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THE IMPACT OF HIV/AIDS ON LIVELIHOODS IN LESOTHO

PHASE 1: MAFETENG

Livelihoods Recovery through Agriculture Programme (LRAP)

Research Component

CARE Lesotho - South Africa

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EXECUTIVE SUMMARY

This report describes the impact of HIV and AIDS on livelihoods in two villages found in Mafeteng district namely:

- Van Rooyen's gate (VR) a semi-urban border post west of Mafeteng town, under the principal chieftainship of Tebang.
- Ha Makhakhe (HM) a typical Basotho village situated east of Mafeteng town, under the principal chieftainship of Matelile.

The aim of this report is to present the findings, conclusions and recommendations of the research to policy makers and service providers with the intention of improving understanding of how HIV and AIDS affects household livelihoods strategies in Lesotho.

Following pilot interviews with four members of Positive Action in Maseru, in-depth interviews were carried out with 29 people in the two villages (17 in Van Rooyen and 12 in Ha Makhakhe). These included 9 purposively selected infected and affected people, 11 randomly selected control households (some of whom also turned out to be affected by HIV/AIDS) and 9 key informants.

Key Findings from the research
Pilot Interviews

Positive Action members who are open about their HIV status benefit from mutual support of other members, and improved health care but they experience stigma in their home villages and their livelihoods are insecure.

Van Rooyen's Gate and Ha Makhakhe Villages
Current livelihoods

Van Rooyen's gate used to depend on border trade and employment in South Africa. The economy is in decline as a result of retrenchment and food insecurity is widespread. Few own fields and gardens, though well kept, are uncultivated due to drought.

Ha Makhakhe is a more typical rural village, dependent on remittances from miners and agriculture. Sharecropping is common and water appears to be abundant. Food stocks are relatively high despite retrenchment.

Incidence, Awareness and Acknowledgement of HIV/AIDS
Incidence

There appears to be a high incidence of HIV&AIDS in both villages. Although quantitative data were not collected, high rates are suggested by the incidence of HIV/AIDS among the interviewees, including four out of 11 randomly selected households found to be affected, and by anecdotal evidence. For example, about two wheelbarrows per week are seen crossing the border at Van Rooyen, carrying the sick to their homes. Of these about two per month are returning to Van Rooyen. In both villages the frequency of funerals was mentioned; teachers commented on the high number of orphans in their schools, while community nurses regularly saw people with symptoms of AIDS. In Ha Makhakhe several houses are boarded up as the parents have died of AIDS and the children have been sent to live with relatives.

Acknowledgement and Awareness
Of the 15 interviewees who are infected or affected 6 did not acknowledge that they or their relatives had AIDS. Five out of these reside in Van Rooyen, suggesting that the level of acknowledgement is higher in Ha Makhakhe than in Van Rooyen. This was also the finding of a WFP report in 2003. For example, one affected elderly lady who has lost 8 of her children and 3 grand children between 1998 – May 2003 claims that these children died of chest pain and TB; her neighbour has also lost 7 of her children alternating with hers.

Denial protects the infected and affected from stigma but limits access to appropriate health care, and may encourage spread of the disease. Thus, stigma was higher in Ha Makhakhe, but medical care was better.

The main sources of information on HIV/AIDS in Van Rooyen were CARE SHARP, and to a limited extent the radio. In Ha Makhakhe the main sources were the District Aids Task Force, radio, schools and Mafeteng Hospital.

HIV/AIDS Education, Care and Support
Home based care support groups are active in both villages, but operate in different ways. The CARE SHARP support group in Van Rooyen is more pro-active in seeking out infected patients and in providing comprehensive care. In Ha Makhakhe the support group established by the District Aids Task Force visits those who come forward voluntarily, in practice mainly the elderly rather than HIV/AIDS sufferers. Two openly HIV positive interviewees avoid the support group due to fear of stigma.

The level of care and support is higher in Ha Makhakhe than in Van Rooyen even though the support group in Van Rooyen appears to be more active. The main reason appears to be that care from family members is more readily given in Ha Makhakhe, perhaps because the level of acknowledgement is higher, and also because social cohesion appears to be higher. The population of Ha Makhakhe also seem to make greater use of the medical supplies and counseling available from Mafeteng Hospital.

In both villages schools attempt to care for orphans and claim that they are not stigmatized. MOHSW contributes towards caring for orphans through payment of fees.

In both villages there appears to be a stark lack of coordination among village leaders, who are individually aware and concerned about HIV/AIDS but do not coordinate or work together. Individually some have an impact through their professional work. They say they would like to coordinate. Some have relevant training, including the community nurses and the priest in Ha Makhakhe, who is a trained counselor. This appears to represent a missed opportunity.

Impact of HIV/AIDS on Livelihoods
In Van Rooyen it is difficult to assess the impact of HIV/AIDS on agriculture since few households have been cultivating fields or gardens because of drought. Agriculture is not a main source of livelihoods as only 10% of households own land. Food insecurity is higher than in Ha Makhakhe and **malnutrition appears to be accelerating deaths from AIDS**. One interviewee had lost her business in vegetable marketing after paying funeral expenses.

In Ha Makhakhe where most households engage in agricultural production as a major livelihood strategy, most of those interviewed appeared to be maintaining agricultural production levels in spite of sickness, caring and deaths due to AIDS. Sharecropping arrangements are continued and family members provide additional labour where needed. However, the sample is too small to draw conclusions about the wider population. Two infected interviewees had left jobs in Maseru on becoming sick, and had returned to the village as dependents on relatives.

Recommendations

- Strengthening **Home Based Care Support Groups**: the CARE SHARP model of using peer educators and of actively seeking out AIDS patients for comprehensive care should be replicated beyond the two villages currently covered by the project in Mafeteng;
- Development of **Village Aids Task Forces**: it is recommended that village leaders and professionals come together to develop a community level strategy to address HIV/AIDS including education, prevention, care and support;
- Encouragement of infected and affected to acknowledge HIV/AIDS should be accompanied by efforts to **eradicate stigma**. For example, people should be encouraged to talk openly in funerals and social gatherings;
- Improved supply of gloves and advice to carers on preventing infection;
- Employment of Positive Action Members (or other people living openly with HIV/AIDS) in the care of infected and affected;
- Homestead gardening should be encouraged especially in Van Rooyen where the food security situation is serious and interest in gardening is apparent. The main constraint is the lack of water.

Table 1: Summary of Contrasting Results in the Two Villages

	Van Rooyen	Ha Makhakhe
Characteristics	Peri-urban border post	Typical rural village
Problems	Drought, food insecurity	
Livelihood strategies	Pensions, piece jobs, beer brewing, prostitution, donations	Agriculture, Mining in RSA, beer brewing
HIV/AIDS incidence	Apparently High	Apparently High
Acknowledgement of HIV/AIDS in the family	Lower	Higher
Awareness of HIV/AIDS in the community	Lower	Higher
Stigma	Lower	Higher
Community support for HIV/AIDS patients	Lower	Higher
Home Based Care Group	Strong (SHARP)	Weak (DATF)
Medical care and counseling for HIV/AIDS patients	Weak (lack of acknowledgement)	Adequate (not ARVs)
Impact of HIV/AIDS on Livelihoods	Masked by drought and food insecurity	Agricultural production apparently maintained

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All personal names have been replaced by initials in the text to ensure that interviewees remain anonymous.

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Definitions of Terms

Affected – any person who cares or is within the household of an infected person and is directly shocked and stressed by the life or death of an AIDS patient.

Infected - any person who has HIV/AIDS. Many are not aware of their status. Those showing typical symptoms of AIDS were regarded by the researcher as infected by HIV/AIDS.

Key informant – individual consulted by the researcher because of their knowledge of the impact of HIV/AIDS in the community. Key informants interviewed included: Chiefs, Teachers, Nurses, Traditional Healers and Priests.

Livelihoods - People's capacity to generate and maintain their means of living, enhance their well being and that of future generations. Includes capabilities, assets and activities.

Shared-cropping – agreement between two or more households to pool their means of production for agricultural production. For example one partner supplies land and labour while the other partner supplies draught power, implements, inputs and labour. Usually the crop is divided equally at harvest. Often the supplier of land is of lower socio-economic status.

Shocks - Sudden events which undermine household livelihoods

Stresses - Ongoing pressures which households and individuals face

Support group – group of volunteers who carry out home based care for the chronically sick (including those with HIV/AIDS) within their village. Groups can be formed on the initiative of the villagers, or with support from outside, for example, from the District Aids Task Force, Ministry of Heath and Social Welfare, or NGOs such as CARE SHARP. Typically, support group members visit the sick regularly and provide medical care and general housework, as required.

Vulnerable - exposure to risks and shocks but with limited capacity to anticipate, manage, resist or recover from shocks and stresses

Vulnerable rural household – defined by the LRAP project as including those suffering from HIV/AIDS or whose nutritional status is declining; and orphan or widow/widower headed households.

List of Abbreviations and Acronyms

AIDS – Acquired Immune Deficiency Syndrome

ARVs - Anti-retroviral drugs

C.B.O – Community Based Organizations

DATF District Aids Task Force

DFID – Department for International Development (U.K.)

HH - Household

ID - Identification Document (RSA)

LRAP – Livelihood Recovery Through Agricultural Program

MADF - Machobane Agricultural Development Foundation

MOAFS – Ministry of Agriculture and Food Security

MOHSW – Ministry of Health and Social Welfare

MOLG - Ministry of Local Government

NGO – Non- Governmental Organizations

SHARP Sexual Health and Rights Promotion Project

STD – Sexually Transmitted Diseases

T.O.R – Terms of Reference

WFP World Food Programme

CHAPTER 1: Introduction

1.1 Background

This research is one of the components of Livelihood Recovery Through Agricultural Project (LRAP) implemented by CARE Lesotho-South Africa in a joint venture with the Ministry of Agriculture and Food Security (MOFS) with funding from Department For International Development (DFID). It seeks to respond to the food security crisis of 2002 through supporting agricultural production of vulnerable households; especially those affected by HIV/AIDS and those headed by widows/widowers and orphans, through improved extension systems of MOAFS and local NGOs. It needs to be noted that LRAP staff do not work directly with farmers but supports the activities of local government and NGOs in promoting food security.

