

**HIV/AIDS VULNERABILITY OF STUDENTS AT THE AT THE NATIONAL UNIVERSITY
OF LESOTHO**

By

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**Submitted in partial fulfilment of the requirements for the degree
Masters in Disaster Management**

In the

Disaster Management Training and Education Center for Africa

At the

UNIVERSITY OF THE FREE STATE

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2012

ACKNOWLEDGEMENT

I would like to begin by thanking the Lord Almighty for life, strength and knowledge; for guiding me to the Disaster Management programme. I am deeply grateful and indebted to so many people and institutions that helped me in one way or another to complete my research successfully. You are all in my heart and I will pray for you. A special word of thanks and appreciation to the following:

- Miss Olivia Kunguma and Mrs Vilma Hossini my two supervisors, under whose mentorship I had the opportunity to learn so much. They rekindled the spirit of hard work and determination in me, and supported me. Without them I would never have been able to finish my research.
- Mr Andries Jordaan overall supervisor to DiMTEC students and who was father, friend and mentor to me. I am very proud to be a student and on the personnel of DiMTEC. He has been a source of inspiration.
- Dr Fabrice Renaud, Dr Joern Birkmann, and the research forum at the United Nations University Environment for Human Security for encouragement and help I received.
- Ms Alice Ncube and Dr Dusan Sakulski for their help and contribution to my studies at DiMTEC.
- Miss Toiyobong Samson-Akpan and Dr Ebenezer Durojaye, you are not forgotten.
- My family, especially Advocate Aderonke Balogun-Fatokun, for her motivation and constant support.

DEDICATION

This work is dedicated to my beloved parents Professor Bola Olujide Balogun and Mrs Folasade Balogun for the sacrifices they made to educate me, and for always being supportive of my decisions. The lessons and memories of our times together will always be a part of me and keep me going.

May your souls rest in peace until we meet again.

DECLARATION

I, **Kehinde Esther Balogun**, hereby declare that all work included in this report is my own work; that none of the work included in this report is a copy of the work of any other current or former candidate or a group of candidates for this research or any similar research; and that all work and other sources (literature or empirical) that were consulted and used for completing this report have been properly and completely acknowledged according to generally accepted principles of Harvard referencing.

Signature: 

Name: Kehinde Esther Balogun

Date: 20th February 2012

ACRONYMS

ARV	Antiretroviral
GOL	Government of Lesotho
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IFRC	International Federation of the Red Cross
NAC	National AIDS Commission
NGO	Non Governmental Organisations
NUL	National University of Lesotho
STI	Sexually Transmitted Infection
UNAIDS	United Nations for Acquired Immune Deficiency Syndrome
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
USAID	United States Agency for International Development
IFRCRCS	International Federation Red Cross Red Crescent Societies

GLOSSARY OF TERMS

The following definitions are chosen to clearly elaborate the ideas or foundation to which the research was carried out.

Vulnerability is defined according to (Birkmann. 2006: 486; Chamber. 1989:1) as a dynamic, intrinsic feature of any community due to exposure to contingencies and stresses and the difficulty which some communities experience while coping with such contingencies and stresses. Furthermore, Chambers proposed an external and internal side of vulnerability:

- **External:** related to exposure to external shocks and stresses and;
- **Internal:** associated with defencelessness, incapacity to cope without damaging losses (Villagran De leon, J.C. 2006: 11).

Turner *et al* (2003: 8074), gave a simple and precise definition of **stress** as (a slow but continuously increasing pressure within the relevant system), while **shocks** are impacts related to very sudden and sometimes unpredictable events such as earthquakes, floods, epidemics, and so on (Villagran De leon, J.C. 2006: 11 & 16).

Susceptibility or Sensitivity: Although researchers use these terms in different literature, within the parameters of this study, the researcher found that both terms have relatively connotes the other. That is both can be summarised to mean, the degree to which a society, community or individuals are easily affected by impacts of shocks and stresses.

Exposure: Elements or system at risk, an inventory of those people that are exposed to shocks.

Resilience: can be described to be a reflective measure of a system's capacity to absorb or maintain its basic functions and structure, in time of shock and stresses (Wisner, *et al.* 2004: 85; Birkmann, 2006:15). The term resilience, although not as heavily debated like vulnerability, has different interpretations. On one side there is the view of resilience being the capacity to absorb shocks and therefore relating to resistance. While on other end, it refers to the ability of a society to regenerate, learn and adapt to stress and shock while maintaining its major functions, which relates to coping and adaptive capacity. However, for the significance of the study, the latter is chosen and further elaborated within the in the Vulnerability Pathway Model.

- **Coping Capacity:** is the manner in which people act within the limits of existing resources and strengths within a system to lessen the effect of a shock (Birkmann, 2006: 435; Wisner *et al* 2004: 113).
- **Adaptive Capacity:** The ability of a system to regenerate and learn and acclimatise to the effects of shocks and stresses.

Risk: According to Alexander (2000: 10) risk is defined as “the likelihood, or the probability, that a particular level of loss will be sustained by a given series of elements as a result of a given level of hazard”. The expected losses (lives lost, persons injured, damage to property and disruption of economic activity or livelihood) caused by a particular phenomenon (Blaikie *et al.* 2006).

Vulnerability Assessment

The process to which the vulnerability of specific elements at risk are analysed or assessed, in the face of a disaster or emanating disaster (Blaikie *et al.* 2006)

Disaster Mitigation

A collective term used to refer to measures, which can be taken to minimize the destructive effects of the hazards and thus lessen the magnitude of a disaster (Blaikie *et al.* 2006)

Prevalence

The absolute number of infected people within a population at a given time. (Barnett & Whitside, 2006).

ABSTRACT

The increasing number of young people around the world, between the ages of 15 and 49 with a high HIV/AIDS prevalence and incidence rate, has warranted attention from the research arena around the world. However, HIV/AIDS is a serious problem in Lesotho with an adult HIV prevalence rate of 23.2%. In 2005, the number of students at the National University of Lesotho was 5,197 students with 29% infection rate. This dissertation estimates the HIV/AIDS vulnerability of students using the Pressure and Release (PAR) model and Vulnerability Pathway model to determine the progression of vulnerability approach. In order to assess the vulnerability of the students, a literature study was undertaken to identify factors that contribute to HIV/AIDS vulnerability. This was later supplemented by an observation method, questionnaires and interviews to establish the factors that lead to the HIV/AIDS vulnerability of the students at the National University of Lesotho. Through this, it is clear level of students' vulnerability to HIV/AIDS before and after infection is high within NUL. It is ascribed to the deep inherent culture surrounding sexual intercourse in Lesotho, which influences students' behaviour and sexual decisions. Although, the behaviour of the students is important in determining susceptibility of students, the university and government commitments determine their coping capacity of the students and subsequently their vulnerability. The partnership of Lesotho government and the university should be established and intensify training of educators, social workers, and establish community based organisations which should address cultural aspects that leads to negative attitude towards HIV/AIDS.

Lesotho is ranked the third highest affected country in the world, with a population decrease from approximately 2.2 million to approximately 1.8 million people from 2003 to 2006 due to HIV/AIDS. Young people in the age cohort 18 – 24 years are most affected and therefore warranting a study at the most significant University in Lesotho.

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CHAPTER 1

HIV/AIDS AND VULNERABILITY OF STUDENTS AT THE NATIONAL UNIVERSITY OF LESOTHO

“In the HIV/AIDS context of university life today, the university culture is in danger of affirming risk more than safety. It is in danger of affirming death more than life”

Anonymous

1 INTRODUCTION

HIV/AIDS is an illness that affects all countries in the world, either directly or indirectly, killing millions of people, especially in Africa. According to USAID estimate in 2008, there are 33.4 million people in the world living with HIV/AIDS, of whom 22.4 million are from Sub-Sahara Africa, 1.9 million new infections and 1.4 million deaths. Pieterse, and van Wyk, B., (2006:1) state that; SADC region is enveloped in a full blown HIV/AIDS pandemic: HIV/AIDS prevalence rates in the region remain the most advanced in the world. According to UNAIDS Lesotho, HIV/AIDS prevalence rate in Lesotho has set it as the third most affected country in the world, with one in four people living with HIV/AIDS (Lesotho, 2005: 1). Lesotho is not spared, as it has some of the highest prevalence rates among young people in the world, in the 20-29 age group (Lesotho, 2005:1). Students are more vulnerable to HIV/AIDS infections because of the exposure to different activities and peer pressure at tertiary level. Groups particularly vulnerable to HIV/AIDS infections; are mostly injecting drug users and sexually active young women and men (London & Patterson, 2002: 964; UNAIDS, 2007: 1, 3).

Young people are at the centre of the global HIV/AIDS pandemic. Because countries vary greatly in population, wealth, educational attainment, and developmental status, the vulnerability to HIV/AIDS varies as well as the difference in national response to the crisis. Young people are at a high risk of contracting HIV/AIDS due to the fact that once they become sexually active, they often have several, usually consecutive, short-term sexual relationships and do not consistently use condoms. In some regions, risk-taking behaviour and vulnerability encompass young people’s knowledge, perceptions, general beliefs and attitudes. This affects their access to health information, and the quality of the relationship between young people and their primary caregivers (National AIDS Programme. 2004: 7, 8).

Furthermore, young people, including tertiary students, often have insufficient information and understanding of HIV/AIDS, and are usually not aware of their vulnerability to the disease or how best to prevent it. An important factor to consider is that groups of people have different levels of vulnerability even if they face similar hazards. Therefore this research seeks to investigate factors that specifically contribute to exposure, susceptibility and the coping capacity of students at the National University of Lesotho (NUL), using the Pressure and Release (PAR) Model to assess their vulnerability to HIV/AIDS. The research aims to create awareness among the students of the university, as well as produce a report that can be used to develop strategies specific to NUL, but could be adapted to other educational institutions.

1.1. OVERVIEW OF LESOTHO STUDY AREA

Lesotho is a small mountainous land-locked country in the southern part of Africa and completely surrounded by the Republic of South Africa. The country is divided into ten administrative districts: Butha-Buthe, Leribe, Berea, Maseru, Mafeteng, Mohale's Hoek, Quthing, Qacha's Nek, Mokhotlong, and Thaba-Tseka. Maseru is the capital city, shown in Figure 1 below. The country seems to be depopulating, with the pandemic mostly affecting the economically productive adult population aged between 15 to 49 years. According to the National AIDS Commission (NAC) and UNAIDS, the population of Lesotho was known to be 2,128,950 in 1999 and in 2009, but the population dropped to 1,924,886 in 2010. With approximately 29,000 new infections having occurred in 2007 alone, it was estimated that 268,000 people in Lesotho were infected (HIV/AIDS Health Profile, 2007:1).

The map of Lesotho shown in Figure 1, demarcates the different districts with a high level of HIV/AIDS prevalence, where the national average rate is 24per cent. compared to other areas in Lesotho. Maseru and Leribe are the highest, with 26per cent and 30per cent respectively. Maseru being an urban area seems to be just as affected as the rural area, Leribe, although, Leribe is four per cent higher than Maseru.

According to UNAIDS 2006, the principal mode of HIV/AIDS transmission in Lesotho is heterosexual contact, specifically multiple concurrent partnerships (Corno & Walque, 2007: 4). In 2004, the World Bank estimated that the impact of HIV/AIDS epidemic will reduce Lesotho's Gross Domestic Product (GDP) by almost one third by 2015 (National HIV/AIDS Research Agenda, 2007: 2; USAID, 2005:1). In the effort to mitigate the GDP reduction, several local and international NGOs have campaigned and still campaigning on different aspects of HIV/AIDS throughout the nation. These programmes, though necessary, had a low success rate in preventing HIV/AIDS transmission.

In the context of the pandemic, Southern African institutions of higher education operate within the epicentre of HIV/AIDS whose sub-population are at a significant risk of contracting the disease (Pieterse & Van Wyk, 2006: 1). This apply especially in countries with a high prevalence rate of HIV/AIDS such as Lesotho, the students are particularly vulnerable. Implication of the 2008 Demographic Health Survey was that Lesotho had the third highest adult HIV/AIDS prevalence in the world at 23.2per cent, and young women in the 15-24 age group had an HIV/AIDS prevalence of 26.5per cent as compared to 15per cent among men of the same age (Lesotho Red Cross Society, 2006: 3). Therefore, students at the National University of Lesotho fall within this age cohort. However, certain communities that operate in this age cohort can contribute significantly to the vulnerability of its members.

1.2 NATIONAL UNIVERSITY OF LESOTHO

The National University of Lesotho (NUL), formally called the Catholic University College, was established in 1975. The University is located in an isolated valley 34 kilometres from Maseru (NUL History. s.a). The university community consists of students, and academic and support staff. There are five faculties (Education, Engineering, Humanities, Science and Social Sciences) and a new Faculty of Health is being established.

