indicates that most the households affected by the HIV/AIDS problem are young. Those who are infected are in their productive years and are breadwinners and decision makers in their households.

3.2.2.2 Community Sources of Livelihoods

In both study areas crop production and livestock husbandry are considered the most important sources of livelihood. Extensive subsistence farming on individual fields is the basis of household livelihoods. The production process is highly labour intensive, especially in highland areas such as Ha Poli, where the sloping terrain makes use of farm implements such as ploughs and animals for draught power imperative. In Matsatsaneng the fields are relatively large because it is in the lowlands but other farming activities are dependent on labour. Crops produced include maize, sorghum, wheat, potatoes and beans.

Livestock production is the pillar of household livelihoods in the mountains, given the constraints on crop production. They provide draught power, wool, mohair and foodstuffs such as milk and meat. Livestock can be sold to provide for children's education and to buy clothing and other food at the market. However stock theft has made this a risky enterprise. Producing vegetables for home consumption was also identified as a useful source of livelihood. Labour comes mainly from the household, although wealthier households hire labour for crop production and animal husbandry.

In both Ha Poli and Matsatsaneng people said that remittances from the migrant workers had ceased to be an important source of income because of the high level of retrenchments. For example, at Matsatsaneng retrenchments have heightened competition between men and women in the production of handicrafts, which used to be mainly a women's activity. At Ha Poli many households have lost income as a result of the phasing out of construction activities on the Lesotho Highlands Water Project (LHWP). These changes have created a variety of hardships for different households, especially lack of cash. Both communities lack economic opportunities and this is particularly important in analysing the livelihoods of households affected by HIV/AIDS.

3.2.2.3 Impact of HIV/AIDS on the livelihoods

3.2.2.3.1 Labour

Agricultural production is the main source of livelihood in both communities, even for households affected by the epidemic. In-depth interviews with affected households revealed that illness had a substantial impact on agricultural yields because of its negative affect on household labour, the mainstay of extensive subsistence farming. Due to loss of labour some farming activities have to be postponed or abandoned. This is true for field cropping, vegetable gardening and livestock rearing. For example, agricultural production depends on the division of labour between adult males and females, and children, who participate under the supervision of adults. Informants from affected households revealed how HIV/AIDS affects the labour available for work in the fields.

> *Normally we would work on the field with my wife, I did my part – ploughing and planting – and she did hoeing. But when she is too sick she cannot work and this started in 2000 when she was expecting a baby (the baby died). When she is sick I have to work on the fields alone or if possible hire labour, which I pay with harvest….*

Another respondent mentioned:

> *My husband can no more cope with work in the fields. He has left me to manage the field alone but my children occasionally help… I'm not used to it because he used to do almost everything and I'm also sick but I still feel better most of the time. So you see we don't have enough harvest as we used to.*

Another infected informant mentioned that before her illness she was sharecropping a field belonging to a friend. Her household contributed labour, draught power and other farm inputs. After her husband's death she has only been able to contribute her own labour, which has increasingly become irregular due to her illness. Two other women indicated that currently only their husbands were involved in farming. In one case the household does not have a field and is involved in co-production. However, since the husband has a full time job he can only work on the fields during the weekend. This was described as a very inefficient arrangement because it leads to delays in important farming operations such as planting. The owners of the field would not provide labour as they were contributing other inputs including draught power.

One respondent reported that their field remained fallow when the husband was sick because household resources had been used to pay for medication and she could not continue with the dual role of caring for her husband, who was terminally ill, and working in the fields. Since her husband's death she has resumed farming activities even though she sometimes feels too weak and has to depend on hired labour, which she pays with farm produce after harvesting. Labour is an important resource for farming households, especially those that are involved in sharecropping because they do not have fields of their own. These tend to be resource poor households that can only contribute labour to the process. One of the widows indicated that her sharecropping arrangement collapsed following her illness.

In some households respondents did not report any impacts on labour. This could be attributed to a number of factors. First, the adult household member infected with HIV was still at the early stages of illness and could still cope with most activities and responsibilities, including farming. Second, the member who was ill had never been actively involved in farming activities. Third, such households had other resources such as cash income, which could be translated into farm labour, and this meant that farming could continue despite the household being affected by HIV/AIDS.