The increased food insecurity is thought to have resulted from escalating economic vulnerability of households that have been hit by various factors such as HIV and AIDS which has impacted tremendously upon people's livelihoods. The pandemic and its consequences have in various ways caused shocks and stresses. Other factors include retrenchments from South African mines, a drop in the Rand/Maloti, and erratic weather conditions that particularly affect the vulnerable households. These combined shocks and stresses are forcing households and communities to seek new opportunities even though prospects are bleak. Some people turn to sharecropping against their will, forced by their circumstances. However, this is a better means of sustaining the lives of vulnerable households than renting of their fields to the well off which often reflects oppression of the better off. Another problem is the fields that lie fallow for years, thereby providing no income at all. Other households have resorted to brewing beer which often has undesirable consequences due to alcoholism such as a rise in social pathologies including theft, and violence especially against women and children.

HIV and AIDS have led to loss of labour affecting productivity in agriculture and other entrepreneurial services. Its patients become extremely weak and they cannot be productive but instead need nursing and caring. The pandemic warrants carers to be close by almost all the time. This is one reason why LRAP has chosen to focus on gardening which can be combined with home based care. The garden produce will provide nutritious food for the sick and family members; be sold for incoming generating especially in vulnerable households.

Another reason for the focus on gardening is that retrenchment has reduced income available to Basotho households and homestead gardening holds the potential to improve food security and nutrition of vulnerable households, while requiring limited investment compared with field crop agriculture.

It has been found that little has been done in terms of research in Lesotho on the impact of HIV and AIDS on people 's livelihoods. This research attempts to address this gap.

1.2 Objectives

The purpose of this research is to improve understanding of policy makers and service providers of the impact of HIV/AIDS on livelihoods, including strategies used in rural areas to maintain agricultural production and the role played by social networks in the villages. The following are the priorities specified in the terms of reference :

- Find the options vulnerable households in Lesotho hit by HIV/AIDS have in maintaining income streams and consumption levels.

- Find out how people affected by HIV/AIDS make decisions about productive activities.

- Find out what role social networks and mechanisms play for HIV/AIDS affected household in Lesotho communities.

1.3 History of the Research Villages

Box 1: History of Van Rooyen's Gate

It was at the beginning of the 20th century when people started migrating from the near-by villages to Van Rooyen's gate. At that time the place was called Ha-Ralintsi. The reasons for the migration were to come closer to the main road that connects Mafeteng and the near-by South African town of Wepener. At this time many people started seeking employment in the mining, railway construction and farming industries in South Africa. Even apart from this, the border crossing was a major center of traffic for people coming to Lesotho as well as those leaving the country for South Africa from the neighboring villages as far as Mohale's Hoek town. As a result business started booming. People started selling bread, home brewed alcohol, fruits, meat and other commodities. Rented houses were built for miners crossing the border; restaurants, cafes and shops were built. Many taxis came to drop workers at the gate and offered free drives for young women and girls to Johannesburg.' Van Rooyen was really nice those days!" as one young lady lamented.

Initially most of the land that forms Van Rooyen 's gate village was fields for farming owned by people from the nearby villages. Over time, migration of local people to Van Rooyen's Gate increased. These included many who were deported from farms and businesses in South Africa as a result of the government's Land Act of 1913, which was intended to clear black people from the land and hand it over to whites for farming. The deportation policy continued until the early 1960s. Initially the present fence that forms the border gate did not exist. People were crossing to and fro as they pleased. The fence was erected in order to control people, including those who had been deported, from illegally migrating into South Africa. People who were deported from South Africa to Van Rooyen's Gate were free to decide where to reside in Lesotho, but Van Rooyen attracted many because of the business opportunities there. People from neighboring villages were also attracted for the same reason, leading to a population concentration.

This concentration resulted into two inter-linked problems. First, the surrounding fields were converted to residential areas. Even those who were interested in farming preferred to sell their fields for residential plots since this business generated a quick return, and was more secure and more profitable than farming. As a result the majority of the population at Van Rooyen's gate do

not own fields. They do own gardens, however, and vegetable production for the market as well as home consumption appears to have been an important livelihood strategy in the past.

The shift to non-agricultural based livelihoods led to the second problem, namely an increased dependence on trade as Van Rooyen was transformed from a typical Basotho village to a semi urban area. The problem has been that once the conditions for booming trade disappeared, there were no alternative livelihoods strategies for the population to fall back on.

The main factor leading to a decline in business opportunities has been the retrenchment of workers from South African mines. The movement of people crossing the border has decreased dramatically and as a result the business boom has also disappeared. Most of the shops are closed or given to Chinese for renting because they are no longer bringing in the desired profit. Most of the houses that were built for renting to the miners have now run out of business too. Furthermore, residents who were employed in the mines are returning home unemployed.

It is challenging for households to experiment with new untested alternative livelihoods strategies and it needs time for people to adjust to the economic decline. Gardening, which could potentially offer a partial solution, has been in decline in recent years due to drought. Hence, the tendency for people to resort to easy but life-threatening options such as prostitution for survival. Poverty is now widespread and it is common for families to go for days without food or have only one meal a day.

Box 2: History of Ha Makhakhe

Towards the end of the eighteenth century Letsie 1 son of Moshoshoe 1 gave birth to a son, in the third house of ‘Mamotena. The mother had initially lost some male infants, so the newly born baby boy was nick named ‘Mamma ‘pretending the baby was a girl, so disguising him against those who bewitched the chief’s wife. The baby was nursed by special women and grew into a huge big man later to be chief Maama .He was allocated the best part of Mafeteng called Matelile. It has distinct red beds producing fertile red soil, while its valleys have dark loam soil along the river banks. It is around this place that Ha Makhakhe is situated. Lately, the soils are becoming exhausted hence the idea of introducing Machobane type of agriculture.

Maama went to the circumcision school with his peers who called themselves *Mathula*, those who hit fearlessly. They have since remained strong supporters of their chiefs; and have actively got involved in agriculture perhaps the reason for the sustainability of agricultural projects here.

Ha Makhakhe is today a typical Basotho rural village, highly influenced by the Christian Catholic Mission, Emmaus, with its primary and secondary schools playing a vital role in the socio economic development of the village and surrounding areas. Social cohesion appears strong, for example households still participate actively in community developmental activities such as digging of furrows for water supply and pits for improved toilets. There appears to be a surplus of water, which can be seen running through the village . The priest and other interviewees expressed concern about water wastage and soil erosion.

CHAPTER 2: Methodology

The research used in-depth interviews of infected, affected and non-affected households, as well as open-ended interviews with Key Informants. The in-depth interview approach was used because it was felt that other approaches, such as sample survey, or focus group, would miss sensitive information about HIV/AIDS.

2.1 Pilot Interviews: Positive Action members

As part of the preparation for the research, pilot interviews were undertaken from the 11th – 17th of August 2003 in Maseru with members of Positive Action. Three infected individuals and one affected were interviewed at the Positive Action office.

Box 3: Positive Action
Positive Action is an NGO which encourages HIV/AIDS infected and affected to come out openly. The NGO aims to provide social and economic support to members, through counseling, exchange of information and income generating projects, mainly crafts including beadwork, which is marketed locally and internationally. Recently the income generating project has faltered and members are not receiving a regular income. However, they remain positive about membership, citing mutual support from other members as the main benefit.

2.2 Village selection

Van Rooyen was selected as one of 2 villages where CARE SHARP (Sexual Health and Rights Promotion Project) is operating (see Box 2) . It was thought that SHARP would assist in identifying HIV/AIDS affected households. Van Rooyen is not a typical village, being a peri-urban border post**.**

Box 4: Sexual Health and Rights Promotion (SHARP)
The overall goal of SHARP! is to Protect and Promote the livelihood security of individuals and households that are affected by HIV/AIDS. The programme aims to reduce vulnerability of households to HIV/AIDS by promoting safer sex among priority groups and facilitating skills empowerment for communities in the prevention of HIV/AIDS and other related problems.

SHARP operates in three border locations: Maseru-Ladybrand; Maputsoe-Ficksburg and Mafeteng. In Mafeteng they operate in two villages, Van Rooyen's Gate and Ha Motlere. The Mafeteng Project Site has been in operation since April 2001.

The main strategies of the project are as follows:
- Peer education amongst priority groups;
- CBO capacity building and strengthening;
- Capacity building of service providers;
- Development of community resource centres;
- Development of community home based care services

In Van Rooyen SHARP has established home- based carers who go around the village to check on the chronically sick three times a week. They provide medication to sustain life, cook, wash up clothing and clean up the houses for the patients who have no one to care for them.

Ha Makhakhe was selected as a typical rural village, where Machobane Agricultural Development Foundation (MADF) is operating [1]. As in Van Rooyen the village home based care support group was the starting point for identifying people infected and affected by HIV/AIDS.

Box 5: Home Based Care in Ha Makhakhe
The support group in Ha Makhakhe was set up by the District Aids Task Force (DATF). As in Van Rooyen, support group members visit the chronically sick three times a week. They provide medication to sustain life, cook, wash up clothing and clean up the houses for the patients who have no one to care for them.

It was hoped to compare SHARP and non-SHARP villages in terms of awareness and acknowledgement.

2.3 Method of selection of interviewees

2.3.1 Selection of HIV/AIDS Infected and Affected.

Because of the sensitive nature of HIV/AIDS support groups were used to help in identification of infected and affected households.

Van Rooyen's Gate - In Van Rooyen, CARE SHARP's (Sexual Health and Rights Promotion project) branch in Mafeteng, together with SHARP's home-based carers assisted in

[1] Machobane is a partner organization with LRAP. It promotes the Machobane system of agricultural production focusing on homestead garden production.

identifying infected and affected households from among the chronically sick. Five households were selected in this way, of which two had infected patients while the other three were affected through recent bereavement.

Ha Makhakhe – In Ha Makhakhe, the home based care support group, formed under DATF, helped select chronically sick interviewees under the instruction of the village headman. However, of the first five selected only one appeared to be infected by HIV/AIDS [2], while the other four were elderly bed-ridden patients suffering from other diseases of old age. Subsequently, the support group took the researcher to a further two households known to have chronically sick people who were not using the services of the support group. Two of these individuals disclosed their HIV/AIDS status and agreed to be interviewees. In total, two infected and two affected were interviewed in Ha Makhakhe.