For many years this institution was the only university in Lesotho. It occupies a unique position in producing and injecting a number of qualified undergraduates equipped with a variety of skills, to assist Lesotho's development. However, NUL has however identified HIV/AIDS as the single biggest threat to both staff and students, prompting the university

authorities to come up with a policy to arrest the spread of the pandemic within the university community. According to the 'NUL against HIV and AIDS' (2009) an HIV/AIDS policy scheme for students was launched at NUL, to assess the impact of HIV/AIDS on the society and to provide a remedial solution. This policy was literally forced into action due to the increasing figures of HIV/AIDS infection among students and staff members at the institution.



Figure 1. 1: Satellite Map of National University of Lesotho

(Source: Google Earth)

Figure 1.1 above shows the satellite map of the National University of Lesotho campus. It includes buildings such as classrooms, offices, hostels, staff houses and so on, and shows clearly the interaction between the community and the outside world. In 2005, the number of students at NUL was 5,197 with 29 per cent infection rate. However, in 2010, though the infection rate was not established, the number of students in 2010 increased to over 11, 142 students (National University Lesotho. 2010: 4). It can only be deduced that, the number of students at risk of contracting HIV/AIDS. It should be borne in mind that some of the students may be HIV/AIDS positive before they enrolled at the University.

The susceptibility of the students also contributes to their level of vulnerability, which later influences the risk of infection. The majority of the students engage in a variety of activities that expose them to contracting the virus. With Maseru being thirty minutes drive from the University

campus, students tend to mix with members of other 'risk groups', the formal and informal workforce of the capital city, increasing their level of risk. The target population that this study seeks to investigate are students of the same institution in Lesotho, NUL.

1.3 PROBLEM STATEMENT

The young adults between age group 15-24 years are identified as the most vulnerable in Lesotho with an infection rate of 23.2 per cent. In addition, young women aged 15-24 years have an HIV/AIDS prevalence of 26.5 per cent and 15 per cent for males of the same age (Lesotho Red Cross Society, 2006: 3). What are the factors that are contributing to HIV/AIDS vulnerability of students at the National University of Lesotho?

HIV/AIDS has negatively impacted the National University of Lesotho. Students are being infected at an alarming rate "*the National University of Lesotho considers HIV and AIDS to be a serious challenge that threatens the development of the institution and the nation...*" (The NUL against HIV and AIDS: sa). The prevalence rate of HIV/AIDS indicates a significant degree of students' vulnerability. There is general knowledge of HIV/AIDS among the students on the campus, due to the nationwide campaigns by local government and international organisation. For example, there are free condoms in the rest rooms, occasionally a temporary free unit HIV/AIDS testing unit within the campus. However, all efforts seem to be ineffective, due to increase in new HIV/AIDS infections rate.

This study therefore, seeks to assess the vulnerability of students to HIV/AIDS at the National University of Lesotho by identifying which factors within the Lesotho and the University, renders the students vulnerable, and to provide recommendations.

1.3 STUDY OBJECTIVES

The objective of this research is to engage in an exploratory, extrapolation and descriptive investigation into the vulnerability of NUL students to HIV/AIDS, and how the combinations of certain factors contribute to their vulnerability. The research will extrapolate the vulnerability of students to the epidemic at NUL. Finally, the research shows a new perspective on the interaction between community and HIV/AIDS vulnerability, and take disaster management a step further.

To achieve the objective mentioned above, the research objective has been divided into three objectives.

1.4.1 Objectives

- To determine the vulnerability of students to HIV/AIDS, at the National University of

Lesotho.

- To establish factors those contribute to students' vulnerability to HIV/AIDS at the National University of Lesotho.
- To avail the results as well as make recommendations to the stakeholders who are involved in the formulation and implementation of policies and strategies to downscale HIV/AIDS in Lesotho, and improve the situation.

1.5 RESEARCH QUESTIONS

The researcher seeks to find answers for the following;

- How vulnerable are the students at National University of Lesotho to HIV/AIDS?
- What are the factors contributing to the vulnerability of the students in relation to HIV/AIDS?
- What can the University, government and non-government organisations do about the HIV/AIDS prevalence?

1.6 RESEARCH DESIGN AND METHODOLOGY

A design is a plan or blueprint of how you intend to conduct the research (Mouton, 2001: 55). This research seeks to understand HIV/AIDS prevalence among these students, mainly using the Pressure and Release (PAR) model and Vulnerability Pathway model to provide information on vulnerability of the students. This study embarked on different research designs. For collection of data, literature study, ethnographic research design, questionnaires and interviews were used. While, for analysis of the data, a discourse analysis, PAR model and the Vulnerability Pathway model were used.

Therefore, data is collected from a variety of primary and secondary sources, in particular interviews and administration of structured questionnaires to students, and using all relevant records from the university clinic. Qualitative approaches using interviews and questionnaires were used to gather data on the university community's views on the vulnerability of students. Semi-structured questionnaires were prepared for discussions. Each student was given prepared statements or questions and then asked to indicate whether they 'agree', 'disagree' or are 'not sure' about each statement.

According to Chilisa, *et al.*, (2001), “complementary purposes in a mixed method design seek elaboration, enhancement, illustration, and clarification of the results from one method with the results from another in order to increase the interpretability, meaningfulness and validity of constructs and inquiry results”. Using interview and questionnaire data complemented statistical data on morbidity, mortality and other vulnerability indicators.

1.6.1 Data collection method

The data collection methods were placed in the order in which they were carried out. A literature study was done first. Then during the field study, over a period of seven days, ethnographic research was carried out, whilst questionnaires were administered.

➤ Literature Review

One of the main benefits of this approach is that it facilitates triangulation and a complementary angle (Chilisa, *et. al.* 2001: 1). Various models have been developed to explain the context and cause of HIV/AIDS, and to identify the vulnerability of people together with a range of responses and coping strategies (Sambrook, 2003:1).

Literature review is to analyse what other authors have said on this issue (Leedy, 2005:65). It reveals that the area of this topic has been extensively covered by various studies, and equally, to show other important aspects that have not yet been covered. In addition, this study draws from researches from various parts of the world on students and within communities with similar composites as NUL. However, knowledge and understanding about how the epidemic is affecting NUL students remains very little due to the fact that most studies conducted in Lesotho are mostly focused on rural indigenous communities. As a means of acquiring detailed information for in-depth description and explanation of the current study, extensive documentation such as magazine articles, newspaper and media reports, and information available on the internet will be collected and integrated with the data obtained, in an attempt to add any other nuances that might reside in these sources (Mouton, 2001: 198).

➤ Questionnaires

Questionnaires were developed and administered to students in order to gather information about the HIV/AIDS, social and sexual behaviour, and stigma/culture of the epidemic within the University and Lesotho. At the end of each day, the completed questionnaires were reviewed by the researcher and checked for validity and omission. Questionnaires helped in obtaining information that could not be obtained by interviews and discussions. The questionnaires entailed both open-ended and closed-ended

questions, to give students more options and freedom in their responses.

➤ **Interviews and field observations**

Field observations and interviews were used to complement the questionnaire responses, to enable observation of student activities and lifestyle of students within the university. However, interviews were held obtain the opinions of experts on HIV/AIDS at NUL and to understand those factors or issues within the university society that fuel the disease. The interviews were also good for getting different perspectives from the counsellors with regard to qualitative insight into how the students experienced and dealt with the HIV/AIDS situation, and after infection.

1.6.2 Sampling methods

With a larger population, the smaller the percentage of that population the sample needs to be (Delpont, *et al.*, 2002:199). The study randomly selected one hundred (100) students from year one, two, three and four, in order to have a fair representation of the University. Students were also randomly selected on the streets of Roma as well as Maseru. Some of the questionnaires were administered in the residences, others in the classrooms. The two counsellors at the university clinic were also selected for interviews in order to collect an expert opinion and understanding of the HIV/AIDS situation among the students.

1.6.3 Data analysis

With the completion of data collection, the questionnaires were captured and computerised for analyses. The multivariate data analysis was adopted to analyse the data collected at the end of the research. The multivariate data analysis is described as the analysis of the simultaneous relationships among several variables (Babbie & Mouton, 2008: 644). According to Hair, *et al.*, (1995:2), multivariate analysis refers to analysis of multiple variables in a single relationships or set of relationships. Facts and figures will be presented in forms of table, diagrams and graphs. The tables, facts and figures will be used to support the logical conclusion arising from the research and necessary recommendations will be made. A report was written on the findings, and the outcome of the interpreted analysed data.

It is critical that HIV/AIDS is investigated, and the indicators being used, relevant. For example, the age or gender of a person will reveal only very general indications of potential resilience and vulnerability. According to (Buckle, Marsh & Smale, 2001:9), obtaining a clearer and more useful picture of the resilience or vulnerability of a person or community, it is necessary to understand the context in which the person lives or the community in which

the person exists. It is therefore necessary to examine the specific circumstances of the person or community.

1.7 DELINEATIONS AND LIMITATIONS

To carry out a vulnerability assessment of HIV/AIDS in an organization such as NUL is a complex exercise that requires a variety of data to estimate both the overall magnitude and context of the vulnerability. "Quantitative data should be available where an institution has a well established management of information system" (Chilisa, *et al.*, 2001: 1). Although the University has several databases, there is no organizational framework that links them together. There are major information gaps, as well, the stigma, secrecy and denial surrounding HIV/AIDS which precludes any comprehensive documentation of HIV/AIDS. Even though many people in Lesotho have died from HIV/AIDS related disease, very few are willing to admit that they or a close relative is sick. The study will not make an effort to explore causative reasons for HIV/AIDS prevalence among students in other higher institutions within the country due to the shortage of time to embark on a broader study.

This study will not investigate strategies to mitigate other disasters that are problematic in the area, but solely make an attempt to investigate, analyze and determine strategies and policies that could improve HIV/AIDS at the National University of Lesotho.

However, the main limitation of this study was time constraints that made it almost impossible to have make an in-depth study of the area. Gathering data and its analyses required a significant amount of time, in which the researcher had to visit various organizations for the information was scattered. Regarding this, the study had to carry out the investigation while the institution was on strike "until further notice". That led to limitation on the data and information collected on site. Another limitation was the lack of time to make a comprehensive study of the institution.

1.8 ETHICAL CONSIDERATIONS

There were important ethical issues that needed to be taken into consideration when conducting research (De Vos, *et al.*, 2005:57-58). HIV/AIDS is of a sensitive nature and the research problem was of a nature to identify vulnerability of individuals as a group. This research was therefore conducted with the confidentiality of participants, expect if suggested otherwise. The sample population was approached with respect and the research was conducted with adherence to ethics and code of conduct of disaster management. No respondent was deceived or coerced to complete the questionnaire and any possibility of

emotional harm to the respondents was avoided. The researcher was objective and avoided value judgment throughout the research process.

1.9 SIGNIFICANCE OF STUDY

According to a research done by Kelly & Murphy in 1992, college students have been recognized as the population most at risk of HIV/AIDS infection, risky sexual experiences, partner change, peer influence, and the use of alcohol and drugs are the behavioural attributes of individuals in the age group that have rendered them potentially vulnerable to infection (Ferrer, *et al.*, 2007: 52). Furthermore, Ratliff-Crain, Donald and Dalton (1999), find that perception of low vulnerability to HIV/AIDS infection is associated with unprotected sexual practices among college students. When low concern about HIV/AIDS is combined with ignorance, the risk of infection among the youth is compounded (Ferrer, *et al.* 2007: 52). It is also important to note that in 2003 UNAIDS found that the majority of the 11.8 million young people living with HIV/AIDS did not know that they carried the virus, and that ignorance increased young people's chances of acquiring HIV and other sexually transmitted diseases (Ferrer, *et al.*, 2007: 52).

However, factors like social, political, cultural, biological and economic contribute to the HIV/AIDS vulnerability of young people, and continue to affect them disproportionately. With very little systematic empirical research undertaken that specifically addresses the actual vulnerability of young people in Lesotho, there is knowledge and understanding through research that HIV/AIDS in Lesotho is affecting an economically active generation (15 -24 years), students included. There is very little or no research or studies conducted in Lesotho that focuses on students in higher education. Most of the research focuses on rural indigenous communities, with subgroup of children, women and the uneducated. This information has been collected through the work of World Health Organization, United Nation Development Program and National and International NGO's own programming experiences. Despite the growing knowledge and understanding of the issue there are still only a few systemic studies available regarding the vulnerability of students in higher institutions, and the role of their organizations in working towards the prevention of HIV/AIDS from disaster management perspectives.