3.2.2.3.2 *Farm Operations*

Some households indicated that chronic illness and HIV/AIDS had not led to any changes in the management of home gardens and in production. Apart from reasons mentioned above, available household members could effectively manage gardens because they were generally small, or the infected person was not responsible for the home garden. This was usually the case where the adult male was sick. This suggests that in the context of HIV/AIDS home gardens are relatively easier to manage than fields.

However, other households reported a decline in production in their home gardens since being afflicted with HIV/AIDS. This was either because they had stopped work on their gardens altogether, or their labour input had declined due to episodes of intense illness that affected the normal activities of household members who were not infected. In cases where both adults were too ill and children were too young to work, the gardens were abandoned. In other cases there had been a decline in production because some activities could not be performed on time. For instance, one respondent indicated that output from his garden had declined because he did not weed at the right time, or because bouts of illness coincided with harvesting. This had led to him losing most of his tomatoes to frost the previous winter. His widowed mother was too old and in poor health so she could not harvest the crop. In most households children were too young to take over.

Factors determining impacts

The experiences of households affected by HIV/AIDS and chronic illnesses show that a number of factors determine the magnitude of impacts on the availability of labour and management of arable land, and therefore on livelihoods. These include:

- The stage of the disease or illness and its symptoms;
- Whether all economically active adults were infected;
- Whether the household could afford paid labour to augment or substitute for household labour; and
- Whether the infected individual was the one initially involved in providing labour or other resources for a particular type of production.

Also, given the traditional gender roles of women as care givers, some had to withdraw labour from farming activities to take care of their ill husbands. Clearly, where symptoms were advanced, or death had occurred as a result of chronic illness or HIV/AIDS, there were discernible impacts on livelihoods.

The insecurity expressed by the respondents involved in sharecropping because they did not have land indicated that the loss of labour due to HIV/AIDS infection intensified the vulnerability of resource poor households. Sharecropping is about pooling and complementing resources, and households enter these arrangements on the basis of the contribution they can make to the production process. It is not surprising, therefore, that loss of capacity can also mean foregoing participation in these activities, which could have a direct impact on livelihoods.

Some testimonies indicated that caring for those with long-term illnesses could have an affect on productive labour. Information from group discussions and from household interviews reiterated this concern. The home-based care strategy adopted by the Ministry of Health and Social Welfare and supported by the Ministry of Agriculture will compound this problem. In addition, as deaths from HIV/AIDS and chronic illnesses mount, agricultural production is likely to be adversely affected by time lost due to mourning. The prevalence of HIV/AIDS has not changed customs related to mourning and bereavement in Lesotho. They will reduce labour available for agricultural production in many ways, thus impacting on the affected households' livelihoods.

3.2.2.3.3 Loss of Assets

In order to understand the impact of HIV/AIDS on affected households, our research included a comparative analysis of the stocks of assets and resources that households held prior to and after the illness. This included an analysis of processes through which assets, apart from labour, were lost.

Household members indicated that from the onset of symptoms families incurred costs for medical treatment and transport to varying degrees. The net impact depends on the diversity of resources that households have, the perceived seriousness of the symptoms experienced, and what members of affected households believed to be the cause of symptoms and therefore the appropriate treatment.

3.2.2.3.4 Cash Income

In households where the infected member was employed, the most immediate impact felt was loss of regular income. In both communities, it was mainly men who had stopped working either because they could not cope and decided on their own to stop working, or they were retrenched because of illness. This happened to people employed in the South African mines and those employed locally, particularly in the construction works on the LHWP. One young male respondent told us how he was retrenched, even though he did not associate his illness with HIV.

> *I fell sick in 1993, I had a cough and chest pains, which would become worse when working. I was hospitalised by the mine authorities where I was diagnosed with TB. Between 1994 and 1999 I was very sick and I was eventually laid off even though I thought my situation was improving….*

Another male interviewee mentioned how he lost his income due to illness:

> *In 2000 I felt sick again after having been better for sometime and I was hospitalised at Hlotse where they diagnosed TB. I was released after being in hospital for three months. I was feeling better so I continued working at the construction sites until I felt that the problem was back again, and they released me around winter last year… I later went to Mamohau hospital where I was told I have AIDS.*

An infected woman indicated:

> *We used to depend on two incomes, my husband's and mine, and then life was much better because he brought something home and I also brought something…. I cannot continue working anymore so the whole family depends on him, I depend on his wages – but it is better because he is supportive.*