Table 2: Purposive Interviewees

	Van Rooyen			Ha Makhakhe	
Case No.	Name	Status	Case No.	Name	Status
1	NT	Infected	18	NL	Infected
2	NM	Infected	19	NS	Infected
3	MK	Affected	20	MA	Affected
4	PL	Affected	21	TI	Affected
5	MM	Affected			

2.3.2 Selection of Control Households

In order to assess if purposively selected households were typical of the village, control households were selected in each village, using random sampling.

Given time constraints, it was hoped that about five control households would be interviewed in each village. This represents a small proportion of the total population which was over 235 in Van Rooyen Sekoting and over 200 in Ha Makhakhe.

In Van Rooyen a random sample was taken from a complete list of households in the village. In Ha Makhakhe a transect walk method was used, with every 16th household selected. The reason was that the method used in Van Rooyen was time consuming. Details of the two methods are given below:

2.3.2.1 Van Rooyen's Gate: Wealth Ranking and Random sampling

It was hoped to cover a range of socio-economic groups, in order to get a representative picture of the village as a whole. It was therefore decided to combine random sampling with a participatory wealth ranking. Control households were then selected randomly from each of the

[2] The researcher made her own assessment in discussion with home based care support group members, based on known typical symptoms of AIDS.

main wealth categories, with a larger sample drawn from the largest category, being the poor. The exercise took five days to complete in Van Rooyen.

Two different groups of six males and six females were selected to rank villagers according to their wealth status.

Sitting at a high place from which every household in the village could be seen, each group discussed and justified the categories for each household. This involved developing definitions of four categories, namely: very poor, poor, average and well-off. Stones were used to illustrate the categories as follows:

One stone denoted extreme poverty category.

*   Very poor

Two stones denoted a lower level of poverty than the above category

* *   Poor

Three stones denoted an average household

*
* *   Average

Four or more denoted well off

* *
* *   Well-off

Later the two groups came together to reconcile their results, justifying each household's wealth ranking.

The groups came up with the following categories.

Table 3: Livelihood Categories in Van Rooyen

Very Poor	Poor	Average	Well-off
Those with no fields, no off farm income, no chickens, no more than one pig. Sewing machine but no business. Depending on washing, cleaning up and ironing friends' clothing or selling apples, bread cakes and brewed beer at the bus stop with minimal profits due to declining business opportunities caused by retrenchment; i.e. less people buying in comparison to five (5) years ago	No fields or up to two (2) fields, no off farm income, no cattle, not ploughing fields due to drought, could have daughter or son who helps once in a while, e.g. providing money for doctor's consultation and food; may have dilapidated Scotch cart due to lack of rain for better yield and sells brewed beer *(joala)*	May be earning South African pension i.e. R700 plus every month; or husband working in the mines as the only bread winner, maintaining two houses; i.e. house for RSA permanent residence and Lesotho household. The one wage earner as a teacher, civil servant or shop- keeper. Sells beer; having a taxi.	Two (2) wage earners, eg a teacher and a miner in a household; Businessman renting shops, selling coronation bricks, having savings in the bank, selling beer and liquor, renting residential flats, has sheep and goats.

Table 4: No. of households in each livelihood category, Van Rooyen

	Very poor	Poor	Average	Well off	Unknown[3]	Total
Number of people	109	44	29	7	46	235
% in each category	46	19	12	3	20	100

In order to take a **random sample**, each household was designated a number, and then the number was written on a piece of paper. This was folded and put in a pile corresponding to the wealth category. Finally, papers were picked randomly from the piles. Seven households were selected in this way and were then visited as control households.

2.3.2.2 Semi-Random Sampling – Ha Makhakhe Transect Walk

A transect walk was done from the upper east end of the village heading downwards towards west. Every 16th household was selected for interview, giving a total of four households.

The selected control households are shown in Table 5 below:

[3] Unknown households are those where members were absent at the time of the research and the chief did not know their whereabouts.

Table 5: Control Households interviewed

	Van Rooyen		Ha Makhakhe
Case no.	Name	Case No.	Name
6	MP	22	ML
7	LP	23	RI
8	KH	24	RR
9	PM	25	LL
10	MO		
11	MT		
12	MH		
TOTAL	7		4

2.3.3 Key Informant Interviews

2.3.3.1 Method of Selection and Justification
A purposive method was used whereby local leaders and professionals were approached to provide background information on the area and on issues pertinent to the research. A good rapport was established to facilitate frank and intimate discussion to gain a deeper understanding of how the informants perceived issues at the community level as they related to their professions, including the impact of HIV/AIDS, shocks and stresses, trends in livelihoods and services available.

2.3.3.2 Number of key informants interviewed in each village

Table 6: Key Informants Interviewed

	Van Rooyen			Ha Makhakhe	
Case No.	Name	Profession	Case No.	Name	Profession
13	TM	Chief	26	MD	Teacher
14	MY	School Principal	27	HM	Priest
15	KM	Priest	28	LT	Community nurse
16	MR	Community nurse	29	MG	Traditional healer
17	LK	Traditional healer			

Five (5) informants were interviewed in Van Rooyen and four (4) in Ha Makhakhe. The chief for Ha Makhakhe is not resident in the village, so was not interviewed.

2.3.3.3 Rationale for selection of Key Informants

Chief – as a community leader, was necessary for accessing the village. It was hoped that he would also:

- give information on the impact of the pandemic on livelihoods, since he registers every death;
- explain how he raises awareness;
- give his view on how HIV/AIDS affects livelihood strategies such as farming;
- indicate what role he plays in the care of orphans who do not have relatives.

Teacher – as someone who is working with pupils especially orphans. To help find out:

- if the school assists the orphans to be aware of services provided by MOHSW;
- the impact of HIV/AIDS on pupils' livelihoods, especially those who have lost parents, and how it affects their education;
- methods of raising awareness among the pupils; i.e. the inclusion of HIV/AIDS lessons in school curriculum;
- how they encourage growing of vegetables at school and home gardens.

Nurse - to give information on health conditions and impact of HIV/AIDS in the area, including:

- how the affected and infected cope with the pandemic particularly the most vulnerable groups such as orphans and widows;
- the services provided for both affected and infected; i.e. the counseling aspect so that the infected should have hope to live with HIV/AIDS, while the affected should accept the health situation of the infected and assist them.

Traditional healer – to find out views on the impact of the pandemic and to:

- provide records of patients who died of HIV/AIDS where possible;
- find out strategies they use to fight the pandemic.

Priest – a community leader who is entrusted with the responsibility of praying for the sick, to find out:

- how HIV/AIDS impacts on his congregation;
- how effective their counseling skills towards infected and affected;
- whether the church provides any services to HIV/AIDS infected and affected.

2.4 Interview Technique

2.4.1 Household interviews

Interviews were conducted at the homes of those selected. At least three visits were made to each interviewee in order to build up a rapport and gain the confidence of the interviewees. On the first occasion, the informant was assured of his/her anonymity, so that he/she could speak under relaxed conditions. A tape-recorder was used to record the final interview , with the consent of the interviewee.

A personal history approach was used whereby the interviewee was encouraged to speak freely about issues of concern to them. However, prompting questions were used to ensure that key topics of the research were covered. These included: family history, details of any sick or deceased members; level of awareness and acknowledgement of HIV/AIDS; care and support of infected and affected; impact of HIV/AIDS on household livelihood strategies; views on how to tackle the AIDS pandemic.

2.4.2 Key Informants

The key informants were visited twice. On the first occasion the purpose was to explain the visit and the intention of the interview and to get permission to carry out the interview. If the informant accepted, a favourable date for the informant to be interviewed was set. On the second visit the interview was done.

Key informants were asked about HIV/AIDS in their community how it affected their work, and whether they coordinated with other leaders.

NB: A brief description of all 29 interviewees is given at Annex 1. Case numbers used in the table at Annex 1 will be used throughout the report.

2.5 Constraints faced during Research

Forty days research was insufficient to cover 29 households interviewed in the two villages, in addition to the pilot participants.

It has not been easy to deal with the issue of HIV/AIDS among people as it is very sensitive. However, other issues of livelihood were responded to with excitement. Although they had been told that nothing in the form of donations would be given, respondents' hopes were that soon a delivery from hunger, stress, retrenchment and unemployment would be provided. They were grateful, their hope was revived and they had a chance to express their feelings in relation to their stresses and shocks.

CHAPTER 3: Results on the Impact of HIV/AIDS on Livelihoods

3.1Pilot Project

Members were enthusiastic about the benefits of Positive Action, although the emotional benefits were more obvious than the economic benefits. There is cohesion among members and they help one another with ideas and advice, particularly on care and herbal treatments. They appear healthier than infected interviewees in the villages.

They have acknowledged their status, and feel that they are better off as a result, although stigma was a major concern, especially in their home villages. Members seem to rely on one or two close relatives or friends for emotional and material support, and are rejected by others in their villages. They had few ideas on how to tackle stigma, preferring to focus on the Maseru based Positive Action activities.

Although one of the main objectives of Positive Action is income generation for the infected, in practice they currently gain little income from their participation. They remain active, coming in to the office daily, to do bead work which is then sold. However, materials seem to be short and marketing has slowed. Lack of employment was the main concern voiced. Two of those interviewed planned to cultivate gardens in their home villages as their main livelihood strategy. Some wish to work at hospitals to help their fellow AIDS patients.

In summary their main problems are unemployment, stigma in their home villages and lack of support from the government officials.

3.2Current Livelihoods Strategies

There is a stark contrast between Van Rooyen and Ha Makhakhe. Van Rooyen is a peri-urban border post area where less than 10 % own land, and dependence on employment in South Africa and border trade is high. Gardening is also an important supporting livelihood strategy, although drought in recent years has led to a decline. Most households own gardens and they are well looked after even though there are currently no plants due to drought. The dams have been dug awaiting rain. Access to seed appears to be another constraint.

The economy is in severe decline due to retrenchment .The small businesses which used to thrive in the area are gone. The fall in the Rand has escalated poverty. Houses are broken down as residents desert for RSA, taking building materials with them. Some women have been left destitute. Almost 20% of the household members have left. Many households consist of grandparents and children as the middle generation are working in RSA.