Therefore one important contribution of this study to the academic field is its ability to examine the vulnerability of students to the HIV/AIDS pandemic from the disaster risk management perspective, using the Pressure and Release (PAR) Model. This model will enable one to determine the level of vulnerability of the students to the HIV/AIDS epidemic at the National University of Lesotho (NUL) in Roma, within the Maseru District. It will also

enable an assessment of the capacity and level of preparedness of national government, the university and students at NUL to combat HIV/AIDS. Moreover, a disaster risk management perspective will enable government to review and assess available laws and policies on HIV/AIDS in Lesotho to provide adequate provisions that can mitigate the situation.

1.10 OUTLINE OF CHAPTERS

Chapter 1: Introduction

The first chapter provides a brief and up-to-date introduction to the study and general explanation of necessity and area of study. It further gives a brief profile of the vulnerability status of National University of Lesotho in relation to HIV/AIDS. Furthermore, it illustrates the aims and objectives of the study and the outline of report chapters.

Chapter 2: Literature Review - HIV/AIDS Vulnerability and Its Global Perspective

The chapter covers topics relating to the general principles of vulnerability. It focuses on students' vulnerability to HIV/AIDS around the world, including Lesotho. Critical analysis of students' vulnerability of HIV/AIDS, problems and challenges are critically examined in this chapter.

Chapter 3: Research Methodology Vulnerability and Theoretical Framework: A Conceptual Overview of Pressure and Release Model

The chapter reflects on a range of quantitative and qualitative methods that were used to gather the data for the study. They include:

- Desktop study, internet information, library information, newspaper sources, literature review, *etcetera*.
- Consultation and interaction with key informant of study, for example counsellors and students.

Chapter 4: Presenting the results of empirical investigation

The chapter outlines the information contained and collected from relevant persons and sources on HIV/AIDS. Preliminary analyses of the collected data are included. Finally, some emerging challenges and vulnerabilities of the students as well as the university are described.

Chapter 5: Discussion and synthesising results into the Pressure and Release Model and Vulnerability Pathways Model

The chapter outlines the information and data collected during the empirical investigation and synthesised it into the Pressure and Release model (progression of vulnerability) and the Vulnerability Pathway model to determine how vulnerable the students are and factors contributing to their vulnerability.

Chapter 6: Conclusion and Recommendations.

This final chapter concludes the study and suggests or recommends ways forward to make progress in improving the quality of HIV/AIDS data, which in the longer term will help in successful HIV/AIDS vulnerability mitigation.

CHAPTER 2

GLOBAL PERSPECTIVE ON STUDENTS VULNERABILITY TO HIV/AIDS

“The global AIDS epidemic is one of the greatest challenges facing our generation. AIDS is a new type of global emergency—an unprecedented threat to human development requiring sustained action and commitment over the long term” (Kofin Anan)

2. INTRODUCTION

Lesotho is being drastically affected by the prevalence of HIV/AIDS which makes it essential to put in place strategies and programmes to respond to the epidemic from a disaster management perspective. This chapter elaborates and systematically unfolds HIV/AIDS vulnerability within the global perspective through region, country and ultimately Lesotho, as a focus of research. The chapter demonstrates how groups of individuals can be vulnerable to HIV/AIDS. It also discusses characteristics of HIV/AIDS with direct relation to exposure, their sensitivity and level of resilience developed over the years. The purpose of this chapter is to review existing knowledge on HIV/AIDS in order to synthesise collective research on vulnerability to a hazard and HIV/AIDS researches. It provides information on the vulnerability of individuals aged 15-24, the age cohort in which the majority of the university students fall. Although university students at the National University of Lesotho are considered to be the vulnerable group of this research, the chapter recognises vulnerability of women to HIV/AIDS in Lesotho, and therefore also assesses how the female students are particularly vulnerable to the epidemic.

2.1 THE GLOBAL PERSPECTIVE OF THE EPIDEMIC

The HIV/AIDS epidemic is unique and the most severe in human history regarding its rapid spread, its extent, depth and the complexity of its impact. It is the first global epidemic of which the world is commonly conscious (Barnett, 2006: 374). Once infected, the HIV/AIDS virus hides and multiplies in the body's defence cells, which so far has made it impossible to develop a vaccine (Hernes, 2008: 3). The disease can be transmitted through various pathways such as mother-to-child, through needles and blood transfusion, but the most common and the fuel of prevalence, especially in Lesotho, is through sexual intercourse. The transition from HIV infection to full blown AIDS disease is usually due to the individual's ability to control the multiplication of the virus that eventually leads to a complete takeover of

the body's immune system. At this stage, the CD4 cells count is so low (<200) that the body is exposed to opportunistic infections that eventually lead to the death of the AIDS patient. AIDS has no known cure and it has a 100per cent mortality rate (Jackson, 2002:1). However, the inability of an individual to control the transition is the virus prejudice and hypocrisy, and political correctness because they lead to a conspiracy of silence, stigma and discrimination against the infected and affected (Hernes, 2008:3).

Since the first HIV/AIDS case was diagnosed in 1981, the world has struggled to come to grips with its extraordinary dimensions (UNAIDS 2004: 13). The HIV/AIDS epidemic has been with us for more than a quarter of a century, but the statistics never fail to shock (International Federation of Red Cross and Red Crescent Societies (IFRCRCS), 2008: 7). The IFRCRCS report (2008:7) states that around 25 million people have died and about 30 million are living with HIV/AIDS today. Based on these trends, the United Nations reports in 2003, projected that globally, there will be 278 million more deaths between 2000 and 2050 than would have occurred in the absence of HIV/AIDS (HIV/AIDS and Adult Mortality in Developing Countries, 2003: 3).

Figure 2 below, shows the global sum (33.2 million) of people living with HIV/AIDS in 2007. It was estimated that of the 33.3 million, 25 million (1.8 - 4.1 million) was estimated as new infection in 2007 alone and the number of deaths was 2 million due to HIV/AIDS in 2007 (UNAIDS Epidemic Update, 2007: 38). According to UNAIDS (2008:33), the most vulnerable people around the world are young people between the ages of 15–24 years. This age group account for an estimated 45 per cent of new HIV/AIDS infections worldwide

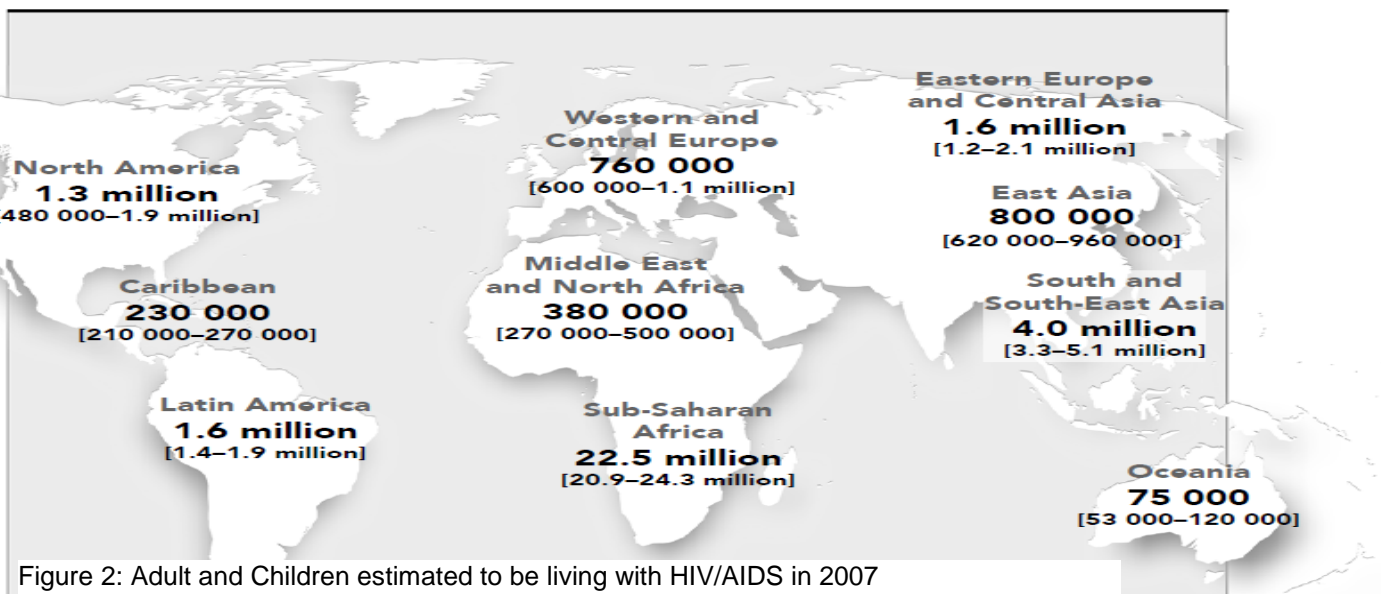


Figure 2: Adult and Children estimated to be living with HIV/AIDS in 2007

(Source: UNAIDS Epidemic Update 2007)

According to UNAIDS in 2007, nearly 33 million people worldwide were living with HIV/AIDS, the majority (up to 28 million) living in Sub-Saharan Africa. In 2007, UNAIDS reported that 75 per cent of HIV/AIDS related deaths occurred in sub-Saharan Africa. The HIV/AIDS prevalence was estimated between 20-28 per cent rate within the age cohort 15-49 (UNAIDS, 2007: 4 & 39). The majority of these infections were through heterosexual transmission. However, in Eastern Europe and Central Asia the HIV/AIDS prevalence rate within the age cohort 15-49 was estimated between 1.5-2.0 per cent in 2007 (UNAIDS, 2008: 48 & 51). The latter shows a major difference in HIV/AIDS prevalence rate, as compared to the same age cohort in sub-Sahara Africa.

In 2002, a UNAIDS report concluded that Latin America and the Caribbean encompassed a wide spectrum of countries with few HIV/AIDS cases, and some of these countries' HIV/AIDS epidemics were similar to countries in parts of sub-Saharan Africa. Although, in the Caribbean the primary mode of HIV/AIDS transmission was unprotected sex with sex workers, with HIV/AIDS prevalence rate estimated at 1.5-3.0 per cent among age group 15-49. Latin America HIV/AIDS epidemic continues to occur more significantly with unprotected sex among men having sex with men (UNAIDS 2007: 29, 31 & 32). Even though there is a similarity of 1.5 - 3.0 per cent HIV/AIDS prevalence rate among 15-49 age groups between the two regions, the mode of transmission is different (sex workers versus men having sex with men).

Unsafe sex between men plays an important role considering the HIV/AIDS prevalence rate in Latin America and the Caribbean, North America, Western and Central Europe (UNAIDS. 2007: 32 & 33). In Sub-Saharan Africa the main transmission mode is through heterosexuals, thereby conveying that both women and men are equally exposed to the risk of HIV/AIDS infection. In Latin and North America as well as West and Central Europe young men are more exposed to HIV/AIDS. The difference between HIV/AIDS prevalence rate of 20-28 per cent in sub-Saharan Africa and 1.5-3.0 per cent in Latin America as shown in Figure 2, indicate the level of exposure within each region. The higher the HIV/AIDS prevalence rate in a given region the higher the exposure of students to HIV/AIDS will be. Therefore, this would indicate that, university students in sub-Saharan Africa are more exposed to HIV/AIDS, than students in the Oceania region. It can therefore be concluded that an individual within the age group 15-49 in sub-Sahara Africa will be more exposed to the risk of infection than in Latin America.

2.1.1 HIV/AIDS vulnerability of students globally

HIV/AIDS can be defined as an Acquired Immunodeficiency Syndrome (AIDS) caused by the Human Immunodeficiency Virus (HIV), which crossed from primate to human (Whiteside, 2008: 1), and currently does not have a cure or vaccine.

In the social science, particularly disaster management, vulnerability to HIV/AIDS is said to be an inherent pre-disposition to be hurt. This suggested a hazard independent susceptibility (Bogardi, *et al.*, 2010: 2). Bogardi, *et al.* (2010: 2), continue by saying vulnerability implies the inherent question, “Vulnerable to what?” Hence without being exposed to this particular “what” or hazard, people may not seem to be vulnerable. However, there is an internal core of vulnerability, which does exist and matter, irrespective of whether the individual or subject is exposed to a hazard or not. For example, a person with a compromised immune system is more susceptible than a healthy person, even if none of them is exposed to a hazard. Thus their susceptibility may turn into hazard specific vulnerability once they are exposed to it, for example, HIV/AIDS.