Loss of income has impacted on the living standards of the affected households, forcing them to make difficult choices. Food shortages and starvation, lack of clothing, lack of basic groceries such as soap, and lack of money to pay for basic services such as grinding maize and sorghum and for medical services were some of the daily experiences of household members interviewed. Households in which the breadwinner is affected and has stopped work experience poverty. As one respondent indicated:

> *I was employed by the LHWP and the job was paying me well… because of this disease I had to stop working and my younger sister was also taken out of school, I don't think that she will ever go back to school since I cannot ever work again, you can also see me, I will never be strong again. All the family money is spent to save my life and the small-time business that I do cannot take us out of poverty.*

The effects of HIV/AIDS were even more serious in households that were already struggling for survival before they were afflicted by HIV/AIDS. Community health workers and counsellors at Ha Poli said that their efforts to mitigate the effects of HIV/AIDS were undermined by poverty. For example, patients were unable to implement dietary advice provided by the health centre.

Those involved in farming indicated that some inputs were left out because of lack of cash income. For those involved in sharecropping, failure to contribute agreed inputs would eventually lead to termination of the 'contract' and loss of their share of the crop. For people with land it means ineffective farming practices and reduced yields. Both have serious implications for food security.

3.2.2.3.5 Savings and Investments

Households where someone had been employed in the South African mines had substantial savings and some investments from remittances. The investments were in both physical and human capital. In the absence of income, these households resorted to savings to pay for medical expenses and all other expenses such as the education and clothing, ordinarily paid for from income. This pattern of expenditure steadily eroded household savings. One woman indicated:

> *When he (husband) worked in the mines, we were comfortable, he bought a planter, scotch-cart and cattle which we still have, and the horse… he also had a savings account at the bank, but not anymore. All the money was used when he fell ill. Because we did not know what was the cause of his illness we consulted so many doctors including traditional doctors. It was only very late when we were advised to come to this hospital.*

Most households used the bulk of savings to pay for medical expenses as the disease progressed. Where death had already occurred, they used money to pay for funeral expenses. None of the infected individuals interviewed were diagnosed within the first six months of the onset of symptoms even though most had immediately sought medical attention from different health care providers. One woman mentioned that she was only diagnosed in August 2000 after she had consulted several doctors, including traditional healers.

> *In the process a lot of money was wasted. I had to use all the money that my husband had left behind when he died in late 1999. I went everywhere including traditional doctors, and I did not just go once and all the time I was paying with money. Even here at the hospital they only diagnosed after I had come several times…. I still don't understand why it takes them so long before they can tell us…. I wish it could be sooner.*

Delays in diagnosing the disease were costly for households. Once HIV/AIDS was diagnosed, almost all those interviewed stopped drifting from one doctor to another and settled on free or cheap medical care obtainable from the hospital supported by the Lesotho Highlands Development Authority at Ha Poli, or the hospital at Leribe. Some respondents regretted the long route to diagnosis as it led them to suspect witchcraft and consult traditional doctors.

Most households belong to community based burial associations. These associations are seen as important networks assisting households to cope with poverty, though their role is limited by

poverty. This results in members who fail to pay their dues forfeiting assistance when they die. Although this is meant to ensure the sustainability of these associations, the current situation of poverty affects the ability of members to pay subscriptions. In both communities some of the interviewed households had not paid their dues for some time. The result is that those who continue to pay benefit from the savings of those who cannot continue to pay and forfeit their benefits.

3.2.2.4 Loss of Livestock

Livestock are among the household assets affected by HIV/AIDS and chronic illnesses. Most affected households have lost other sources of income and are now selling livestock to meet medical expenses. The increased sales of livestock deplete assets and deprive some households of cattle needed for draught power in the fields. Households have also lost livestock through stock theft, said to have reached pandemic levels, particularly in the mountain areas. These losses are a major factor inhibiting effective land use, as mutual support in the community is based on people having some resource to offer, even if it is only one draught animal. Helping young people with nothing to contribute towards production is a relatively new phenomenon that communities are still grappling with.

Funeral expenses and other cultural obligations, such as the requirement to slaughter a cow when a household member dies, have also exerted pressure on household resources. In both communities people pointed to instances of more than one person dying in a family within a short period of time. At Ha Poli community leaders mentioned that they often buy coffins on credit for the most destitute households, but even before they can settle these debts they have to buy another coffin, sometimes for the same family.