Due to drought and economic decline food stocks are very low. Fields and gardens have lain fallow for three to five years due to erratic weather conditions. Poor households rely on limited piece work, and handouts from neighbours, while many of the average households depend on South African pensions.

Ha Makhakhe is a typical rural Mafeteng village, where livelihoods depend on wage employment in RSA and agriculture, and food stocks are relatively high. Sharecropping is

common, as many who own land lack implements. Some breadwinners are retrenched miners, while others are still mining. There are many female headed households. Most interviewees were widowed (five) or had absent husbands (two). Some residents observed increased social pathology – alcohol abuse leading to crime, especially women and child abuse.

TABLE 7a Livelihood Strategies of 29 Interviewees in 2 villages

Livelihoods strategies	Agric.	Self-employed	Employed	Dependant	Savings	Other	Total
Number	6	4	6	14	1	4	35
%	17	11	17	40	3	11	100

Table 7b: Ownership and use of Gardens in Two Research Villages

Gardens	planted	Unplanted	no.garden	total
Number	9	15	4	28
%	32	50	18	100

3.3 Incidence of HIV/AIDS

Quantitative data on the incidence of HIV/AIDS in the two villages was not collected during this research. An attempt was made to obtain data on deaths but the Chiefs did not have this data available. However, case study material, together with observations and other anecdotal evidence suggests that the incidence of HIV/AIDS is high in both villages. It had been anticipated that incidence might be higher in Van Rooyen since it is a border town, where transactional sex is widespread. However, incidence appeared to be as high in Ha Makhakhe.

In both villages purposive interviews were held with HIV/AIDS infected and affected. This sample cannot tell us about incidence of HIV/AIDS since the sample was not randomly selected from the population. However, it is striking that two out of seven randomly selected control households in Van Rooyen and two out of four control households in Ha Makhakhe had lost close relatives to AIDS. Furthermore, one of the Key Informants in each village was also affected by a recent death in their family from AIDS.

Table 8: HIV/AIDS infected and affected among 29 interviewees

Village	Infected	Affected	Not Affected	Total
VR - Purposive	2	3	0	5
VR – Control	0	2	5	7
VR - Key Informant	0	1	4	5
HM – Purposive	2	2	0	4
HM – Control	0	2	2	4
HM – Key Informant	0	1	3	4
Total	4	11	14	29

The impression is that the **sick are dying faster** in Van Rooyen because of the **higher incidence of hunger and poor nutrition.** Support group members mentioned that many of their patients had died, leaving only two who were currently sick. One of the two infected people who were interviewed died during fieldwork. More rapid deterioration of health in Van Rooyen may also be associated with the lower levels of acknowledgement and consequent lack of appropriate care (see section 3.4 below).

3.3.1 Anecdotal evidence for high incidence of HIV/AIDS in research villages:

1. Wheelbarrows: in Van Rooyen it was said that two to three wheelbarrows cross the border post per week, carrying a sick person returning home. About two wheelbarrows per month come home to Van Rooyen. The researcher observed one such wheelbarrow during her research.
2. Incidence of funerals: In Ha Makhakhe one home based care support group member commented that the previous weekend had been the first with no funeral in the village since at least the beginning of the year, if not before. The Chief mentioned that coffins were made from old wardrobes and other furniture to reduce the cost.
3. Empty houses: In Ha Makhakhe it is a common sight to see empty, closed up houses where parents died of AIDS and children are now with other relatives.
4. Patients: In Ha Makhakhe the community nurse estimates that about 40% of her patients are HIV positive, although only one has come out openly.
5. School pupils: Teacher in both villages commented on the high numbers of orphans in their schools.

Box 6: Orphans. (Teacher in Ha Makhakhe (MD, Case 26))
"We have many children whose Members of family are sick. They even absent themselves from school as nurses. Many children are orphans i.e without mother and father. This has escalated lately. In my class only I have two whose parents are both dead. We even ask for help from the Government. In fact there are three because the other one hates being called an orphan. However she is well dressed. Generally the orphans are many this is only my class. I diagnose such children because we live amongst them in this village. The one we didn't know comes from Ha Mosala a village distant from here."

Box 7: The Chief's view on incidence of HIV/AIDS in Van Rooyen (TM, Case 13)
"Five years back people had enough for their families, through their businesses. But now life has changed drastically due to retrenchment, poverty has escalated and death toll has risen. We bury people almost every weekend. HIV/AIDS has affected a lot of people here. We have seen people being fetched from the gate on wheelbarrows, young people on the verge of dying. Many people are dying; most of them come from RSA already on the verge of dying through HIV/AIDS. At times we go to an extent of requesting assistance from the Ministry of Local Government through social welfare for coffins since some people do not have means. The resources are so scarce that at times we make coffins with pieces of old wardrobes and planks for babies, while we cook some potatoes and cabbage for funerals. Slaughtering of cattle for burial has contributed into more poverty because some people borrow money for this purpose and there after have nothing to live on."

3.3.2 Case Studies suggesting high incidence of HIV/AIDS

Some interviewees had suffered the loss of many family members to AIDS. For example, MP (Case 6), a widow living in Van Rooyen, lost her husband, eight of her ten children and three grandchildren to AIDS. ML, a widow living in Ha Makhakhe, lost four of her ten children, a son-in-law, a daughter-in-law and two grandchildren all to AIDS. Both of these were control households, randomly selected from the village populations.

3.4 Acknowledgement of HIV/AIDS by infected and affected

Acknowledgement among affected and infected appears to be higher in Ha Makhakhe than in Van Rooyen, based on those who were interviewed. In Van Rooyen neither of the two infected interviewees acknowledged their status, and three out of five affected interviewees did not acknowledge that relatives had died of AIDS. By contrast, in Ha Makhakhe both of the infected and three out of four affected openly acknowledged that they or their relatives had AIDS.

Table 9: Acknowledgement of HIV/AIDS by infected and affected

	Van Rooyen	Ha Makhakhe
Infected acknowledge	0 / 2	2 / 2
Affected acknowledge	2 / 5	3 / 4
Total acknowledge	2 / 7	5 / 6

Box 8: Denial: MP, Van Rooyen (Case 6)
MP lost 9 children and 3 grandchildren between 1998 and May 2003. Only one of these deaths was clearly not from AIDS. Three died from TB, others suffered chest pains, loss of weight and sores. However, MP does not acknowledge that they died of HIV/AIDS. She mentioned that her neighbour also lost seven family members. She said "each time my neighbour loses a child I get scared that I will lose someone" One of the orphans she cares for is a peer educator with SHARP.

The community nurse in Van Rooyen said that only one of her patients had ever asked if he had AIDS. He died two days later.

It had been anticipated that acknowledgement might be higher in Van Rooyen due to the presence of the CARE SHARP programme in that village. The higher level of acknowledgement in Ha Makhakhe may be due to outreach, health care and counselling provided by Mafeteng Hospital. Residents of Van Rooyen tend to use various South African medical services, indeed many of the inhabitants are South African citizens. Another possible reason is that the community is more fragmented in Van Rooyen. The Chief of Van Rooyen commented: "People normally hide their HIV/AIDS status and others used to run away from the issue. Even when the awareness campaign was done, they did not attend."

3.4.1 Consequences of degree of Acknowledgement: Care and Stigma

Observed consequences of acknowledgement of HIV/AIDS by the infected and affected are:

- Appropriate medical care and counselling help the patient and may prolong life. Infected in Ha Makhakhe receive medication and counselling from Mafeteng Hospital. In Van Rooyen

the infected received basic care from the SHARP home based care support group but were not being treated for HIV/AIDS from any medical centre.
- Stigma increases. In Ha Makhakhe stigma was mentioned by two openly infected and one openly affected interviewee as well as by several key informants. Stigma was not mentioned in Van Rooyen. Denial may thus serves to protect the community from stigma.
- The risk of spread is reduced (see Case Study of NL Box 12 below).

Box 9: Stigmatized. (NS, Case 19)
'people do stigmatize here, they call me names. But I do not care because I have accepted, because even those who do not have HIV/AIDS will still die. We need to talk a lot about HIV/AIDS to stop people from stigmatizing'

Box 10: Fear of stigma leads to avoidance of support group (MA, Case 20)
MA lives in Ha Makhakhe, where she cares for her sister, recently returned from Maseru, sick with AIDS. Both acknowledge that MA's sister has AIDS. But because of the fear of stigma, MA does not call on the home based care support group for help in caring for her sister. If she needs help she goes secretly to her cousin, who is a support group member. In two neighbouring households the parents died of AIDS, and the children were taken to stay with relatives. The houses were closed up. This has led to fear.

However, stigma was denied in schools. The teacher at Ha Makhakhe insisted :"there is **never** a time when other learners stigmatize orphans about their parents' death or sickness, never (*shakes her head*). They are not even sure as the nurse often talks of '*sefuba'* common cold and not HIV/AIDS."

Box 11: NL: a victim of lack of acknowledgement (Case 18)
NL, who lives in Ha Makhakhe, is sick with AIDS. She went for a test after her infant died aged 3 months, and she found she was HIV positive. She encouraged her husband to get a test. He also tested positive, but seemed quite unperturbed, as though he had already suspected his status. NL concluded that her husband's first wife probably also died of AIDS. Furthermore, she suspects that her husband knew this before marrying her. She had unwittingly married a man who knew that he was HIV positive. Her husband is much older than her. He works at a mine in Caltonville, and sends money regularly. NL feels she is better off since she came out openly, despite the stigma she experiences.
"There are may people with HIV/AIDS who are hiding and cannot get help. I do not have much hope for them as they do not know how to get help and what solutions are available. They pretend they have been for tests but they are lying. Yes they do stigmatize people they also sigmatized me. They said I have Aids and I am hiding. There is a lot of ignorance and people are not ready to accept. They are still in denial. I went to Mafeteng for an HIV/AIDS tests and was positive. In Carltonville, they also confirmed my status as positive. **"**
NL does not use the home based care support group in Ha Makhakhe, possibly though fear of stigma or because she doesn't need their help. She says that now that she has come out openly she gets better care and cares for herself better. She receives medication from Mafeteng hospital.