Authors like DiClemente, Forrest and Mickler (2005); Fisher, Bryan and Misovich (2002); Hendershot, Stoner, George and Norris (2007) and many more, have conducted various research on the vulnerability of students within tertiary institutions. However, within and beyond these studies it has been found that although there are underlying factors that are synonymous to student vulnerability to HIV/AIDS, the level of vulnerability differs from one tertiary institution to another and from region to region. Therefore it is logical to investigate factors contributing to HIV/AIDS vulnerability of students at the National University of Lesotho as compared to other universities.

This acknowledgment led to the analysis of a study carried out in China among 1, 874 students from 19 universities in the Jiangsu Province, with the highest incidents of STDs (Clemens, *et al.*, 2004: 107). The authors understood that sexually transmitted diseases (STD) increase the risk of HIV/AIDS infection for individuals as compared to those without an STD. Moreover, the researchers found that most students in China did not use condoms to prevent HIV/AIDS or STDs, but primarily to avoid unwanted pregnancies. In general most Chinese students did not subscribe to the more traditional view of premarital sex. Although, considered to be the best way of preventing infection, the lack of freedom to openly express or choose when to engage in sexual intercourse made it an unrealistic option. According to Clemens, *et al.* (2004:112) students found having condoms in their possession were regarded as “perverted and immoral” and those found having sex on university premises were punished and could even face expulsion. Only about one-fifth believed that their classmate or college friends were engaging in sex, although 50 per cent of the students

became pregnant before marriage (Clemens, *et al.*, 2004:109). The Chinese government has recently introduced HIV/AIDS education and prevention programmes among adolescents and young adult, but the traditional cultural views continue to limit the populations' freedom of speech.

On the contrary, Croatia does have a HIV/AIDS prevention programme, but a number of schools were forced to drop HIV/AIDS prevention programmes in the school curriculum due to criticism by the Croatian Bishops' Congregation for promoting the use of condoms (Ajdukovic, *et al.*, 2007: 64). Croatia prides itself on being a stern catholic country. The study was done among 1, 093 students at the University of Zagreb in Croatia and came to the conclusion that 74 per cent of respondents did not believe Croatian traditional views of sexuality as being a factor in sexual matters or decisions (Ajdukovic, *et al.*, 2007: 60). Ajdukovic, *et al.*, (2007: 60) found that on average 85 per cent of students at the university had already had sexual intercourse, in contrast to an average of 15 per cent among Chinese students (Clemens, *et al.*, 2004:112). Although both studies identified that sexual abstinence before marriage was strongly promoted in this country, it only went as far as how deeply rooted the cultural views or values were instilled in a student.

A research done by Bacak, *et al.* (2009: 3) suggests that the danger about enforcing sex before marriage is that it may delay sexual debut, but then may also have an adverse effect on subsequent contraceptive use. This exposes students to HIV/AIDS before they fully understand the risks of having sexual intercourse. In Croatia, a stern religious belief is inherent in the society to reduce these risks and enhance moral values. This hampers the government's ability to implement HIV/AIDS campaign, like condom use and therefore increases risk of infection to HIV/AIDS. For example, in the study with the Croatia students about 76 per cent of those who were sexually active were using condoms, while in China being seen with a condom was shameful. However, the question of traditional cultural views did not surface in a study conducted among Seton Hall University in New York. Factors like alcohol consumption, using drugs and multiple partners were defining behaviours of students to have sexual intercourse, in complete contrast to Croatian and Chinese students. It is not being said that these factors do not sexually mould behaviours in Croatia and China as well, but they seem to be of lesser significance. The American study reported that 65 per cent of Seton Hall University students were using condoms during their last sexual intercourse (Teague, 2009: 532).

In addition, in all the studies the students admit that students in general are more exposed to the risk of infection due to the independence from family and increased contact with peers, classmates and the outside world. For example, in the case of China, the report found that

young female students were being lured to wealthy men with cars outside the university campus.

The above-mentioned studies suggest that students have some awareness of HIV/AIDS, although there were some misconceptions about contracting the disease from a public facility in Croatia and China. Nevertheless, HIV/AIDS education and public awareness programmes were available and perhaps even to the point of saturation. Most of the students perceived their risks of HIV/AIDS infection to be lower than that of their peers.

2.1.2 International legislation and laws of HIV/AIDS

HIV/AIDS epidemic has grown to unexpected levels in just a few years in some countries, while it has levelled off in others. However, in the effort to combat the epidemic, legislations and laws were developed by international bodies, which were commissioned to countries as rules and regulations to develop policies and programmes in order to address the epidemic.

In 1996, an international expert consultation group convened by UNAIDS and the Office of the High Commissioner for Human Rights, which included human rights experts, representatives of national AIDS programmes, people living with HIV/AIDS, and Non-Governmental Organizations (NGO), prepared guidelines for states on the application of international human rights law in the context of HIV/AIDS (London & Patterson, 2002: 965). These guidelines are now known as the “International Guidelines on HIV/AIDS and Human Rights”.

The guidelines addressed such complex issues such as confidentiality and disclosure of HIV/AIDS status by applying international legal principles. It established a profound relationship between HIV/AIDS and human rights. According to UNAIDS (2006: 6), the international human rights system explicitly recognized HIV/AIDS status as a prohibited ground of discrimination. At the same time, the impact of HIV/AIDS highlighted the inequities and vulnerabilities leading to increased rates of infection among vulnerable groups, and thereby contributed to a renewed focus on economic, social and cultural rights (UNAIDS. 2006: 6). Among other things, the Declaration called on all member states to create national emergency strategies incorporating “HIV/AIDS awareness, prevention, care and treatment elements” (UN, 2001) to which Lesotho is a signatory.

However, these laws or guidelines developed by these organisations, have differential influences on regions and countries’ policies and programmes. Their differences are apparent through their economic and political arena of the respective countries. With the case of Lesotho, programmes and projects are mostly focused on rural areas due to

previous identification that lack of education is a major contributor to the pandemic. Therefore a city like Maseru is undermined.

In 2000, the Pan African National Red Cross and Red Crescent Societies Conference, strongly supported by National Societies from other regions, adopted the Ouagadougou Declaration stating that National Societies in Africa commit to “responding to the HIV/AIDS pandemic as an unprecedented humanitarian and development disaster in Africa, by massively scaling up their response in terms of advocacy, prevention, care and mitigation” (International Federation of Red Cross and Red Crescent Societies, 2008: 11). This was followed by, a United Nations General Assembly on a Special Session on HIV/AIDS with 189 Member States, including Lesotho, adopted the Declaration of Commitment on HIV/AIDS in 2003 (UNAIDS, 2003: 6).

The Declaration of Commitment reflects the global consensus on a comprehensive framework for effective action to achieve the Millennium Development Goal to halt and reverse the epidemic by 2015. Recognizing the need for multi-sectoral action on a range of fronts, Lesotho supported the Declaration of Commitment to respond to and prevent new HIV/AIDS infections, by expanding health-care access, and to mitigate the epidemic’s impact. In 2001, Lesotho recognised and adopted the Declaration of Commitment as a central tool for advocacy and accountability.

As defined in the Declaration of Commitment, success in the fight against HIV/AIDS is measured by the achievement of concrete, time-bound targets. This is the area from which many government and non-government organisations used to develop policies, strategies for specific group of individuals within a given nation. That was one of the reasons the Millennium Development Goals (MDGs) were created and each country-level target defined. The level of HIV/AIDS activities, programme and policies in Lesotho was built on the pre-existing International Guidelines on HIV/AIDS and Human Rights and the signatory of commitment to the Declaration to global response to HIV/AIDS.

2.1.3 Lesotho legislation and policies

In 2001, the Government of Lesotho formed the Lesotho AIDS Programme Coordinating Authority (LAPCA) in response to the growing and profound effect of HIV/AIDS (Nyabanyaba, 2008:19). The Lesotho Government continued to demonstrate the highest commitment by politically responding to the impact of HIV/AIDS on its population and by launching the government’s official document entitled “Turning a Crisis into Opportunity: Strategies for Scaling Up the National Response to the HIV and AIDS Pandemic in Lesotho” in 2004 (Nyabanyaba, 2008:19). A key challenge outlined in the document is to make every citizen of Lesotho, HIV/AIDS competent, thus acknowledging that in addition to poverty and

hunger, a major factor in the spread of the pandemic is lack of education and awareness about the disease. The document outlines some of its strategies for the education of the nation on HIV/AIDS, with a view to changing risky behaviours, as well as the promotion of awareness and the reduction of the stigma attached to the disease.

In addition, Lesotho formulated a three-year rolling National Strategic Plan, 2000/2001 – 2003/2004. The aim of the Plan was to control the spread of HIV/AIDS and mitigate its impact, particularly with regard to vulnerable groups. In 2005, the Lesotho government established an Act of Parliament, for an effective national coordination mechanism to strengthen and enhance the national response to HIV/AIDS (National AIDS Commission, 2006: 4). However, according to Makoa (2004: 71), the policy would seem to be destined to remain a declaration of intent that might never translate into a programme.

Legislations

- *The Constitution of Lesotho, No. 5 of 1993 (as amended up to 2001).*
- *Sexual Offences Act No. 3 of 2003.*
- *National AIDS Commission Act No. 8 of 22 August 2005.*
- *Legal Capacity of Married Persons Act No. 9 of 2006 .*

The National AIDS Commission Act No. 8 of 2005 is the only official government document totally dedicated to the prevention and reversal of the spread of HIV/AIDS. The Act provides for the establishment of a National AIDS Commission as a body responsible for the development and coordination of strategies and programmes for combating HIV and AIDS, as well as for facilitating implementation, monitoring and evaluation of programmes for provision of policies and guidance over implementing structures for related matters (Lesotho, 2005: 940). Through the creation of this Act, policies and strategies have been developed over the years in order to contain the HIV/AIDS situation. The Act also made it possible for National University of Lesotho to draft a HIV/AIDS Policy in 2002. However, there are other Acts that provide and support the National AIDS Commission Act, for instance the Legal Capacity of Married Persons Act 9 of 2009 rectifies the inequality between husband and wife.

Under the customary law, women are regarded as minors while married women are under the guardianship of their husband and unmarried women are under their fathers' guardianship. The Legal Capacity of Married Persons Act states that the marital power which a husband has over the person and property of his wife is repealed. The Act gives

equal powers to spouses in assets and liability as joint estates, and to which a spouse can by virtue of law operate without the consent of the other spouse (Lesotho, 2006: s.a). This Act basically equates women to men in Lesotho and accordingly empowers women, to which female students are included, either married or not due to the equal rights amendment. Although, this law relates to married students and informs that the law recognizes women as equal to men may have an impact on behaviour of men to women and vice versa. However, traditionally women are regarded as minors, regardless of age may be difficult to eradicate.

In addition, the *Sexual Offence Act* of 2003, provides for the case of HIV/AIDS, that applies to force, whether explicit or implicit, direct or indirect, physical or psychological against a person; in the event that the accused is HIV/AIDS infected with no prior knowledge shall be deemed punishable to up to ten years imprisonment and the accused is given a death penalty if there is prior knowledge of infection (Lesotho, 2003: 255).

2.1.4 HIV/AIDS Strategies and Policy of National University of Lesotho

The National University of Lesotho aligns itself with the National HIV and AIDS Policy and the National HIV and AIDS Strategic Plan (2006-2011) in order to develop policies, strategies and programmes to prevent and mitigate HIV/AIDS on the campus. The University does not have an institutional policy on HIV/AIDS in place although a draft policy and strategic plan was produced in 2002. The draft policy summarises the University's vision, policy commitments and strategies in preventing the spread of HIV/AIDS, and creating an environment where all staff and students have a positive attitude, conducive to acceptable behavioural change and where staff and students living with HIV/AIDS can live positively with their status without discrimination or stigma.

The draft policy contains a strategic plan, which outlines actions to be taken by NUL staff and students on policy formulation; capacity building; advocacy; information generation; dissemination and storage; fundraising; networking; care and support; and community service. The strategy also envisages the formulation of an official NUL HIV/AIDS policy, the generation and increase of HIV/AIDS awareness and knowledge, the eradication of stigma and discrimination, the mobilisation of HIV/AIDS resources for HIV/AIDS-related activities and the establishing of an HIV/AIDS resource centre. In addition, the draft policy also enshrines collaboration with other institutions, the incorporation of HIV/AIDS into the University curriculum, and support and counselling for

staff and students. However, it should be noted that the actual draft still remains a draft, and no finalizing action has been taken in order for it to be implemented.

2.2 HIV/AIDS IN SUB-SAHARA AFRICA

The UNGRASS noted in 2000, "... with grave concern that Africa, in particular sub-Saharan Africa, is currently the worst-affected region, where HIV/AIDS is considered a state of emergency which threatens development, social cohesion, political stability, food security and life expectancy and imposes a devastating economic burden..." (Cohen, 2002: 1). It is affirmed by Balilana (2005: 12), that more than 20 million Africans have already died of HIV/AIDS.