3.2.2.5 Food Insecurity

Both communities faced over-arching constraints on food security. Matsatsaneng indicated that agricultural inputs were not available and Ha Poli pointed to lack of sufficient arable land and lack of relevant extension support. Against this background chronic illnesses, including HIV/AIDS, have directly impacted on food security. The impact of illness on various sources of livelihood and survival strategies goes beyond agriculture to affect all ways of producing or securing food.

The affected households studied consisted mainly of young people in their productive years: young spouses and other adults. Various discussion groups, including the elderly women at Ha Poli confirmed this. At Matsatsaneng, where people do not acknowledge HIV/AIDS infections, they argued that the pattern of chronic illness had not changed, though they also mentioned that persistent coughs and diarrhoea, believed to be caused by the “wind from the west”, were common in the community, and mainly affected men with a history of employment on the mines and other young people. In both situations, however, cash and non-cash income sources have been affected through loss of labour and increased demands on household resources.

Some households experience almost daily food shortages. In other cases there is no money to process available food grains. But, most importantly, some members of households affected by HIV/AIDS mentioned that yields from their fields were not sufficient to take them to the next harvest season. They mentioned a number of reasons. For example, that yields had declined due to loss of fields to the LHDA. Households that lost fields due to the project receive annual compensation in the form of food grain. However, some respondents indicated that they occasionally have to sell the food they receive in compensation to meet other needs including payment for health services. One of them said he was no longer able to do odd jobs such as thatching and cutting wood for other people because of illness. When his wife was seriously ill they

opted to sell maize and beans from their compensation food packages. As a result the household had to go for three full months without maize.

Food insecurity is also the result of failure to effectively manage fields. Sharecropping, while it ensures access to food in the situation households face, results in lower net yields For example, in one household both parents were infected by AIDS and were already too weak to work in the fields. To avoid leaving their land fallow they entered a sharecropping arrangement. This reduced their net yield since the participating households shared the output. This illustrates how HIV/AIDS increases the vulnerability of those who are infected and affected in a situation where circumstances are already unfavourable.

3.2.2.6 Loss of Indigenous Knowledge

Apart from the direct impacts that HIV/AIDS has on livelihoods through loss of labour and income, many children will grow up without the guidance of their parents. This is because HIV/AIDS mainly affects young adults who are primarily responsible for socialising children. Their death leaves a wide gap between grandparents and children.

Children will have difficulty learning how to produce effectively in the fields because their parents will not be there to train and supervise them while their grandparents will be too weak to assist. At Ha Poli the community is already operating under serious constraints due to prolonged drought and massive land losses to the LHWP. As a result harvesting enough food is a struggle in which they have to use tactics learnt over a period of time. For example, they mentioned *molutsoane* the rain making ritual as one tactic.

Household demographic changes due to adult mortality suggest that there will soon be many young orphans who have missed the opportunity to acquire survival skills from their parents. Much indigenous knowledge on food production will disappear with negative impacts on livelihoods. The anticipated demographic changes are a serious challenge for sustainable livelihoods.

3.2.3 Institutional Impacts

3.2.3.1 Loss of Trained Staff and Decline in Agricultural Services

Like other sectors, government and non-government organisations at grassroots and national levels have lost employees to the disease. For instance, the AIDS section of the Ministry of Agriculture reported that some members of its extension staff have died of the disease. This is deemed very serious since they were an important link between the communities and government, which relied on them for information on the real agricultural needs and aspirations of rural people. Ironically, they were the same people the Ministry of Agriculture was training to act as caregivers to HIV/AIDS infected households. Without extension services communities will not be able to improve their agriculture. This will affect their nutritional status and worsen the situation of individuals already affected by the virus.

The loss of potential caregivers at grassroots level will be even more devastating for infected households. Apart from the hospital and LHWP, there are no institutions offering HIV/AIDS support at grassroots. The caregiver programme, a promise that had not yet materialised in areas such as Ha Poli and Matsatsaneng, nevertheless offered something for infected households.

3.2.3.2 Loss of Capacity

In Lesotho, 80 per cent of rural people depend mainly on agriculture for their survival. Over the years the Ministry of Agriculture has embarked on strategies to improve agriculture and achieve food security. This has meant a total reorientation of the agricultural sector and the adoption of policies such as crop diversification and privatisation to generate income and employment for rural people. However, the Ministry expressed fears that the escalating death rate would severely limit the human resources needed to carry through its plan and there would be a shortage of local entrepreneurs to take over the services provided by the Ministry. In this way HIV/AIDS would have a negative affect on the capacity to generate income through agriculture.