3.4.2 Awareness of HIV/AIDS in the community and sources of information

In both villages virtually all of those interviewed were aware of the existence of HIV/AIDS, although again awareness seemed to be higher in Ha Makhakhe. In Van Rooyen some denied that they had ever seen someone with AIDS in their village, and even in Ha Makhakhe, where the level of awareness and acknowledgement is higher, people are not prepared to mention names of those affected or infected.

In some cases interviewees seemed highly aware of AIDS yet continue to deny its existence in their own family. For example, a teacher in Ha Makhakhe claimed her husband died from beating by the police, but the symptoms appear to have been from AIDS. She also shows some symptoms herself but appears not to acknowledge. However, she does acknowledges a high rate of AIDS in the community, and has three orphans in her own class.

The main sources of information on HIV/AIDS in Van Rooyen are firstly, CARE SHARP and secondly the radio. Most interviewees appeared to have had some contact with SHARP, and some had relatives who were peer educators (see Box 9 above). Despite this, the level of acknowledgement remains low. Radio reports claim that HIV/AIDS is rife in Van Rooyen, but some listeners who were interviewed deny this, especially those who are infected and affected (MP, Case 6, Affected, MH, Case 12, Not Affected).

The main sources of information on HIV/AIDS in Ha Makhakhe are the District Aids Task Force through pitsos; radio; schools[4]; and Mafeteng hospital.

3.5 HIV/AIDS Education Care and Support

3.5.1 Home Based Care

Home based care support groups operate differently in the two research villages.

Box 12: Home Based Care Support Groups
The Home Based Care Support Group in Van Rooyen is supported by the CARE SHARP programme. The group actively seeks out chronically sick people including HIV/AIDS patients. Group members provide comprehensive care for sick, including cooking and housework as well as medical care. There are about 10 members, mostly men. Some are also peer educators (see Box 4).

The Home Based Care Support Group in Ha Makhakhe was established with training from the District Aids Task Force in Mafeteng. According to their training, their strategy is to visit only those who came forward voluntarily, and they appear to be visiting mainly elderly chronically sick people who did not have HIV/AIDS. There are two active members, both women. Several interviewees who were open about HIV/AIDS chose not to use the support group for fear of stigma (see above).

The role of the home based care support group in Van Rooyens is described by the Chief as follows:

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[4] HIV/AIDS is incorporated in the school curriculum for secondary schools, but not yet in primary schools.

Box 13: Home Based Care in Van Rooyen (Chief, Case 13)
Ever since SHARP was introduced here it has helped a lot, people are better educated and understand better. The fear is gone, they try to interact. We help the sick, bathe them, and teach them what and how to eat. People do not refute the idea of HIV/AIDS, they are even aware of its victims. However, the victims have not confirmed their status. Many people want to be members of SHARP. The organization encourages victims to eat vegetables, garlic, ginger and others. Due to lack of water vegetables have died. Initially radish used to be available but due to drought there is none.

One of the patients visited by the support group was also appreciative:

Box 14: Help from the Home Based Care Support Group (Case 1, NT)
"I get help from home based care givers, they are volunteers, men assist in bathing me, make up my bed, women sweep, clean and cook and feed me. If there is no food, vegetables or paraffin they give me some. I never go without meals. I give them money if I have any so that they can buy me something. I take herbs like Hloenya, Lerara tau, tsoene (traditional herbs) and tablets called Panamols. (*Showed tablets under mattress*) I also get Nicotine acid from my niece, Mosimoli who works in the Chinese factory in Maseru, and I get other medication from the chemist. As for improving my life I need medication and food. (*He laughs*).

However, although the support group in Van Rooyen's Gate appears more effective, care from family members and the community appears to be stronger in Ha Makhakhe. This may be because the level of acknowledgement of HIV/AIDS is higher in Ha Makhakhe, and also because social cohesion appears to be higher. For example in Ha Makhakhe, communities still participate actively in community developmental activities like digging of furrows for water supply and pits for improved toilets. Even if the member is sick there will be a representative from the family. The population of Ha Makhakhe also seem to make greater use of the medical supplies and counseling available from Mafeteng Hospital. Patients claim that Mafeteng Hospital provides excellent services and counseling for HIV/AIDS patients. They also claim that the Mine health units provide them with special medication.

In Van Rooyen support from family members seems to be weaker, perhaps partly because of the lower level of acknowledgement. Support from the community also seems to be weaker and there appears to be less social cohesion generally. People no longer share, or give things to relatives or friends, perhaps due to greater poverty. They seem to be breaking the Basotho norm of extended family relations. Everybody is more concerned for the survival of their own family. Patients in Van Rooyen are also not using local medical facilities as they do not acknowledge their HIV status. However, they do get medication from home based carers in the support group.

3.5.2 Village Leadership

Five village leaders were interviewed in Van Rooyen and four were interviewed in Ha Makhakhe (see Table 6). In both villages there appears to be a stark lack of coordination among village leaders, who individually are aware and concerned about HIV/AIDS but do not coordinate or work together. Individually some have some an impact through their professional work. They say they would like to coordinate. Some have relevant training, including the community nurses and the priest in Ha Makhakhe, who is a trained counselor. **This appears to represent a missed opportunity.**

The most active of all the leaders interviewed is the **priest** in Van Rooyen who works with the youth. His comments on his role were as follows:

Box 15: The role of the Priest (Case 15, Ha Makhakhe)
“There are no people infected who come forward and openly talk to me about this problem. People are turning the sickness into top secret. However there are three people who were members of my congregation who died and according to the symptoms that I know died of the disease. Yet I was still told that it was chest problems and a running tummy. I do not particularly meet with infected people but I call people collectively and talk about HIV/AIDS for instance with the church youth. I would suggest that people who teach about the disease should include us and chiefs when having such workshops as this can help a lot since we work with a lot of people and as such we can spread the message to reach a wider spectrum of our people. “

The priest in Ha Makhakhe trained as counselor in the United States of America. He appears to be highly aware but not very active. He observes AIDS symptoms during last rites and burials.

The **Chief** in Van Rooyen is President of SHARP support group. He described his role as follows:

Box 16: The Role of the Chief (Van Rooyen, Case 13)
As a chief I actively participate in SHARP events here. My relationship with carers is very good. I have been elected as carers president. Oh lady! I encourage vegetable growing even if it can be one tomato with manure. I also advise people to avoid fields lying fallow. Maize is scarce eating it is like eating meat really. They can even snatch it from you if they see you eating it.

My responsibilities as a chief are to protect the orphans, to ensure that no one abuses them. I also register them for assistance for example donations. The main challenge facing me concerning orphans is their education; I have assisted many to go to schools using my own money. My relationship is also very good with traditional healers and the church leaders. The community relates very well with police, they work together in many issues through my assistance. At personal level I also relate well with policy makers from the government from various department. “

School principals in the two villages are active in supporting orphans and pupils whose family members are sick.

Box 17: Orphans in Schools (School Principal in Van Rooyen’s Gate, Case 15)
“I know of children whose parents are dead because we have a rule of financial assistance to a bereaved family, through the contributions paid by the pupils. At times some come and tell me unofficially that their parents are late. I hate the idea of children who are sent out of school or sit and mourn their parents’ death I encourage them to come to school. I do not have a role really, I bring a child who is bereaved closer to me, talk to her a lot to let her forget such a problem. As a principal I encourage teachers to do so too. In relation to helping them there are no means apart from giving her food to go home with at times. Moreover, there are people at district level who come and teach lessons on HIV/AIDS. Children do not show their bereavement because it is our principle to avoid staying at home if one’s relative is dead but if he is sick we encourage them and tell them that they will be fine. I never do anything in relation to HIV/AIDS, because the HIV/AIDS home based group was going around teaching about the pandemic. There has never been any report of stigmatizing (*She sways*) rather empathy and pupils contribute twenty to fifty

cents to the child of the bereaved. Death does not lead to performance decline may be it is due to having grown up with the grandparents."

(Teacher in Ha Makhakhe, Case 26)

"Our motto was to contribute for each bereaved child. This has failed due lack of knowledge in such cases. There is nothing we do, except to ask for finance from Government in terms of fees and they have been included in the list of those in need of donations. The village assists in seeing to it that they get donations otherwise, they incur problems. The impact of this is very painful. When you realize there are orphans whom you can't help, it is painful. We never approach their families because they are poor. We call them to know about Government funds. We influence the relatives to buy uniform for such orphans. My suspicion is an HIV/AIDS process because the manner parents go looks the same as the symptoms taught about AIDS.

In Van Rooyen the community nurse encourages patients to do homestead gardening for nutrition (this is part of her role as community nurse).

Box 18: The role of the community nurse (Ha Makhakhe, Case 28)

"I have diagnosed HIV/AIDS patients. They constitute about 4 in 10 of my patients. HIV/AIDS indicators are mostly loss of weight, thrust in the mouth, persistent cough, and anemia and sores all over the body. Only one has come out openly. Most are women aged between 20-30. My approach towards these HIV/AIDS patients is to enable them to come from time to time. Those who come I ask them to get to the doctor for counseling. However, the one who has openly acknowledged never comes for medication. There seems to be fear or loss of hope. I encourage healthy eating, for example in combating T.B. The solution could be education to know that AIDS does not kill immediately, but should be taken as a disease like any other disease. Give courage, inform them about nutrients that can sustain life."

The only Key Informant who was not ready to discuss the issue of HIV/AIDS was a Traditional Healer interviewed in Ha Makhakhe. She claimed to know nothing about the disease.

Box 19: Traditional Healer in Ha Makhakhe (Case 29)

"I know nothing about traditional healing and its role in relation to HIV/AIDS. I can't claim I know how to heal AIDS, No. Asking me what other people use to heal or alleviate HIV/AIDS is a difficult question; I do not know I have already told you that I do not know anything about HIV/AIDS. I don't need any precautions to prevent infection from patients. You seem to want to trap me. 'Mapalesa! I have never once had an HIV/AIDS patient."