Furthermore, the epidemic continues to be a major development challenge for the continent, and threatens the efforts to achieve the MDGs. In sub-Saharan African countries with a HIV/AIDS prevalence of 20per cent and above, it is estimated that Gross Domestic Product (GDP) will show substantially slower growth (UNAIDS, 2001: 4).

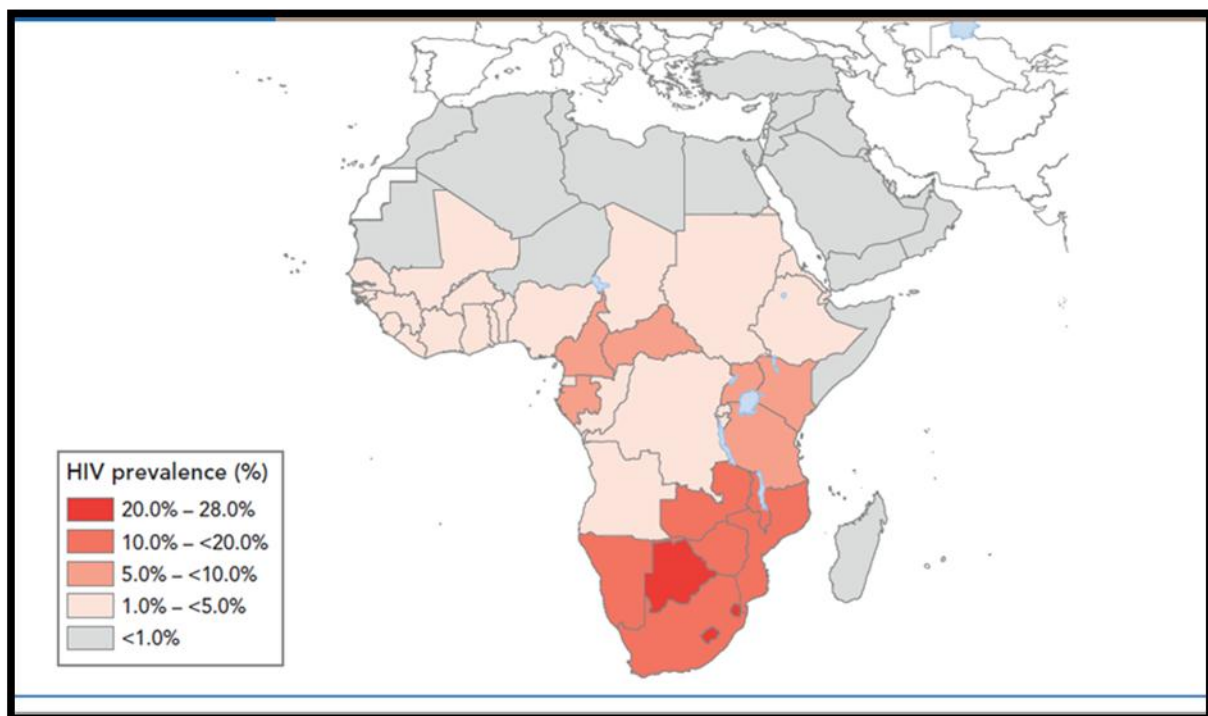


Figure 2 1: HIV/AIDS prevalence (%) in age cohort (15 - 49), 2007.

(Source: UNAIDS. 2009: 39).

Sub-Saharan Africa remains the worst-affected region in the world as seen in Table 1 below, with the highest prevalence in Southern African between 10-28 per cent, see Figure 2.1.

Across the region, rates of new HIV/AIDS infections have increased since its discovery in the late 80s. However, Uganda has managed to reduce HIV/AIDS prevalence from 14 per cent in the early 1990s to about 4.1 per cent in 2003, the only country in Africa to achieve such a drastic reduction (Bakilana, Bundy, Brown & Fredriksen, and 2005:4). UNAIDS (2008), concluded that sub-Saharan Africa accounted for two-thirds (67per cent) of the global total of 33 million people living with HIV/AIDS, and 1.9 million infections occurred in sub-Saharan Africa in 2007 as well as an additional, 76 per cent of the 2.1 million deaths that occurred in 2007 (Bakilana, et al. 2005: 4 & 5).

This means that at least 3.5 million people are expected to die from HIV/AIDS related illnesses, before the end of 2016. Such a simple calculation as above, demonstrates the scale of the impact of the epidemic in sub-Saharan Africa. In many parts of Africa, infection among young people continues to increase, including students. It is estimated that of the 12 million young people infected with HIV/AIDS world-wide, about 72 per cent (8.6 million) live in Sub-Saharan Africa (Jooste, *et al.*, 2009:1). The severity of the epidemic among young people varies significantly by country, reaching as high as 40 per cent in Swaziland (Jooste, *et al.*, 2009:1).

TABLE 1: Estimated Adults (15-49) with HIV/AIDS in sub-Sahara Africa 2003

	Less than 2 per cent	2 per cent - 4.9 per cent	5 per cent - 9.9 per cent	10 per cent+			
Mali	1.9	Congo	4.9	Tanzania	8.8	Swaziland	38.8
Benin	1.9	Chad	4.8	Cote D'Ivoire	7.0	Botswana	37.3
Madagascar	1.7	Ethiopia	4.4	Cameroon	6.9	Lesotho	28.9
Niger	1.2	DRC	4.2	Kenya	6.7	Zimbabwe	24.6
Gambia	1.2	Burkina Faso	4.2	Burundi	6.0	South Africa	21.5
Senegal	0.8	Togo	4.1	Rwanda	5.1	Namibia	21.3
Mauritania	0.6	Uganda	4.1			Zambia	16.5
		Angola	3.9			Malawi	14.2
		Ghana	3.1			CA Republic	13.5
		Eritrea	2.7			Mozambique	12.2

(Source: 2004 Report on the Global HIV/AIDS Epidemic. UNAIDS, 2004).

As Table 1 illustrates, HIV/AIDS prevalence varies significantly across the African continent. Seventeen countries have estimated prevalence rates above five per cent, which may be

considered the point at which the epidemic moves into the general population (Bakilana, *et al.*, 2005:2). Statistics show that most affected are those within the 15 -49 age cohort and it is clearly evident that the majority of university students fall within this age group. However, Southern Africa continues to bear a disproportionate share of the global burden of HIV/AIDS: 35 per cent of HIV/AIDS infections and 38 per cent of HIV/AIDS deaths in 2007 occurred in that sub region. UNAIDS (2007: 15), estimated that 1.7 million (1.4 million–2.4 million) people were newly infected with HIV/AIDS in 2007, bringing the total number of people living with the virus to 22.5 million (20.9 million – 24.3 million) (UNAIDS, 20028: 32). As seen in Table 1, Swaziland is at the top of the list followed by Botswana, and Lesotho ranking third. In Swaziland, for example 26 per cent of the population, that is one in four adults, is HIV/AIDS positive. This is the world's highest HIV/AIDS prevalence rate. In Botswana and Zimbabwe, where one out of every three adults is HIV/AIDS positive, the situation is particularly dire. Therefore students within certain countries, depending on the HIV/AIDS prevalence, are more exposed to HIV/AIDS than in other countries.

The impact on young people, particularly students is exacerbated by the fact that the population of sub-Saharan Africa is quite young relative to other regions in the world. Young people are at particular risk and 62 per cent of the world's young people living with HIV/AIDS are in sub-Saharan Africa (Carbaugh & Kates, 2006: s.a). Unlike other regions, the majority of people living with HIV/AIDS in sub-Saharan Africa (61 per cent) are women (UNAIDS, 2007: 15). Young women are especially vulnerable; young women and girls, in the 15–24 age group comprise 76 per cent of all young people estimated to be living with HIV/AIDS in sub-Saharan Africa; in some countries within the region, infection rates are up to six times higher among young women, compared to men. It is hence likely, that women and girls of this age cohort in Lesotho will be significantly more vulnerable to HIV/AIDS than their male counterparts.

It is important to note that the age cohort 15-24 is chosen due to the fact that most university students fall within this age group and general information is used in order to supplement lack of information that would otherwise shed some light on the vulnerability of this age group at a higher institution.

2.2.1 HIV/AIDS and student vulnerability in Africa

One young person in the 15–24 age group contracts HIV/AIDS every 15 seconds (UNICEF, 2005). However, within sub-Saharan Africa the HIV/AIDS prevalence rate differs significantly. For example in Central Africa, countries like Burundi and Burkina Faso have far less HIV/AIDS prevalence as compared to the Southern African countries.

A research “*Challenging the Challenger: Understanding and Expanding the Response of Universities in Africa to HIV/AIDS*” orchestrated by the World Bank, was conducted in six universities in Africa: The University of Benin, The University of Ghana, The Jomo Kenyatta University of Agriculture and Technology and The University of Nairobi (Kenya), The University Namibia, The University of Western Cape (South Africa) and The University of Zambia. The finding of the report paints an unsettling image of how most of the institutions intentionally ignore the presence of the disease due to layers of secrecy, denial, fear of stigmatisation and discrimination (Sub-Saharan Africa, 2001:188). In the University of Benin, the question of HIV/AIDS has never been officially or unofficially mentioned during any of the students’ activities or other assemblies (Kelly, 2004. 6). This case is considered to be a state of denial on the part of the university, similarly University of Ghana and University of Western Cape. Such denial leads to the general belief that the disease is a distant situation and not yet real on campus. Like in most universities in Africa, silence and denial are common, and the lack of systematic HIV/AIDS data in the University of Nairobi and the Jomo Kenyatta University in Kenya, are due to denial and lack of risk acknowledgement. This usually leads to the university not stating whether a student or staff death is HIV/AIDS related or not, as is the case in the University of Zambia.

According to Kelly (2004: 18), students at all the universities seem to be generally aware of the existence of HIV/AIDS, and know the basic facts about its transmission. The earlier worldwide misconceptions that HIV/AIDS could be transmitted through saliva or mosquito bites, are no longer very common (Kelly, 2004:18). Kelly continues that in almost all universities, new students are provided with information on HIV/AIDS as part of their orientation programmes when they first arrive on campus. Therefore students tend to acknowledge that HIV/AIDS is a problem on campus.

Important shortcomings still relevant, is that students’ have basic knowledge about both HIV/AIDS and STDs, and believe that oral contraceptives prevent HIV/AIDS infection and that the HIV/AIDS virus can pass through an undamaged condom (Kelly 2004: 18). In relation to students from China, Croatia and United States, there is widespread evidence that African students do not generally regard themselves as being seriously at risk of HIV/AIDS infection (Kelly, 2004: 18). A survey at the University of Ghana found only 40 per

cent of the students was at risk of contracting the disease. While the University of Zambia experienced an annual rate of HIV/AIDS related death to be more than 1 in 50 in the first semester of year 2000, which was an exceptionally high rate for individuals who were clustered in the 20–30 age range (Kelly, 2004:18). The investigation into South Africa universities, found a similar situation with student attitudes manifesting denial, fatalism and an air of invulnerability (Kelly, 2004: 6).

2.3 OVERVIEW OF HIV/AIDS EPIDEMIC IN LESOTHO

Disasters, especially those caused by natural hazards like earthquakes, are not the greatest threat to humanity (Blaikie, Cannon, Davis & Wisner, 2004: 3). In the year 2000, His Majesty King Letsie III declared HIV/AIDS as a national disaster (GOL, 2006: 2). However, the *Disaster Management Act* has not been amended to accommodate it (Belle, 2010: 37).

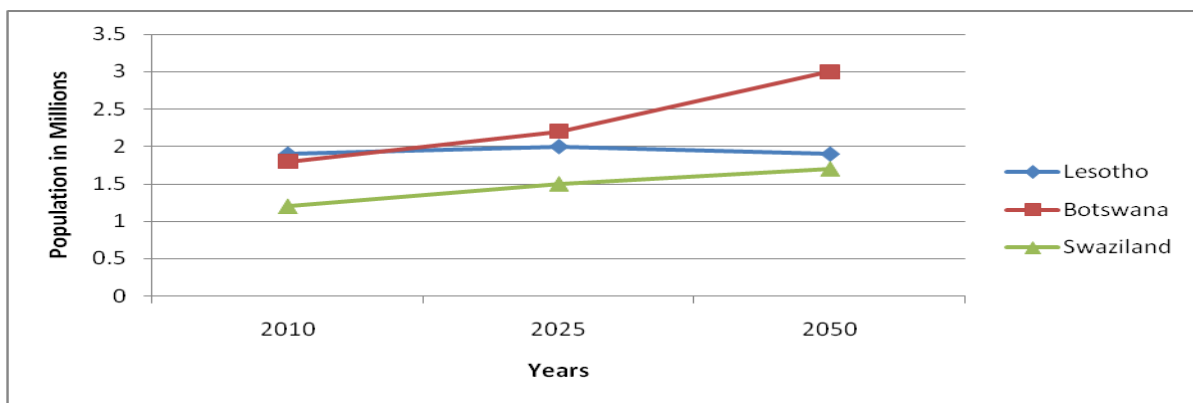


Figure 2 2: Projected population (millions) 2012 - 2050.