The LHWP initially trained a lot of villagers to do jobs on the project. Over the past years they have lost many of their trained staff members and contract workers due to the virus. This also represents a loss of income to people in Lesotho.

3.2.3.3 Overburdened Personnel

In response to the HIV/AIDS situation, the Ministry of Agriculture has given grassroots staff such as extension officers additional duties to cater for HIV/AIDS victims. One extension officer complained that in addition to her usual responsibilities as an Assistant Livestock Officer, she had been burdened with HIV/AIDS activities.

Though this approach saves the government the expense of hiring additional staff, lack of time and the fatigue experienced by existing staff mean that HIV activities become a secondary duty.

3.2.3.4 Lack of Control Over Staff

It has been argued that the magnitude of the HIV/AIDS pandemic requires the involvement of all the people since it is impossible for governments to hire special AIDS personnel given their budgetary limitations. This would also not give the problem the national recognition that it requires but would limit activities to one section of government. With these arguments in mind, the National AIDS Programme (NAP) of the Ministry of Health trained and used health workers and public health centre staff as counsellors for HIV/AIDS infected individuals. However, the strategy brought many problems. The head of NAP reported that since the programme lacked control over the health workers, they only did counselling when other duties were finished, if they were ever finished. In some cases NAP questioned the kind of counselling service provided since most of the staff were not trained counsellors.

3.2.3.5 Financial Burden

Due to the increase in patients with HIV/AIDS related diseases there is overwhelming pressure on institutions to identify the causes of ailments so that they can provide proper treatment. However, institutions generally lack the finances to do this effectively, leading in some cases to loss of integrity. For instance, the Mamohau hospital relies on clinical case identification and cannot conduct HIV tests. Community members have questioned this practice, arguing that without conclusive evidence they should not be recorded as HIV positive. As a result they are reluctant to consult the hospital when they have infections. Lack of reliable technology, and the stigma attached to HIV/AIDS are having a negative impact because even infected people are avoiding counselling sessions for fear of prejudice and rejection.

Most of the AIDS related activities including the counselling programme by the Mamohau hospital are supported by the LHDA. This support is useful but its sustainability is questionable, as it seems that after 2003 most of the activities of LHDA will be withdrawn.

3.2.4 Impacts on Community Support Systems

Various impacts resulting from HIV/AIDS threaten the survival and cohesion of community solidarity and support systems. Actions and behaviour that were once unthinkable have become common due to the HIV/AIDS pandemic. In the past for example, where children lost one or both of their parents through an accident the extended family would provide unconditional support until they were independent. In cases where a widow was not able to care for children they would be distributed among the extended family members to lessen the burden on her. Unfortunately, this kind of support was already starting to erode due to poverty, but the magnitude of HIV/AIDS pandemic and the accompanying stigmatisation of victims are accelerating the process.

3.2.4.1 Overwhelmed Community Support Systems

The pandemic has overwhelmed community support systems to such an extent that they can no longer cope with its consequences such as the need to take care of orphans. Though extended families are taking in some orphans, other institutions have had to intervene to take care of the growing number of abandoned orphans. For example, the health workers' group at Ha Poli stated that traditional institutions lacked the capacity to look after the orphans, and the hospital had to take care of those who were abandoned. The Counsellors' and Health Workers' groups at Ha Poli mentioned that they were establishing village based support groups in the community to take care of abandoned orphans. However, if the stability of a long established institution like the extended family is crumbling in the face of poverty and AIDS one wonders what needs to happen to ensure that these village based groups survive, especially as they will rely on the same poor people. It is unlikely that unless government and NGOs make deliberate efforts to give the system technical and financial support it has little chance of thriving.

At present a few identified infected individuals attend counselling sessions once a month through an initiative supported and funded by the Lesotho Highlands Water Project, which also provides transport and food during the sessions. Mamohau Hospital assists with free medication such as vitamins and pain killers, provides health education to the general community and gives demonstrations of the nutritional requirements of HIV infected people. Although these sessions only reach a few people they consume a significant amount of resources. Replicating them on a larger scale would require a lot more resources.