3.5.2.1 Lack of Coordination among Village Leaders

Coordination among leaders in relation to HIV/AIDS appears to be weak in both villages. In Ha Makhakhe the nurse and teacher are both accountable to the priest as all work under the Catholic Mission. However, they do not coordinate in relation to HIV/AIDS even though it affects all three of them in their work. In Van Rooyen the chief claims that he coordinates well with the traditional healers and church leaders, although this was not confirmed by the priest who was interviewed:

Box 20: Lack of Coordination
Priest in Van Rooyen
"I have met neither chiefs nor support groups and discussed this problem. They are also ashamed to talk about it at the funerals sessions. I think the problem is that they do not acquire the permission of the deceased family to talk about the cause of death, as they would consider it a disgrace to the family. However, I have been invited to two meetings where the issue was the forth-coming local government."
Priest from Ha Makhakhe
"No I have never met chiefs relating to this HIV/AIDS. We have no HIV/AIDS support groups. No these could be a new idea. I haven't met chiefs nor support groups. If these people were open it would be easy. We don't talk about it. How can I help someone who is hiding?"
Teacher in Ha Makhakhe
"Our relationship with the community working with patients is not in any way active. We do work with chiefs in terms of crime but not sickness. We have support groups. We use gloves from the support groups a lot, but not tablets. We never work with traditional healers. We only work with nurses who deliver services and advice. We do encourage gardening a lot, though villagers steal vegetables, however we have fenced the yard now. We teach about HIV/AIDS a lot because it is in the syllabus. It even encourages vegetables and fruit usage."
Community nurse in Ha Makhakhe
"I have never met the chief in relation to HIV/AIDS. I have not seen the support groups, I only heard of them in September this year. I was once invited by the teachers in 1999 to give lessons on STDs (sexually transmitted diseases) and HIV/AIDS to learners in different schools.
I have never asked for a chance to talk about HIV/AIDS. However the Rev. father does talk of it during the services. I have never talked to traditional healers either, and I never get patients who have been to the traditional healer."

3.6 Impact of HIV/AIDS on Livelihood Strategies

Given the small sample size it is not possible to generalize from the case study examples given below. However, HIV/AIDS has had a major impact on all interviewees who were infected or affected, as illustrated in Table 10 below. In Van Rooyens the impact of HIV/AIDS is compounded by extreme poverty and hunger. Households in Ha Makhakhe appear to be coping better.

3.6.1 HIV/AIDS and Food Security

Low agricultural production coupled with the lack of alternative employment in a time of economic decline has led to food insecurity in Van Rooyen. According to the home based care support group hunger is accelerating deaths from AIDS. Eight patients have died in Van Rooyen recently and hunger is thought to have been a contributing factor (SHARP project manager, personal communication).

Box 21: Hunger and HIV/AIDS (Case 1 NT elderly AIDS patient)
I eat papa with salty water at times. I feel better if I have eaten green vegetables, soup or had a glass of milk. All these ease my pain and my sickness. Having fields is useless because we are in the same boat with those who have not because we do not have food. Even if the government sent tractors it would be of no use because of the drought.
Ntate NT passed away during the period of fieldwork

3.6.2 HIV/AIDS and Agriculture

3.6.2.1 Van Rooyen

In Van Rooyen the main reasons for low agricultural production are that most people do not own fields (only 10% own fields), and the area is prone to drought. Most families have gardens which have not been cultivated for the past two years, and most have rain water collection dams which are currently dry.

However, the priest in Van Rooyen believed there was potential;

Box 22: Agricultural Development Prospects (Priest in Van Rooyen, Case 15)
People are no longer cultivating land not because of HIV/AIDS but the blame is with the government because it encourages them to sit back and await donations or handouts. The best donation would be more water for irrigation and construction of effective dams. So that people can work and not await donations. Homestead gardens are poorly attended to so we depend on vegetables from South Africa, yet we can grow our own. All vegetables survive here, I would encourage potatoes and pumpkin as they last longer.

Given the impact of drought it is difficult to identify the impact of HIV/AIDS on agricultural production in Van Rooyen. For example, in one household the infected 17 year old girl said she was too sick to work in the garden (Case 2). But nothing had been planted in the garden at the time of interview due to drought. However, one infected man (Case 1) appeared to have abandoned his garden for the past three years due to sickness from AIDS, while an AIDS widow (Case 6) had been unable to farm since the death of her husband (see Box 24 below). On the other hand another AIDS widow in Van Rooyen (Case 3) had maintained a thriving garden (the best seen in Van Rooyen) throughout her husband's sickness.

Box 23: Impact on Livelihood of loss of breadwinners to AIDS: MP, Van Rooyen, (Case 6)
Lost husband and nine of her ten children, together with three son-in-laws, to AIDS. Cares for five orphaned grandchildren. Now suffers heart problems, she says from grief due to loss of her family. She now depends on domestic piece jobs.
"I used to work in South Africa when I was still well. Later I worked at the border post as a housewife. I worked so that I could get money for my grandchildren. I have two fields but no means to cultivate them. Chief Letapata Letsie threatens to take them since it has been years since they were cultivated. Someone promised sharecropping but did not live up to his promise. He complained that the fields were too far away. I used to plough them during my husband's life. One other problem is that the climate is dry. I used to grow maize and pumpkin in the garden but due to lack of water I cannot. I do not have a dam because I am afraid my grandchildren might drown."

3.6.2.2 Ha Makhakhe

In Ha Makhakhe all of the seven interviewed households who were infected and affected by HIV/AIDS had agriculture as a major livelihoods strategy. In two cases agriculture was financed through a salary in the mines, and in three cases sharecropping was practiced. In all but one case agricultural production appeared to be maintained by the households in spite of sickness, caring and deaths due to AIDS. The case where this did not occur was an AIDS orphan, RI, aged 17

(Case 23). Her parents' fields and garden now lie fallow as there is no-one to cultivate them since they died. RI depends on her relatives.

Box 24: Farming continues despite AIDS: NL, Ha Makhakhe, (Case 18)
NL used to farm, but now cannot due to sickness. She continues to be the decision maker in farming but now her 5 step-children and 2 children do the work. The children work harder but have not dropped out of school. NL continues the sharecropping arrangement she had before she fell sick, whereby her sharecropping partner provides labour and implements. She appears to be maintaining her previous level of production. Food stocks in the house are relatively high. About ten 50kg bags of maize were observed, even though the harvest failed this year due to drought. The garden is not cultivated except for pumpkin, as NL has always concentrated on fields crop production. NL falls into the Average livelihood category.

3.6.3 HIV/AIDS and Other Livelihoods

Four of the 15 interviewees who were infected or affected by AIDS had lost non-agricultural livelihoods due to AIDS. In Van Rooyen one man left a building job when he fell sick (Case 1), and one woman lost her business in vegetable selling after paying funeral expenses (see Box 26). In Ha Makhakhe two women left employment in urban areas to return home sick, as dependents on relatives (see Cases 19 and 20).

Box 25: Impact of Funeral Expenses on Livelihood: MM, Van Rooyen (Case 5)
Her husband has taken much of their property to RSA where he resides, leaving her poor even before she incurred the funeral expenses for her son and daughter-in-law who died of AIDS. She cares for two orphans.
"I cannot continue with my business (marketing vegetables) since I spent all my money for the burials, so I do not have any starting capital. I depend on maize meal donations and when they are finished I rely on people who bring their clothes for knitting and sewing. If there are no handouts I rely on my nephew who is not working either. If he cannot assist I ask other members of the community. I do not have fields as they were taken by my husband's first wife. I have a small plot, which I usually ask some one to cultivate for me during the rainy season, but now it is dry. Since last year there has not been any rain. I plant the garden on my own although lately I have been sick. As you can see there are vegetables, although they are not doing well because of drought and frost. I get seeds from people around here, friends and farmers."

Box 26: Loss of livelihoods due to AIDS: NS, Ha Makhakhe, (Case 19)
NS worked as a storekeeper for 3 years until her contract finished. She then sold jerseys and T-shirts in Maseru. When she got sick she had to return home to her widowed mother. She is now dependent on her mother who farms. Her Mother continues farming at same level of production, despite having to care for her daughter. She sharecrops with a man who does the ploughing.

Box 27: Impact on the carer: MA, Ha Makhakhe, Case 24
MA's sister worked as a domestic in Maseru. She returned home to live with MA in Ha Makhakhe when she was already very sick in June 2003.
"The sickness has affected my daily routine because I can't leave her alone. She is seriously sick, but is conscious of what is happening. I can easily get to the garden as it is closer but I can't join village activities such as the common water pump project as it is a little bit far". *She has not experienced a planting season while caring for her sister. She sharecrops, providing land, draught and implements, presumably the other partner provides labour. She has heard of Machobane and is interested to learn but not a participant. She has a garden but no vegetables at the time of interview. The impression is that agricultural production will be maintained.*

Table 10: Impact of HIV/AIDS on Livelihoods

Case	Village	Name	Sex	HIV status	LL status	Livelihood	Impact of HIV/AIDS on livelihood
1	VR	NT	M	Infected	v. poor	Money from niece, gardening	Stopped building work when he got sick. Garden not cultivated since 2000 due to sickness
2	VR	NM	F	Infected	v. poor	Mother does domestic piece work in the village, father milks cattle in RSA	Garden not planted due to drought, infected 17 year old girl too sick to garden
3	VR	MK	F	Husband died of AIDS	Average	Husband's terminal benefits, gardening, poultry	Garden maintained during husband's sickness and since his death to AIDS in July 2003.
4	VR	PL	F	Father died of AIDS	Average	Dependent on Case 3	Daughter of MK
5	VR	MM	F	Son & daughter -in-law died of AIDS	v. poor	Dependent on step-son from husband's first marriage, and friends (husband deserted her)	Used to market vegetables. Used up working capital on funeral expenses Now depends on donations.
6	VR	MP	F	Husband and 8 children died of AIDS	v. poor	Domestic piece jobs, support from granddaughters, MOHSW	Unable to farm since husband died in 1992. Garden not cultivated due to drought.
7	VR	LP	F	AIDS orphan	v. poor	Orphan dependent on Case 6	Orphan dependent on Case 6

13	VR	Chief TM	M	Niece died of AIDS	average	Pension, rent, Chieftainship allowance	Chief cares for orphaned children of niece.
18	HM	NL	F	Infected	average	Mining salary from husband, agriculture	Too sick to farm, but maintains production with children & sharecropping.
19	HM	NS	F	Infected	average	Dependent on Mother, savings from previous employment.	Used to sell clothes. Mother farms with sharecropping. Agric production apparently not affected.
20	HM	MA	F	Carer of infected	average	Mining salary from husband, agriculture	Mobility restricted by care of sister. Agric production likely to continue. Sharecrops
21	HM	TI	F	Mother is infected	average	Dependent on parents, agriculture	Mother periodically sick but parents continue to farm
22	HM	ML	F	Children and grand children died of AIDS	poor	Agriculture	She & husband continue to farm after loss of 4 children and 2 grandchildren to AIDS. Resources run down through funeral expenses.
23	HM	RI	F	AIDS orphan	v. poor	17 year old orphan dependent on relatives	Fields and garden not cultivated since death of parents to AIDS.
26	HM	MD	F	Husband thought to have died of AIDS	average	Teacher salary, agriculture	Continues to cultivate fields and garden following death of husband

3.7 Other impacts of HIV/AIDS on Livelihoods

- HIV/AIDS appears to have exacerbated **food insecurity**, especially in Van Rooyen, where agricultural production is limited and the economy is in decline;
- Only one case was recorded where HIV/AIDS led to **sale of assets**. MP, Case 6, in Van Rooyen sold furniture to pay for the burials of her children and grandchildren.
- ♦ No cases were found where interviewees had lost **access to land** either to relatives or to the chief as a result of HIVAIDS deaths. The chiefs in both villages continue to support people's access to land.