(Source: 2010 World population Data Sheet. Population Reference Bureau).

As mentioned earlier, Lesotho’s population growth has stalled from 1,862,275 people in 1996 to only 1,880,661 people in 2006, less than a single percentage point increase over the period (Owusu-Ampomah, *et al.*, 2009: 58). As seen in Figure 2.2, Lesotho’s population over the period of 40 years will not increase above two million. An increase will occur in the next 15 years; however it will start to decline again. Figure 2.2 shows that if HIV/AIDS in Lesotho is not stabilised, serious consequences will be suffered by the country, through depopulation.

According to the Lesotho Red Cross Society (2006: 2), the epidemic has contributed to the decline in life expectancy of the Basotho from 60 years in 2003 down to 40 years in 2005.

Despite government efforts to control the spread of the epidemic, infection rates continue to rise. HIV/AIDS has by far been the most underlying cause of death, with approximately 12,000 AIDS-related deaths in 2008. The epidemic has struck at every level of society and many of the developmental achievements of the post-colonial era are being eroded. UNAIDS (2004), has shown the life expectancy has dropped to 36 years. Lesotho currently has the lowest growth rate in the Southern African region; the population growth rate declined between 1996 and 2006, from 1.5 per cent to 0.08 per cent. Considering the explanation mentioned above, it can be said that HIV/AIDS has affected all the components of the population structure of Lesotho (Belle, 2010: 103).

Lesotho faces a serious and worsening HIV/AIDS problem, with at least one in three adults infected (Red Cross Society, 2006: 2). This translates into approximately 350,000 people living with HIV/AIDS.

TABLE 2: Estimated HIV/AIDS positive Adult in 2008

	Estimated HIV-positive adults in 2008	Estimated new adult infections in 2008	Estimated annual AIDS deaths in 2008
Male	110,000 (90,000-130,000)	10,000	5,000
Females	150,000 (130,000-170,000)	11,000	6,000
Total	260,000 (230,000-290,000)	21,000	11,000

(Source: UNGRASS Country Report. 2009: 14)

Table 2 above, is an estimate by UNGRASS, a Country Report in 2010. It shows the adult HIV/AIDS prevalence rate for 2008 was 23.6 per cent (UNGRASS, 2010:3 & 4). This was an increase of 0.4 per cent from 2007; with approximately 21,000 new adult HIV/AIDS infections in Lesotho. The increase, therefore exacerbates the already vulnerable nature of individuals and Lesotho as a nation (UNGRASS, 2010:4). However, one thing to bear in mind is that decrease in HIV/AIDS prevalence do not necessarily indicate a reduction in risk of infection (Hallett, *et al.*, 2006). The true indication of risk reduction will have to be the reduction in number of new cases within the country. A constant reduction in new infection over a certain period could be an indication of behavioural change.

Results from the 2004 Lesotho Demographic Health Survey (LDHS), indicate that 24 per cent of adults aged 15-49 in Lesotho are infected with HIV/AIDS. HIV/AIDS prevalence in

women age cohort 15-49 is 26 per cent, while for men 15-59; it is 19 per cent, as shown in the Table 2. The table also shows both sexes, rates of infection rise with age, peaking at 43 per cent among women in their late 30s and 41 per cent among men age 30-34. HIV/AIDS prevalence is substantially higher among women, in the age cohort 15-24, with women at 35.4 (7.9 + 24.5) per cent and 13.7 (5.3 + 19.2) per cent, in Table 3 below.

TABLE 3: HIV/AIDS prevalence by age

Per centage HIV positive among women 15-49 and men age 15-59 who were tested, by age, Lesotho 2004						
Age	Women		Men		Total	
	Percentage HIV/AIDS positive	Number	Percentage HIV/AIDS positive	Number	Percentage HIV/AIDS positive	Number
15 - 19	7.9	729	2.3	615	5.3	1343
20 – 24	24.5	613	11.4	411	19.2	1025
25 – 29	39.2	446	24.3	300	33.2	746
30 – 34	40.3	380	41.3	254	40.7	635
35 – 39	43.3	317	38.7	186	41.6	503
40 – 44	28.5	300	33.9	127	30.1	427
45 – 49	16.8	245	27.8	119	20.4	364
50 – 54	na	na	16.2	139	16.2	139
55 – 59	na	na	16.6	104	16.6	104
Total age 15-49	26.4	3,031	19.3	2,012	23.5	5,043
Total age 15-59	na	na	18.9	2,255	23.2	5,286

Note: "HIV positive" refers to HIV-1 only.

na = Not applicable

(Source: Lesotho Demographic Health Survey. 2004: 233).

There is a significant increase in the number of new infections between 2004 and 2008, as seen in Table 2 and Table 3. For example, an estimated infection of men in 2004 is 4,267 with an increase to 10,000 male infections in 2008.

Since the first diagnosed case of AIDS in 1986 the number of people living with HIV/AIDS in Lesotho has risen rapidly. Of the estimated 81 270 individuals requiring antiretroviral therapy (ART), only 21 710, or 25.6 per cent have access (Owusu-Ampomah, K., Naysmith, S & Rubincam, C 2009: 8). Owusu-Ampomah.*et al.* (2009:8) continue to argue that, more than half of those infected nationally (56 per cent) are women, and in the 15-24 age cohort 71 per cent of those infected are female.

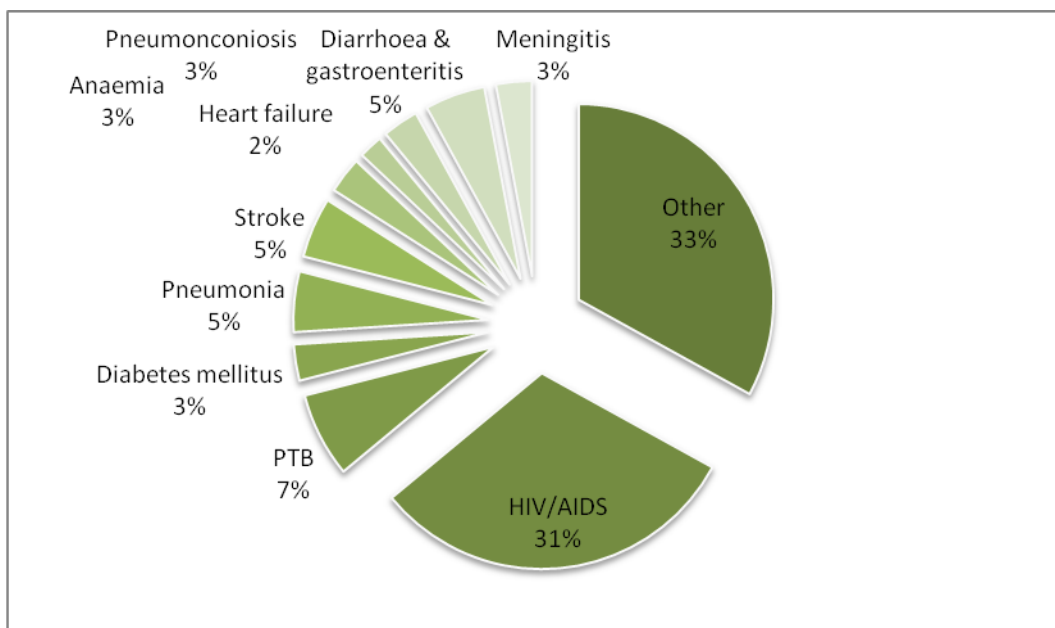


Figure 2 3: Main cause of Adult female death in Health facilities, 2007

(Source: Owusu-Ampomah et al., 2009: 58)

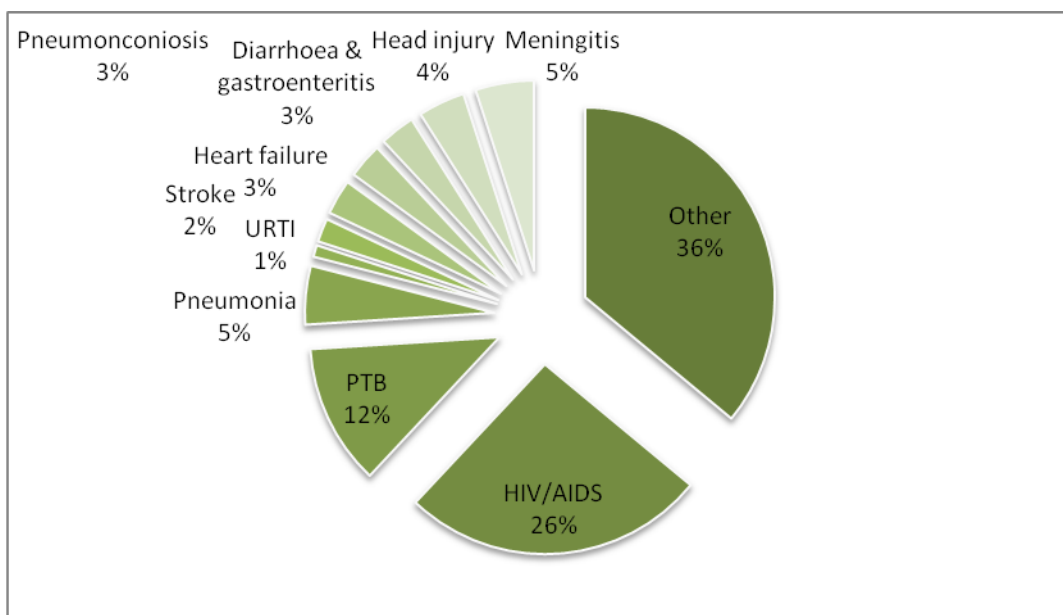


Figure 2 4: Main cause of adult male death in health facilities, 2007

(Source: Owusu-Ampomah et al., 2009: 58)

As shown in the above Figures (2.3 & 2.4), 31 per cent of female deaths in Lesotho are caused by HIV/AIDS, while for men HIV/AIDS causes 26 per cent of deaths. Figure 2.3, shows that the main causes of adult deaths in Lesotho, HIV/AIDS accounts for 27 per cent of deaths among adult males. While, Figure 2.4, shows that 32 per cent of deaths of females

are caused by HIV/AIDS therefore leading to the assumption that female students are more vulnerable to HIV/AIDS in Lesotho.

2.3.1 HIV/AIDS between 15-24 age group in Lesotho

Generally, cases of HIV/AIDS infections among the youth aged 15-24 represent more recent infections, and serve as an important indirect measure for assessing trends in incidence among young people according to several socioeconomic and risk behaviour indicators. One in nine persons aged 15-24 in Lesotho is HIV/AIDS positive (HIV Prevalence and Associated Factors: 242). HIV/AIDS prevalence among young women is 15 per cent while among young men it is six per cent (Bureau of Statistics, 2005: 242). The HIV/AIDS rate's rapid rise within this age group, for both females and males, expose more young people to the possible transmission of the HIV/AIDS virus. According to the Bureau of Statistic (2005: 243) infection rates are higher among young women in urban areas compared to those in rural areas. This translates to the idea, that students at the NUL are more exposed to HIV/AIDS, and therefore probably more at risk of infection. However, with men in urban and rural area HIV/AIDS rates are virtually identical, and clearly lower than those for women; only 15 per cent in the urban areas as compared to ten per cent in the rural areas.

2.4 THE CORRELATION BETWEEN GENDER AND HIV/AIDS

It has been documented that HIV/AIDS infection is higher among women as compared to men. The biological factors, a weak economic base, gender inequalities and poor relationship can account for the high rate of HIV/AIDS infection among women (Seloilwe, 2005: 8). Women's larger mucosal surface makes them more susceptible to the HIV/AIDS infection.

The research *Sub-Saharan Africa: HIV/AIDS on University Campuses* (2001: 188) found that the social life of students on campus and the particular biological vulnerability of female students put female students at risk due to their inability to negotiate for either no sex or safer sexual practices. The synonymous finding in most of the university is the lack of empowerment. Female partners consent under duress to intercourse in order to preserve a relationship, to avoid being beaten, as well as ensure financial support or to repay favours.

Multiple partners are a common factor of high-risk behaviour of both sexes. Women have sex with multiple partners to have, for instance someone who pays for rent, and another one who pays for transport, food and so on (Seloilwe, 2005: 7, 8). While on the other hand, male students consider it prestigious. Kelly (2001:18) suggests that the prevailing climate on

university campuses encourages, and may even be a breeding ground for these factors and thereby facilitates the spread of HIV/AIDS.

