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Assignment #3

As pandemics are known to come and go, the HIV/AIDS epidemic has been persistent in Lesotho for years. The structures of most families in the country have been uprooted due to the invasiveness of the disease, and social, political, and economic discourses that have ultimately been at odds. The following report is designed to inform on AIDS prevention in Lesotho.

There are many primary, secondary, and tertiary reasons for the structuring of the AIDS epidemic in southern rural Africa. One of these reasons is the geographical situation of the country in relation to its economic needs. Ellen Block and Will McGrath assert in *Infected Kin* that the need for Basotho men to travel to South Africa to work in mines while wives and children were left home to tend to agricultural needs is what set the stage for waves of the disease to come later. They write that "once HIV began to spread in South Africa, migrant laborers were among the most vulnerable populations…" (Block, McGrath, 10-11). The long periods spent away from their homes made them susceptible to the disease via sex, and it subsequently spread throughout Lesotho once South African mining came to an end. It didn't spread so vigorously just through sex, however; it was transmitted through kinship lines via pregnancy and breastmilk, something that can only be treated by antiretroviral (ART) medication (which did not become a widely spread resource until recent years.)

Funding for HIV/AIDS in Lesotho is scattered, unorganized, and stigmatized through "an array of public and private funds" (Block, McGrath, 12), that has resulted in little national organization of funds and facilities. Rural families are forced to travel and risk other complicating conditions, or wait for mobile healthcare opportunities that may never come. Antiretroviral medication is expensive and patients may need multiple rounds of it, which is subject to board approval in Maseru (Block, McGrath, 13). Ministry of Health regulations call for three sessions of AIDS and ART education, patients can begin "Test and Start" treatment immediately, a "pilot program based on WHO regulations" (Block, McGrath, 13). However, Lesotho still lacks the overarching infrastructure to successfully man treatment facilities and

services. Healthcare workers are limited and underpaid, despite there being a unique development of kinship care.

A majority of the elderly Basotho population are caregivers, as AIDS has reshaped family life and now a majority of sick children remain under the care of grandparents and other kin elders. Block and McGrath mention that a lot of the elderly were no longer sexually active when the epidemic hit, but there are still some sick elderly being cared for as well as doing the caring themselves because people are living longer and becoming grandparents due to treatment (Block, McGrath, 8). There is also a power imbalance at play between doctors and patients as a result of a lack of education amongst the elderly—the elderly, as caregivers, are also exercising agency by way of deciding how to proceed with care and treatment and voicing openly their opinions on doctors, Sesotho or otherwise (Block, McGrath, 93). Educating the elderly in Lesotho has allowed them merely *more* options for how to administer care, both through the use of biomedicine and "indigenous healers" that share their cultural understanding. This proves AIDS treatment and prevention in Lesotho to be something requiring a holistic approach, which cannot be ignored. However, a lack of education also influences the elderly to resist the benefits of biomedicine. The ederly need to be provided comprehensive educational plans, developed by health organizations and community chiefs in tandem, so as to ensure that eldery people living with HIV or caring for a child with HIV can be fully prepared.

Many young adult Basotho people lack access to a high level education, although primary education is free. Education is important in determining marriage outcomes for young women who have abandoned their elder's ways of marrying early and uneducated; in the words of Nkhono, "education is life" (Block, McGrath, 99). It is obvious that without improved health education alongside more advanced technology, there is little hope for minimizing the presence of AIDS in Lesotho. However, there is a culture of privacy in the matters of "bodily afflictions" and a stigma held by the Basotho as it being "any other disease" that makes approaching community education difficult (Block, McGrath, 102). There is a sense of "competing sources of information" that muddy the understanding of the disease and its effects in Lesotho; it often comes from the top (with little regard to the cultural subtleties that render it ineffective) and then is spread incorrectly by word of mouth. There is a stigma in the West about AIDS in Africa, and

it is undoubtedly useless to ask a Basotho person to trust, unknowingly, the information they hear. Block and McGrath assert that attempts made by local chiefs to spread AIDS awareness lack the "follow-up, consistency, and depth" to have any real impact on the way Basotho people live their lives (Block, McGrath, 109). Hoping to grant all Lesotho people a well-rounded education may be difficult if not unrealistic, but because primary education is available up until age 13, prevention and education methods need to be "adjusted to address the localized, social implications of AIDS knowledge and associated behavioral changes" (Block, McGrath, 110) in primary school and be reinforced through social kinship ties.