Extension workers attached to the Ministry of Agriculture's HIV unit are promoting Home Care Support Groups to assist communities in establishing vegetable gardens and support networks to look after the sick. This is an extra mandate over and above their normal duties. Extension workers said that the HIV/AIDS pandemic has overstretched their responsibilities to an extent that they feel there is no longer a breathing space. As a result they feel tired and demoralised. It was therefore not surprising when community members in both study areas claimed that they had never heard of such programmes in their areas since the extension workers are so overburdened that it is impossible to reach all the communities.

3.2.4.2 Weakened Kinship System

The Basotho people have always had a deep-rooted kinship system consisting of the extended family of brothers, sisters, uncles, aunts, cousins and grandparents that functioned as a safety net, supporting more vulnerable groups in the society. These safety nets are themselves increasingly vulnerable and unreliable. For example, in both study areas, the women's groups explained that it was the responsibility of the extended family to look after the sick and take care of orphans. However there were reports of orphans being cheated out of their parents' property by uncles who

wanted to enrich themselves. By the same token some widows had been expelled or dispossessed of their late husbands' land and assets.

The prevalence of the HIV virus has further weakened kinship ties resulting in some people neglecting their duties of looking after members of the extended family when disaster strikes. Respondents said that in the past people would travel hundreds of miles to reclaim a distant relative rather than let their own blood disappear. Currently, due to HIV/AIDS the opposite is true, people are abandoning very close relatives on their doorsteps and sometimes even denying them what is rightfully theirs.

3.2.4.3 Stigmatisation

Stigmatisation has hampered efforts to take care of orphans, treat sexually transmitted infections (STIs) and establish village based support groups.

We have seen that sometimes people do not co-operate with hospital staff because of the stigma attached to infection. Hospital staff label patients with HIV/AIDS type symptoms as immoral and HIV positive, and blame them for being promiscuous. To avoid being labelled prostitutes or AIDS victims members of the women's group at Ha Poli said that sometimes they do not report STIs to hospitals. This has led to an increase in the incidence of STIs and sometimes allows STIs to progress to a stage where they are incurable. For example an elderly women at Ha Poli reported:

> *These young girls hide the diseases until they rot and smell… and as a result they do not get cured and some die.*

Similarly, due to stigmatisation, some orphans do not get the care they deserve from the extended family according to traditional custom. Some orphans are neglected and abandoned due to the stigma attached to AIDS. People say that fear of infection and contamination is the reason for not taking in orphans.

The depth of poverty has led to social disintegration that is exacerbated by the impacts of HIV/AIDS. This has led to the collapse of support systems that would normally take care of orphans like the extended family or local institutions such as the church.

3.2.5 Responses to HIV/AIDS

In response to the effects of HIV/AIDS the affected households and infected individuals have adopted a number of strategies such as sharecropping, livestock sales and *mafisa* to hold onto assets like land and to foster food security. This section examines these strategies and their relation to land tenure provisions.

3.2.5.1 Sharecropping and Food Security

Under normal circumstances households with no fields or too little for their needs, would engage in sharecropping. The co-producers involved in sharecropping were either relatives or friends who pooled resources such as labour and draught power to produce crops for subsistence. Some households sharecropped when they did not have the resources to work their land. Poor households and widows were the common actors in this arrangement. There were also households that sharecropped because the breadwinner(s) or household head was chronically ill. In most cases this was a male adult or a widow.

Households and individuals infected by the pandemic stated that sharecropping has become increasingly important to them, especially where both husband and wife are infected and cannot cope with agricultural activities, since it assures them part of the harvest. One infected respondent explained that before she and her husband became infected they never sharecropped, since her husbands' remittances were enough to purchase agricultural inputs and pay for extra labour if it was needed.

> *Presently without sharecropping my family would have no food at all, I would also lack necessities such as soap, Vaseline and candles, which I buy after, I have sold part of the harvest.*

Sharecropping arrangements are more common in Ha Poli than Matsatsaneng. This is logical since most of the households in Ha Poli lost their land to the LHWP compelling them to enter into such arrangements.

Infected households point out that sharecropping not only fosters food security but also ensures that their fields do not lie fallow when they are too ill to farm them. This avoids the danger under the present land tenure system of fallow agricultural land being reallocated to other households who can use it efficiently.