2.4.1 Sub-Saharan women and HIV/AIDS vulnerability

Women have become the face of the epidemic in Africa. Economic, social and cultural factors contribute to sub-Saharan African women's vulnerability to HIV/AIDS (UNAIDS, 2006). According to UNAIDS, UNFPA and UNIFEM (2004), women in Africa are particularly vulnerable to HIV/AIDS due to cultural traditions, and their economic dependence on men. The issue is a 'crisis of gender inequality' (UNAIDS, UNFPA and UNIFEM, 2004) because women generally over space and time have always been considered to be the weaker sex, and thereby translated to have less power over their bodies and lives than men (IFRC, 2008: 47). Women, whether single or married, are unable to negotiate the use of condoms, in many African countries including Lesotho. For example, increasing numbers of married women are becoming infected because their husbands visit sex workers; marriage increases the vulnerability of many women to HIV/AIDS. Sexual violence is another major threat to girls and women; rapists and violent partners often do not use condoms.

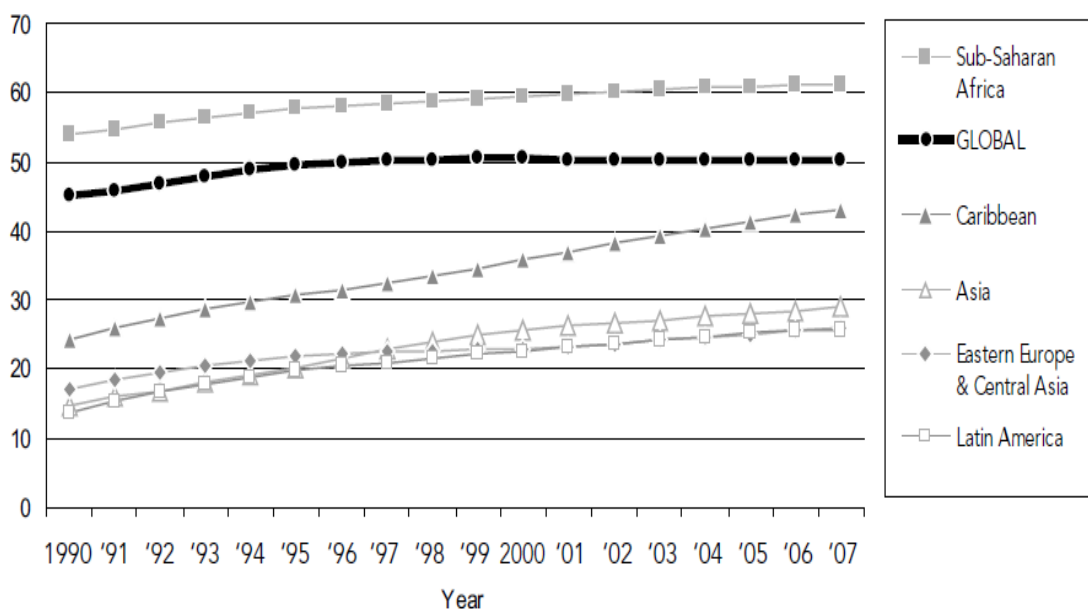


Figure 2 5: Per cent of adult (15+) living with HIV/AIDS who are female (1990-2007).

(Source: UNAIDS. 2007).

Figure 2.5 shows the extent and different levels of HIV/AIDS epidemic among women. Since 1990 the number of women living with HIV/AIDS in sub-Saharan Africa has been the

highest. Subsequently, heterosexual transmission between couples is still the predominant mode of HIV/AIDS spread in sub-Saharan Africa. For the region as a whole, women are disproportionately affected in comparison with men, with especially stark differences between the sexes in HIV/AIDS prevalence among young people. It is estimated that 8.6 million youth are living with HIV/AIDS, of whom two-thirds are female (Jooste, 2009: 3). This figure also relates to the fact that female students and females in general have a significant higher vulnerability to HIV/AIDS in sub-Saharan Africa. This will be further discussed in the following section.

2.4.2. HIV/AIDS vulnerability of women in Lesotho

According to Owusu, *et al.*, (2009: 37, 38), women are more predisposed to infection than men; physiologically females are more susceptible to sexually transmitted infections (STI), including HIV/AIDS. Consider Figures 2.3 and 2.4, with female HIV/AIDS-related deaths at 31 per cent and male at 26 per cent.

Women are also more vulnerable to sexual violence in Lesotho. The recent 2008 Reproductive Health Survey from Lesotho reported that “*about 13 per cent of male respondents and 14 per cent of female respondents say they personally know someone who has been raped in the past 12 months*”. Violence is committed almost exclusively against young females, one in three reported rapes fall within the 15-19 years age range (Owusu, *et al.*, 2009: 38). Socio-cultural practices, such as widow inheritance and polygamy, further increase the risk of exposure to infection.

In addition to abandoned spouses trading sex for additional incomes, intergenerational relationships are an important phenomenon driving the epidemic in sub-Saharan Africa (Owusu-Ampomah, *et al.*, 2009: 42). In Lesotho, sexual intercourse between young girls and much older males is one of the most important factors influencing the spread of HIV/AIDS among young women. The 2004 Lesotho Demographic Health Survey (LDHS) showed that 7.2 per cent of young women (15-19) who had sexual intercourse with a non-married, non-cohabitating partner in the last 12 months did so with someone ten years or older than themselves.

Marriage for women in Lesotho occurs relatively early on in life with one in five girls between the ages of 15-19 being married. Traditionally, women have been dependent upon male family members for economic support and representation. Unable to own or inherit property, women were legally considered minors until the Government passed *the Legal Capacity of Married People's Act* in 2006 (Owusu, *et al.*, 2009: 38). Owusu, *et al.*, continue to argue that

“high rates of prevalence and mortality among women of reproductive age also has serious implications for the health and wellbeing of other vulnerable populations”.

2.5 CONCLUSION

The vulnerability to HIV/AIDS is a global issue and thus affect everybody whether directly or indirectly. Some countries within certain regions are adversely more affected than others, with sub-Saharan Africa and Asia being the most affected. International legislations have been declared to combat the disease to which some countries, including Lesotho conformed. However, vulnerability of a certain group of people to HIV/AIDS varies, depending on the country, and conversely with main mode of transmission in regions.

This chapter provided an overview of HIV/AIDS in countries outside Africa and factors that contribute to students' vulnerability to HIV/AIDS within those countries. The review then proceeds to analyse countries within Africa as well as some universities to depict students' vulnerability to HIV/AIDS in Africa. HIV/AIDS legislations and national policies in selected African countries were identified.

Finally, Lesotho was considered using the availability of information to understand how students at the National University of Lesotho could be vulnerable to HIV/AIDS. This included the laws and legislation declared to fight against HIV/AIDS, and reduce the spread of the epidemic. The following chapter, however, will discuss the vulnerability context of the National University of Lesotho.

CHAPTER 3

VULNERABILITY AND THEORETICAL FRAMEWORK: A CONCEPTUAL OVERVIEW OF PRESSURE AND RELEASE MODEL

“...with grave concern that Africa, in particular sub-Saharan Africa, is currently the worst-affected region, where HIV/AIDS is considered a state of emergency which threatens development, social cohesion, political stability, food security and life expectancy and imposes a devastating economic burden...” (Cohen, D. 2002: 1)

3. INTRODUCTION

The HIV/AIDS epidemic undermines development of Lesotho, by affecting the groups that are the most economically productive. This reduces the capacity of individuals, families, communities and a nation to cope with the complex social, political and economic issues, thus further deepening the conditions in which HIV/AIDS transmission thrives. The different views on vulnerability are reflected in various analytical models and concepts and how to systematize them (Birkmann, 2006: 18).

This chapter focuses on understanding the concepts within disaster risk management using the pressure and release (PAR) model as the main theoretical framework for this research (Blaike, 1994; Wisner *et al.*, 2004:50). The PAR model demonstrates how vulnerability of people is rooted in their social, economic and political processes or underlying causes that create dynamic pressures that transform to unsafe conditions that put the students at risk of HIV/AIDS infection. The model explains how the progression of vulnerability in Lesotho, exposes students to the HIV/AIDS pandemic. It will provide an initial basis to understand the students' vulnerability at NUL and to update relevant future measures to mitigate HIV/AIDS. In addition a conjunction model or theory of HIV/AIDS Vulnerability Pathway is used to deepen the understanding of the vulnerability of the student.

3.1 DEFINING VULNERABILITY

The term 'vulnerability' is used more and more frequently in the areas of social science research into and the prevention of HIV/AIDS (Delor & Hubert, 2000:1557). According to Sinha (2006:1), an event occurring in a given society does not usually mean a disaster but when coupled with the vulnerability of human and environmental condition it translates to a disaster. Vulnerability therefore plays a significant role in the degree of disaster impact. The

higher the impact of a disaster the higher their level of vulnerability, therefore Lesotho with a 23 per cent of national HIV/AIDS prevalence rate is considered high and vulnerable.

Sinha (2006: 122) emphasises the importance of understanding the definition of vulnerability in order to assess risk to a given hazard. Vulnerability is a function of many factors and has been studied by various researchers like Bohle (2001), Turner (2003), and Wisner (2006). The common factor in these researches is that without the knowledge of vulnerability, there is no way risk to a certain hazard will ever be known. That is vulnerability to a certain hazard determines the risk to that particular hazard. According to Bankoff, Frerks and Hilhorst (2004: 71), vulnerability is the propensity to suffer loss and to find difficulties in recovering from a hazard impact (Blaikie *et al.*, 2004: 50). In this case the propensity is to suffer loss due to HIV/AIDS infection to the body, and finding difficulties in recovering from the impact of HIV/AIDS, from lack of capacity to cope and fully recover.

Going further to clarify the arbitrary in defining vulnerability, Prabhas (2006:128) provides a definition given by Timmerman (1981), suggesting that vulnerability is a degree to which a system (NUL) may react adversely to an occurrence of a hazardous event (HIV/AIDS epidemic), and the capacity of the system to absorb and recover from such an event. Based on this definition, Turner *et al.* (2003) propose vulnerability as the degree to which a system, sub-system or component of a system is likely to experience harm due to exposure to hazard, either a perturbation or stress/stressor.

According to Birkmann (2006:38) a system is comprised of factors such as coping and adaptive capacity, resilience, exposure and sensitivity, and the system's ability or inability to recover from the impact of a given hazard. Birkmann continues by suggesting that viewing or understanding vulnerability as "those conditions that increase the susceptibility of a community to the impact of hazards, it also depends on the spatial dimension, by which the degree of exposure of a society or local community to hazard is referred to". However, the common denominator of the above definitions and other definitions not mentioned, is the fact that *vulnerability* can be defined as a loss in a system or within a system, and the system's ability or inability to recover from the impact of a given hazard.

For the purpose of this research, *vulnerability can be seen as the degree to which physical, social, economic and even political makes an individual and community susceptible to the damaging effects of a hazard* (South Africa, 2002; UNISDR, 2008:12). Individuals, households or communities could face vulnerability in the face of a potential hazard (UNISDR, 2008). Vulnerability is an important component of the disaster risk equation and disasters occur only when hazards such as HIV/AIDS hit people or communities which are very vulnerable and which lack resilience (Jordaan, 2008).

3.2 UNDERSTANDING HIV/AIDS VULNERABILITY

HIV/AIDS risks can be defined as a “product” of hazard and vulnerability whereby vulnerability is the least known component of an equation, which may express risk (R) as a function of the hazard (H) and vulnerability (V):

$$R = f(H, V)$$

Thus predicting the hazard (multiple sexual partners, frequency of sex and sex without protection) may not tell the whole story about HIV/AIDS risk, as the underlying vulnerability to the hazard has to be established simultaneously. Hence, risk is a function of the hazard and vulnerability. However, in itself vulnerability is a multidimensional, multi-attributed feature (Bogardi, Damm & Fekete, 2010: 2). It is usually characterized by its social, economic, environmental, physical (body) and institutional dimensions. Bogardi, *et al.* (2010: 2), continues by saying vulnerability implies being exposed to this particular hazard. However, there is an existing inherent vulnerability, irrespective of whether the individual or subject is exposed to a hazard or not (Bogardi, *et al.*, 2010: 2). For example, a person with a compromised immune system is more susceptible than a healthy person, even if none of them is exposed to a hazard. Thus their susceptibility may turn into hazard specific vulnerability once they are exposed to it: say HIV/AIDS. Thus vulnerability (V) is the function of susceptibility (S) and exposure (E): $V = f(E, S)$.