MCS, or Mokhotlong Children's Services, is the main (only) facility providing comprehensive orphan AIDS care to the surrounding population of 100,000. It is the most comprehensive in the sense that children under five are welcomed and cared for when able, they make home visits, and help caregivers. There are small clinics and NGOs in the area, but none provide the same extent of care. MCS service is a much more wholly involved program than a hospital would be with their patients. Food and medicine was kept track of by Block, and there was a lot of assistance from foreign aid and health workers, volunteers, and caregivers. There was a mix of Sesotho, Zimbabwean, Congolese, and American workers that were a part of the program. However, medical personnel was still stretched thin and underpaid.

The 10 districts of Lesotho are overseen by the ministry of health, supported by hospitals, clinics, and private organizations. However, the ratio of health care workers to patients is well below the WHO standard, and any are untrained or are only holding temporary post in Lesotho as a means of getting to their destinations (Block, McGrath, 7). Local government-run hospitals and clinics offer free ART medications, testing, and care for all kinds of illnesses but may sometimes require patients to travel further to other hospitals to receive the care they need. NGOs, while there are many in Lesotho working to combat the negative physical and social impacts of HIV/AIDS, are "wildly uneven, notoriously difficult to navigate, and have contributed to depoliticization and social unrest" (Block, McGrath, 78). Hospitals and clinics are hard to reach for the rural Basotho population. Many require a two or three day trip where they can become exposed to other risky conditions. Illnesses besides HIV that were considered "Sesotho" illnesses encouraged people to seek treatment from indigenous doctors if possible, but

the medical clinic is still a widely used resource. Although many Basotho see healthcare as a means of managing symptoms, they still have an understanding of how to utilize their available medical resources and take advantage of them (Block, McGrath, 94). Fees, travel troubles, and more make it difficult for vulnerable Basotho people to get the care that they need. Better, long-term health employees and more secure funding from aid or the government must be implemented to improve their experiences.

Kinship is an especially important knot in the relation between HIV/AIDS and social structure in Basotho. It is very common for multiple generations to be involved in the lives of the children, and often take them in to foster when their parents pass away. Many people in the area are caretakers, were caretakers, or were fostered by caretakers in their time. According to Block and McGrath, it was normal for children to move around households but were always treated with love and care because grandparents, the most common caregivers, could not meet all of their physically demanding needs (Block, McGrath, 149). However, poverty and inadequate access to resources can lead to caregivers struggling to keep their children healthy and clean, but still treating them as their own. Caregiving was not only an act of love, but as a sign to the community that one is a good, active participant. For support, caregivers seek other caregivers. Children are often passed between homes to ensure that they can receive enough care if one household is becoming too full. Families were often so big that it was rare for children to be placed with nonkin or in orphanages in Maseru (Block, McGrath, 153). Luckily, ART medication is free, especially for orphans. MCS often plays a role in placing children with family members and supporting caregivers by way of home visits. Caregivers often struggle with poverty and getting to and from clinics, and so home visits are an especially helpful means of support. New children are orphaned and in need of a new home every day, and all of this relies on family members thrown in crisis-fostering; funding for home visits, more medications so as to send families home from the clinic with a longer supply to save trips, and providing effective means of public transportation could provide some relief for caregivers.

In order to assist Lesotho in caring for its HIV positive population while working to minimize the epidemic is no small feat. Basotho people are living in extreme poverty with little to no work opportunities, are not properly educated on how the virus will affect them, and all the

while are caring for many AIDS orphans and HIV positive children. Comprehensive educational programs catered to the elderly as well as the young adult population will allow the two generations to be empowered in doing their part to try to stop the spread of HIV. More experienced and long term healthcare workers, and the facilities they work in, need clear and secure funding from Merasu, surrounding countries, and aid organizations abroad as well as an increased load of ARV on a schedule. Caretakers will always value their kin, and so must seek other ways to improve their lives besides giving them up, and public transportation and home visits may a place to start.