- **Theft** did not appear to be a problem for interviewees in either village, although the chief in Van Rooyen had had sheep stolen, and one interviewee in Ha Makhakhe mentioned theft as a stress in her life (Case 18).
- **Fear** of the impact of HIV/AIDS was evident in both villages, as was fear of the future for those who were infected and affected. However, some orphans appear to be putting a brave face on their circumstances.

Box 28: Hopes for the Future: LP, Orphan cared for by MP, (Case 7)
"My life has changed considerably since my mother passed away. During her lifetime I used to have more food, I was well clothed and we had money. I want to continue schooling until I become a nurse because I want to help people fight against certain diseases. I have heard about HIV/AIDS. I also teach other children about the pandemic. In fact I fight against it. I am a Peer Educator with SHARP. Once I get a job I want to buy furniture and fence the fields, so that I can plough. I will buy a tractor and plough and irrigate the fields".

3.8 Coping Strategies for HIV/AIDS

Given the small sample size it is difficult to judge how widespread the observed coping strategies might be. It is hoped that this study can serve to highlight issues for further investigation.

3.8.1 Coping strategies of HIV/AIDS patients

- **Denial** seems to be a major strategy for the infected and affected. However, it may limit access to care and support from medical services. For example, NM, (Case 20), a 17 year old girl denies ever visiting a doctor and claims she has piles. Denial can also encourage the spread of HIV/AIDS. For example, NL, (Case 18) the young second wife of a husband who seems to have known his positive HIV status on marriage, following the death of his wife from AIDS, (see Box 12, p.26).
- Using the local **home based care support group** is a strategy for some. In Van Rooyen, where the support group is more pro-active in seeking out people who need care, it does seem to be used and appreciated by those infected with HIV/AIDS although the patients generally do not acknowledge their status. In Ha Makhakhe one infected patient and one carer avoid the support group as they fear stigmatization. This may be because the general level of acknowledgement is higher in Ha Makhakhe. They think the support group people 'will talk' and they say they don't need the help of the support group as they know their status and are receiving medical support from Mafeteng Hospital (NL, Case 18 and MA Case 20).
- **Mafeteng Hospital** is used by residents of Ha Makhakhe but not by Van Rooyen. The outreach and care programs have a good reputation, and at least three of those interviewed had been for HIV/AIDS tests and openly acknowledged their status.
- Infected interviewees mentioned **exercise and diet**, using natural herbs and green vegetables as strategies which they adopted to improve their health;
- The **traditional healer** in Van Rooyen advises the use of herbs such as '*BOBATSI*' nettle , '*Tikamotse*', and *'Lerara tau'* that is to be used with great care. (Case 17)

3.8.2Coping with Caring

- **Gardening**: two cases were found where carers continued with homestead gardening (Case 3, MK and Case 20, MA). However, MA was unable to joining village activities;
- **Sharecropping**: no cases were found of new sharecropping contracts as an impact of AIDS but three families with infected members were able to continue with agricultural production because of their ongoing sharecropping arrangements (Cases 18, 19 and 20)
- **Support groups**: provide carers with gloves and advice;

3.8.3 Coping with Funerals and Death

Strategies adopted to cope with funerals and death tend to undermine future livelihoods. For example:

- **Sale of assets:** MM (Case 5) used up her working capital to finance family funerals (see Box 26). MP (Case 6) sold assets to pay for funeral expenses;
- **Destruction of assets:** the Chief in Van Rooyen mentioned that people were destroying furniture to build coffins, especially for children's coffins;
- **Slaughtering of livestock** for funeral feasts. Using the family's own stock undermines future livelihoods. The Chief of Van Rooyen suggested that purchase of livestock for funeral feasts was encouraging cross-border stock theft.

More positive coping strategies include applying to the **MOLG** to finance coffins, and using local **burial societies** for mutual financial support.

3.8.4 Coping with the impact of HIV/AIDS on livelihoods

- **Dependence on handouts:** two interviewees in Van Rooyens depend on handouts as a result of HIV/AIDS. NT (Case 1) became sick while working on a building contract. He also stopped gardening and had no means of livelihood before his death to AIDS. MP (Case 6) sold assets to pay funeral expenses and now depends on handouts from neighbours. Food aid distributions were observed in both research villages during field work;
- **Dependence on family members**: sickness due to AIDS led to job losses and dependence on family members for two interviewees in Ha Makhakhe(Cases 24 and 25)
- **Maintenance of agricultural production:** in six out of seven affected households in Ha Makhakhe agricultural production appeared to be maintained despite sickness, caring and deaths due to AIDS (see section 3.7.1)
- **Maintaining high levels of food stocks:** this was a general observation in Ha Makhakhe;
- **Pensions and saving:** although no cases were found among interviewees, many households in Van Rooyens depend on South African pensions.

3.8.5 Coping Strategies for Orphans

- **Financial assistance**: orphans are supported by the schools in accessing financial assistance from MOHSW, to enable them to continue schooling;
- **Staying with relatives**: several of the interviewees had taken orphans into their families;
- **Emotional support**: teachers stressed that orphans were not stigmatized and that they tried to give emotional support, although formal counseling services were not accessed.

CHAPTER 4: Conclusions and Recommendations

4.1 Conclusions

The main purpose of this research is to improve an understanding of how HIV/AIDS is affecting households and the strategies adopted by individual households to address these impacts in Lesotho. The analytical frame work has been CARE's livelihood frame work which focuses on strategies including production, income and consumption activities, human, social and economic assets, processing and exchange activities; approached through an understanding of decision making processes within households[5]. The main conclusions of this research are presented below:

4.1.1 Positive Action

Positive Action members who are open about their HIV status benefit from mutual support of other members, and improved health care but they experience stigma in their home villages and their livelihoods are insecure.

4.1.2 Van Rooyen and Ha Makhakhe

- **Incidence** of HIV/AIDS appears high in both research villages, although statistical data were not collected. The Chief's statistical records on births and deaths were not available;
- Despite the work of SHARP peer educators, the level of **acknowledgement** of HIV/AIDS is low in Van Rooyen, and lower than in Ha Makhakhe.
- Paradoxically, if HIV/AIDS is not acknowledged (as in Van Rooyen) people are less afraid to ask for help from the **home based care support group**. In Ha Makhakhe where acknowledgement is higher, people avoid the support group for fear of being identified as having HIV/AIDS and consequent **stigma**. This may be related to the approach of the support groups in each village.
- On the other hand, where the community acknowledges HIV/AIDS **care and support** in the community appears to be stronger. Acknowledgement and support are higher in Ha Makhakhe than in Van Rooyen. Relatives and neighbours assist the infected and affected in various ways.
- Communities do not appear to be using available human resources. For example, leaders are not coming together to develop a **community level HIV/AIDS strategy** even though some are well qualified in HIV/AIDS.
- Van Rooyen illustrates a strong link between **food insecurity and HIV/AIDS**. HIV/AIDS patients appear to be dying faster in Van Rooyen and hunger appears to be a contributing factor. People in Van Rooyen attribute death by the pandemic to hunger more than to HIV/AIDS.

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[5] For a definition of CARE's livelihoods framework and an example of its application see Livelihoods in Lesotho by Stephen Turner et al (2001) CARE, Lesotho.

- HIV/AIDS is having an impact on **livelihoods**. Several interviewees have lost their livelihoods due to sickness and death from AIDS. However, most appear to be maintaining agricultural production, through increased support from relatives and continued sharecropping.
- Various types of **coping strategies** were noted among infected and affected. Some appear to be erosive of livelihoods, such as sale of assets or destruction of furniture to build coffins, while others are non-erosive such as the increased use of family members in agricultural production and reliance on donations from both community and outside.
- Although Ha Makhakhe is a participating village in the **Machobane Rural Development Foundation** (MADF) only two of the interviewees mentioned the approach and none were participants. This could be because they were more inclined towards extensive farming (fields) rather than gardening.
- **Social pathology** (drinking, abuse of women and children) is a concern raised by interviewees, especially key informants in both villages;
- Concern was also voiced about **environmental degradation**, and the failure of government to address it. For example, the Chief in Van Rooyen mentioned that it would be better to address the water supply problem in Van Rooyen than donate food aid. There were also complaints about the late arrival of government subsidized inputs and equipment in Ha Makhakhe.

4.2 Recommendations

4.2.1 HIV/AIDS Care and Support

The following problems in relation to HIV/AIDS care and support were noted:

- ♦ Home carers handle HIV/AIDS patients without gloves
- ♦ Inadequate nutrition of AIDS patients (especially in Van Rooyen)
- ♦ Infected/affected are not always using home based care support groups (Cases 19 and 20);
- ♦ Stigma (Cases 19 and 20);
- ♦ Lack of public debate to address HIV/AIDS issues;
- ♦ Lack of coordination among leaders (see section 3.6.1)
- ♦ Many orphans (Reported by teachers)
- ♦ Abuse of orphans and bereaved (comments by Key Informants)
- ♦ Fear and lack of hope;
- ♦ Lack of available local records on births and deaths;

These problems suggest the following recommendations:

4.2.1.1 Improved supply of gloves and advice to carers on preventing infection

This issue could be taken up nationally by LAPCA and MOHSW and locally by the Home Based Care Support Group, Village AIDS Task Force, and / or local medical practitioners.