However, households also mentioned that sharecropping meant smaller yields for them since they had to share the harvest with another household. The problem of reduced yields was reported by one of the infected respondent as follows:

> *Sharecropping is useful to a lesser degree to my family since the yields that I used to get even before I got sick were already low and did not last me until the next harvest. Therefore if I have to share those with another family it means I will practically starve. Nevertheless sharecropping is better than nothing because nobody would give me part of the harvest for free if I did not engage in this arrangement.*

Similarly, respondents who could not look after their livestock due to chronic illness entered contractual arrangements such as *mafisa* with other households. Under this system a household lends livestock to another household, usually that of a relative, which tends the stock and benefits from the services or products it provides. Services include draught power, while products include milk, wool, and mohair. Respondents said that, unless the partner is very far away, they still have access to livestock services and products.

The HIV/AIDS virus infected a farmer who relied mainly on livestock and crop production for livelihood. Within two years he was too sick to even go to the open range where he used to graze his livestock. Initially his wife helped him and looked after the animals. When his condition worsened his wife had to devote most of her time to nursing him. On some days the livestock remained in the yard for the whole day. In the end the ailing man's brother took the animals under the *mafisa* arrangement. Since he lives in a nearby village the woman goes every evening to get some milk for the ailing husband. The brother has also promised to help them during the ploughing season.

The woman commented that the arrangement has taken a load off her shoulders and she is now able to spend more time with her husband while still enjoying the benefits of their livestock.

Nevertheless not all farmers benefit from this arrangement. One woman explained that after entering into an arrangement with her husbands' brother, who lived in the highlands, she never heard from him and at the time of the interview did not know whether the animals were alive or not.

It should be pointed out that very few affected households possess livestock since most of them have been sold to cover medical expenses.

3.2.5.2 Livestock Sales

Livestock sales are one way in which affected households respond to the epidemic. The following is the case of one family that sold its livestock to cover expenses incurred because of the virus.

> We used to lead a very comfortable life when my husband was working for the LHWP. When he got sick and was retrenched, and within a year I also became sick, we suspected witchcraft. A traditional healer who diagnosed food poisoning –*sejeso* – as the cause confirmed our suspicions. However, he could not cure my husband. By the time we had changed to other traditional healers we had cleaned out my husband's retrenchment package and were already selling livestock to meet the medical bills and perform the required rituals. By the time he was told that he was sick with AIDS we had already sold all our livestock.

Another man indicated that he sold his livestock to pay for school fees after he lost the income that he used to get from the South African mines.

Livestock sales have taken on new dimensions with the advent of HIV/AIDS. In the past Basotho sold their livestock to meet household needs but it was very rare for them to clean out the kraals. Medical costs, funeral expenses and cultural obligations such as the requirement to slaughter a cow when someone dies have changed that pattern with negative effects on livelihoods.

3.2.5.3 School Dropouts

Respondents related that the virus has negatively affected their children's education. One couple lamented that because the disease has weakened them both, their eldest son who is only ten years old has had to drop out of school to take over his fathers' responsibilities of looking after the livestock. The situation is worse for the girls. Although they are older (fifteen and thirteen), they not only have to perform the household chores such as gathering fuel wood, cooking and taking care of younger siblings, but also have to nurse their ailing parents.

Sometimes children are withdrawn from school simply to cut down on household expenses as a coping strategy.

> One woman reported that although her husband never had a steady job he used to do odd jobs such as collecting building stones for other households and thatching houses. However, when he became too weak to do this and could not fully participate in agricultural activities, the household was left without income. They therefore withdrew their children from school because they could no longer afford school fees and other school requirements.

Withdrawing children from school obviously has far reaching implications for sustainable livelihoods and development. Such children are likely to be trapped in a vicious cycle of poverty because they will be unable to use new production technologies due to lack of education. Also due to their limited capacity as a result of poor education they will contribute less to the country's development.

3.2.5.4 Coping with Household Chores

Although a lot of villages in the study areas have piped water and sick women do not have to walk long distance to get water, children were still allocated tasks when parents were not coping.

> *I am glad that I trained my children to do household work when they were still very young because I am now relying on them to do household tasks such as the collection of firewood, maintaining the homestead and looking after the children and myself. A lot of times that means they have to miss school. Our boys also hardly ever have time to play since they have to do some of the agricultural activities.*

Friends and relatives were also reported to have assisted such homesteads, though to a limited extent. The high prevalence of HIV/AIDS and other illnesses in the community has undermined this kind of humane assistance.