4.2.1.2 Strengthening of Home Based Care Support Groups:

The CARE SHARP model of using peer educators and of actively seeking out AIDS patients for comprehensive care should be replicated beyond the two villages currently covered by the project in Mafeteng. The approach used in Ha Makhakhe of passively waiting for HIV/AIDS patients to come to them is not effective. More effort is needed by the support group in Van

Rooyen to encourage the infected and affected to acknowledge their HIV/AIDS status. However, this should be accompanied by efforts to tackle stigma in the community.

Support groups should be supplied with sufficient gloves for distribution to those caring for HIV/AIDS patients in the home and others who come into contact with them, for example priests and teachers.

4.2.1.3 Development of Village Aids Task Forces:
It is recommended that village leaders come together to develop a community level strategy to address HIV/AIDS including education, prevention, care and support. The Task Force could be responsible for some or all of the following:

- Encouraging **public debate** about HIV/AIDS issues including incidence, acknowledgement, stigma, and care of patients and orphans. For example, the task force could take the initiative in encouraging people to talk openly at funerals and social gatherings
- Providing **information** on local services to the community for example on where the nearest testing and counseling facilities are located; nutritious crops to grow for HIV/AIDS patients; herbal remedies to alleviate symptoms;
- Encouraging **community mobilization** to address HIV/AIDS. All citizens should take responsibility for AIDS patients in their community;
- Initiating and/or developing the **home based care support groups**;
- Ensuring that **gloves** are accessible to carers and others who come into contact with HIV/AIDS patients;
- Ensuring that HIV/AIDS patients have adequate **nutrition** (for example, through organizing community food distribution, donations from the better off, or communal gardens);
- Ensuring that **orphans** are adequately cared for, protected against abuse and are receiving available benefits from government (this combines the current role of the chief and the teacher);
- In consultation with the community inviting outside organizations for assistance, for example, **LRAP partners**.

4.2.1.4 Employment of Positive Action Members (or other people living openly with HIV/AIDS) in the care of infected and affected
Some Positive Action members suggested that people living with HIV/AIDS could assist in the AIDS patients wards in hospitals. They could also be employed to work in communities.
The possible benefits include:

- Employment for people living openly with HIV/AIDS;
- Encouragement of infected and affected to live positively
- Support to education and prevention of HIV/AIDS
- Tackling stigma
- Encouraging of testing and disclosure of HIV status

It is often more convincing for advice and education to be provided by those living with HIV/AIDS, who may have similar experiences to the target audience.

This could be initiated by **MOHSW, or other employers of health personnel.**

4.2.1.5 Orphans

- Guidance and counseling skills should be available to the communities to cope with the increasing numbers of AIDS orphans suffering stress and trauma. This issue could be taken up be **LAPCA and / or MOHSW;**
- The issue of abuse of children and women who are often already stressed and shocked by HIV/AIDS should be investigated and addressed by **Ministry of Home Affairs**;

4.2.1.6 Records on Births and Deaths

Improved recording of births and deaths could assist in monitoring the spread of HIV/AIDS.

4.2.2 Livelihoods

The following problems in relation to Livelihoods were noted:

- Link between food insecurity and health of HIV/AIDS patients (especially in Van Rooyen);
- Drought as the key constraint on garden production in Van Rooyen;
- Lack of access to vegetable seeds in Van Rooyen;
- Apparent wastage of water in Ha Makhakhe;
- Soil erosion in Ha Makhakhe;
- Excessive drinking perhaps related to underemployment;
- Need for non-agricultural employment options especially in Van Rooyen;
- Unemployment of positive action members (this is addressed in 4.2.4 above).

4.2.2.1 Support to Homestead Gardening in Van Rooyen through LRAP Partners

Van Rooyens could benefit from support to homestead gardening. Gardening appears to have been an important livelihood strategy in the past but is currently constrained by drought and poor access to seeds. Well kept garden plots and dug rainwater collection dams suggest that interest is high. Appropriate interventions might include water harvesting and seed supply.

Despite its peri-urban status **it is recommended that Van Rooyens be considered for homestead gardening support from LRAP partners** because of the widespread hunger observed by the researcher, which appears to be accelerating deaths from AIDS. The strong link between hunger and deaths from AIDS in Van Rooyen has also been observed by the SHARP support group. **The need for increased food aid in the short term should also be considered.**

4.2.2.2 Environmental Initiatives in Ha Makhakhe

The researcher observed soil erosion and wastage of water in Ha Makhakhe. These problems were also noted by Key Informants. They could be tackled in collaboration with **MOAFS through the UES** approach if voiced as a priority by the community.

4.2.2.9 Income generating skills

The need for non-agricultural employment opportunities is widespread in Lesotho, but acute in Van Rooyens which has suffered particularly badly from retrenchment due to its dependence on trade opportunities provided by cross border traffic. Current reliance on South African pensions may not be sustainable. Other options such as beer brewing and prostitution may undermine livelihoods in the long term. Off-farm employment is also required in Ha Makhakhe. **It is recommended that this issue be addressed by relevant policy makers and service providers**.

In summary, the impact of HIV/AIDS in the research communities appears to be high, and with the continuing high death rate it is likely that orphans will be left with no-one to care for them. There is therefore an urgent need for MOAFS, LAPCA, MOHSW and other ministries together with the service providers and all policy makers to act promptly. This is the right time for CARE Lesotho-South Africa through LRAP to intervene and help the vulnerable poor, including HIV/AIDS affected families to over come food insecurity.

Annex 1: Brief description of each of the 29 interviewees.

No	Vill age	Name	Sex	Selection method and HIV/AIDS status	Brief Description
				PURPOSIVE HHs	
1	VR	NT	M	infected	Widower. No more income as builder, no relative to care for him, often without nutritious food, only papa with water, jokingly referred to as 'mafi a khoho'. Died during fieldwork. Did not acknowledge he had AIDS
2	VR	NM	F	infected	17 year old girl, loss of weight, patches all over body, complains of piles. Does not acknowledge she has AIDS. Says she has never been to a doctor, mother says expelled by nurses.
3	VR	MK	F	affected	In mourning robe for spouse. Claims he died of chest pains and loss of weight. Heard of SHARP and it carers. Knows nothing of HIV/AIDS. Keeps the best garden near tap.
4	VR	PL	F	affected	Daughter of MK
5	VR	MM	F	affected	Deserted by husband and 3 sons. First son and daughter-in-law died of AIDS as well as her brother-in-law. She acknowledges this. She cares for their three orphans. Used up working capital for vegetable marketing to pay funeral expenses.
				CONTROL HHs	
6	VR	MP	F	Affected	Between 1998 and May 2003 lost 8 children (3 from TB, 5 chest pains) and 3 grandchildren (chest pains). Sold household assets for funerals. Does not acknowledge AIDS. Cares for 2 orphans.
7	VR	LP	F	Affected	Orphan grandchild cared for by MP. Aims to fence grandmother's fields when she grows up.
8	VR	KH	M	Not affected	Well off, owns shopping mall rented to Chinese, flats rented to civil servants. Organizes CBO piggery. Aware of HIV/AIDS.

9	VR	PM	M	Not affected	Progressive farmer, owns tractor, passion for agriculture
10	VR	MO	F	Not affected	Very poor. Garden uncultivated. Aware of HIV/AIDS and SHARP
11	VR	MT	F	Not affected	29 year old wife of taxi driver. Has spade for gardening. Aware of HIV/AIDS. Member of piggery CBO
12	VR	MH	F	Not affected	24 year old with 3 children, claims never to have seen AIDS patient, though heard it is rife on radio.
				KEY INFORMANT	
13	VR	TM	M	Village chief	First to reside in VR. Once a policeman, now a pensioner. President of SHARP support group.
14	VR	KM	M	Priest for Assemblies of God	Diploma in Theology from University of Free State
15	VR	MY	F	Principal of School	Supports AIDS affected pupils
16	VR	MR	F	Community nurse	Perturbed by HIV/AIDS among villagers
17	VR	LK	M	Traditional healer	Trained in Pretoria, practice restricted by Boers. Keen on agriculture. Two children at university.
				PURPOSIVE HHs	
18	HM	NL	F	Infected	Tested and open about status. Married widower whose wife died of AIDS. Husband probably knew he was HIV positive on marriage. She uses herbs and nutritious foods. Avoids support group as fears stigma.
19	HM	NS	F	Infected	Tested positive. Sees support group. Gets medication from Mafeteng hospital. Husband left her in 1994. Has a son at university.
20	HM	MA	F	Affected	Caring for sister with AIDS since May 2003. Sister left work in Maseru when sick and is now dependent on her. Caring restricts MA's movements. She can get to the garden but not join in village activities. Agriculture is her main livelihood strategy.
21	HM	TI	F	Affected	Mother has AIDS. She is disturbed when her mother gets sick.

				CONTROL HHs	
22	HM	ML	F	Affected	In mourning robe. Lost 6 children to AIDS Acknowledges cause of death. 'I am not alone loosing my children. What surprises me is a man dies a woman follows and vice versa. Many look unhealthy'.
23	HM	RI	F	Affected	17 year old orphan lost both parents and sister to AIDS. Misses parents, but appreciates loving care by community and social welfare support.
24	HM	RR	F	Not affected	Hates AIDS 'what kind of disease is this that kills youth?'. Sharecrops. Member of burial society.
25	HM	LL	M	Not affected	89 year old man. 'People fight over donations, but hunger knows no church'. Hears of people dying, perhaps of AIDS
				KEY NFORMANTS	
26	HM	MD	F	Teacher at Catholic mission school	3 orphans in her class. Children absent themselves from school to look after the sick.
27	HM	ME	M	Catholic Mission Priest	What stresses and shocks him is denial 'yet we are in the age of AIDS'. Hates stigmatization. Advocates helping people to help themselves. 'Do not give me a fish but teach me how to fish'. Advocates water harvesting rather than food aid.
28	HM	LT	F	Catholic Mission community nurse	Invited to give lessons on STDs and AIDS in schools in 1999.
29	HM	MG	F	Traditional healer	Claims to know nothing of AIDS. Reluctant to talk.