Although, researchers like Birkmann (2006) have generally defined vulnerability to hazards. McCarthy, *et al.*, (2001) contribute by defining vulnerability as a “...degree to which a system is susceptible to and is unable to cope with adverse effects...” to which in this case an adverse effect is constituted by the negative of impact or effect of HIV/AIDS. Having said this, *Disaster Reduction Institute* (DRI) in a report to the *Department for International Development* (DFID) of England (Villagran De Leon, 2006), provided a formula that encompassed the parameters of vulnerability:

$$\text{Vulnerability} = \frac{\text{Exposure} \times \text{Susceptibility}}{\text{Coping Capacity}}$$

In this formulation, Vulnerability itself is seen as a combination of Exposure, Susceptibility, and inversely related to Coping Capacity. In order to determine the vulnerability of a student or students at NUL, there needs to be a combined effort to understanding their exposure to HIV/AIDS, their susceptibility and the coping capacity they need to combat the epidemic. The conceptual depiction of the above-mentioned vulnerability equation will contribute to a wide understanding of vulnerability.

3.3 DISASTER MANAGEMENT AND RELEVANT CONCEPTS

3.3.1 Disaster Management

According to South Africa *Disaster Management Act* (2002:6), Disaster Management is a continuous and integrated multi-sectoral, multi-disciplinary process of planning and implementing measures which aims at:

- Preventing or reducing the risk of disaster.
- Mitigating the severity or consequences of disaster.
- Emergency preparedness.
- Rapid and effective response to disasters.
- Post disaster recovery and rehabilitation.

3.3.2 Disaster

A disaster is often described as a result of the combination of: the exposure to a hazard; the conditions of vulnerability that are present; and insufficient capacity or measures to reduce or cope with the potential negative consequences within a community or society (UNISDR, 2009: 4). UNISDR (2009:4) continues to describe disaster impacts as including loss of life, injury, disease and other negative effects on human physical, mental and social well-being, together with damage to property, destruction of assets, loss of services, social and economic disruption and environmental degradation.

HIV/AIDS is a slow-onset biological disaster (Wisner, 2004:188), which results in loss of life, adversely affecting the human physical, mental and social well-being and subsequently, resulting in the loss of assets, services and disrupting economic as well as environment processes. The intricate nature of HIV/AIDS and its ability to affect every aspect of human environment, makes the poor primarily susceptible to the disease, be they poor nations or poor people living in rich nations (Whiteside, 2008:i). Though there might be some link between HIV/AIDS prevalence and poverty rate through the interface of vulnerability (as shown with regions in Chapter 2, it may not be taken as a causal relationship.

3.3.3 Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome

HIV and AIDS are two interrelated terms, which are often used together as seen in this research. However, it is essential that this research differentiates the term for the purpose of clarity. AIDS is an acronym which stands for Acquired Immune Deficiency Syndrome and it is caused by HIV (Jackson, 2002:3). AIDS is an illness that has been discovered in the early eighties through research conducted by Gottlieb in 1981. AIDS refer to the damage to the immune system of a healthy individual who is infected with the HI virus (Brynard &

Burger, 2001: 175). AIDS is a complex illness associated with different infections and different types of cancer cells. According to Fan, Conner and Villarreal (1998), AIDS is a transferable disease and therefore is viewed as an epidemic, as it is also transferred through blood, sex and/or birth (Brynard & Burger, 2001: 175). The transmission occurs through the HI virus (HIV), an acronym for Human Immunodeficiency Virus, which eventually damages the immune system and develops into full-blown AIDS ultimately resulting in death. No effective cure has been found for this deadly disease. People may be infected with the virus for many years before full AIDS (acquired immune-deficiency syndrome) develops (Wisner, *et al.*, 2006: 185). The time span of HIV transforming to AIDS is depends on the care taken to slow down the process.

3.3.4 Resilience

According to the 2009 UNISDR paper, resilience is said to mean the ability to “resile from” or “spring back from” a shock. The resilience of a community in respect to potential disaster is determined by the degree to which the community has the necessary resources, and is capable of organizing itself both prior to and during times of need. One way to build community resilience is to establish effective social networks (Jordaan, 2008). Unfortunately such social networks within the university is one of the factors contributing to the student’s vulnerability; partly due to economic, social and cultural factors as explained later in this research.

3.4 THE PRESSURE AND RELEASE (PAR) MODEL

The pressure and release model is based on the notion that disasters are an interaction of two major forces: those processes generating vulnerability on one hand, and on the other hand a hazard event (Birkmann, 2006: 29) The PAR model is used in the research and it is explained below:

The PAR model (Figure 3.1) explains the progression of vulnerability in a society and shows that a disaster only occurs when hazards like HIV/AIDS afflict vulnerable groups within societies that also lack coping capacities (Wisner, *et al.*, 2004:50). The pressure in the PAR Model comes from two opposing direction; the hazard direction and the vulnerability direction while the release is how the impacts can be reduced by reducing vulnerability (Wisner, *et al.*, 2004:50). The progression of vulnerability consists of three interrelated parts which shows how dynamic pressures translate root causes into unsafe conditions (Wisner, *et al.*, 2004:50).

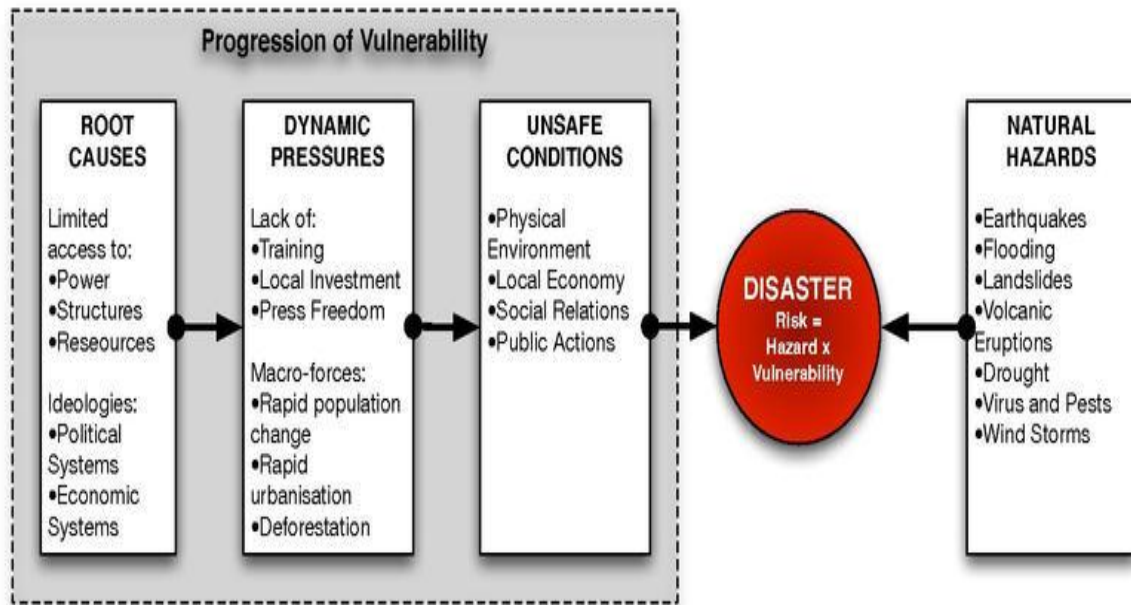


Figure 3 1: The Pressure and Release (PAR) Model

Source: (http://en.wikipedia.org/wiki/Social_vulnerability#Pressure_and_Release_.28PAR.29_Model)

In the following subsections, each component of the PAR model is explained with relevance to the Vulnerability of National University of Lesotho students to HIV/AIDS. The foundation for the pressure and release model (PAR) is the idea that a disaster occurs due to intersection of two opposing forces; with those processes generating vulnerability on one side, and physical exposure to a hazard on the other. Figure 3.1 resembles a nutcracker, with increasing pressure on people arising from either side - from the vulnerability and from the impact (and severity) of the hazard on those people at different degrees of vulnerability. The "release" idea is incorporated to relieve the pressure, and therefore reduce vulnerability (Blaikie, 2006:50).

3.4.1 Root Causes

Vulnerability is not a situation that just happens. Most often, it has developed as a progression from Underlying Conditions, to Dynamic Pressures, to Unsafe Conditions. These underlying or root causes (basic fundamentals and ideologies on which the society is built) answer the question WHY dangerous or unsafe conditions persist (Understanding vulnerability. s.a: 5). The article continues to state that, if the fundamental causes of disaster risk are not addressed, then the disaster situation will soon repeat itself (Understanding vulnerability. s.a:5). The economic, demographic and political processes within a society, over time give rise to vulnerability by their combined ability to determine how people with a society access various resources, as well as how power with the society is distributed

(Blaikie, 2004:52; Birkmann, 2006: 31). Birkmann goes on to suggest that root causes share a close relation to good governance.

3.4.2 Dynamic Pressures

These are elements or factors within the society that are immediate causes of the unsafe conditions. They are processes and activities that have 'translated' the effects of root causes into unsafe conditions, thereby answering the question of HOW unsafe conditions have arisen (Understanding vulnerability. s.a:5).

3.4.3 Unsafe Conditions

These are the vulnerable contexts where people are exposed to the risk of disaster, which makes the community vulnerable to a particular hazard such as HIV/AIDS. In addition, there are factors like an unstable economy and low-income levels, having to engage in dangerous livelihoods (unprotected sex) or having minimal food entitlements, and so on (Understanding vulnerability. s.a:5).

3.5 WHY PRESSURE AND RELEASE MODEL?

There have been a number of models developed for the purpose of assessing vulnerability in disaster management that could be used to explore, describe and explain the vulnerability of students at the national university of Lesotho to HIV/AIDS. For example, one of these models is the Bohle Model (Villagran De Leon, 2006), which explains the relationship between vulnerability, coping capacities and assets (economic, socio-political, infrastructural, ecological, and personal). The opposing sides of the model depict the external sides of vulnerability while the internal side relates to coping capacities. The model suggests the higher the assets people control, the lower their vulnerability (Villagran De Leon, 2006:14). However, the model does not really give guidelines on factors or indicators to identify; in addition it may be considered to be more appropriate in case of crises and conflicts.

On the other hand, the Turner Model gives suggests of indicators to assist as guidance for vulnerability assessment. The model proposes the notion of vulnerability as the degree to which a system or sub-system, or system component is likely to experience harm due to HIV/AIDS via exposure (Villagran De Leon, 2006:16). Turner's concept of vulnerability incorporates multiple disturbances which emanate from human and natural environment (Villagran De Leon,. 2006:16), indicators developed to determine exposure, sensitivity and resilience level within a given place, region or world. However, as relevant as this model could have been to the research, Lesotho does not have sufficient quantitative data necessary to develop such indicators for the analysis.

Another model regarding vulnerabilities is the Birkmann and Bogardi Conceptual Model (BBC model) developed by Birkmann and Borgadi (2004). The model uses three types of vulnerabilities (economic, social, and environmental) as well as aspects of coping capacities and exposure proposed by Chamber and Bohle (Villagran De Leon, 2006:17). Villagran continues to suggest that understanding of vulnerability in the model is with the idea that socio-economic system vulnerabilities is on the one hand while on the other hand environmental vulnerabilities. Assessing these two simultaneously shows a close link to the debate of vulnerability within the *climate change community* (Villagran De Leon, 2006:17). This model does not, however, include physical vulnerabilities which lead to economic losses, somewhat significant to HIV/AIDS. HIV/AIDS cannot be considered separate from the physical vulnerabilities (exposure and susceptibility) of the individual, leading to deterioration of the bodily strength and thereby leading to economic loss over space and time through sickness and death, only and only if the level of coping capacity is low.

An additional model to the above-mentioned model is the Pressure and Release (PAR) model. The model defines vulnerability as a characteristic of a person or people in relation to their capacity to anticipate, cope with, resist, and recover from the impact of a hazard (Vilagran De Leon, 2006:18). The model proposes the progression of vulnerability associated with the root causes, dynamic pressure, and unsafe conditions. The strength of the model lies not only in the capacity to define the vulnerability of people, but also to explain its generation through the three step process.

The PAR model helps identify the connection between the risks students of NUL face and the reasons for their vulnerability to HIV/AIDS. The model shows how HIV/AIDS is perceived within the broader patterns of society and how analysing it within the content of the progression of vulnerability will provide an efficient and effective understanding to develop policies that can help to reduce HIV/AIDS and mitigate other associating hazards, while at the same time improving living standards and opportunity more generally (Blaikie, 2006:4).

Although the PAR Model is used in the research as the main theoretical framework, the inter-disciplinary and multi-sectoral nature of the disaster risk management discipline as well as the nature of the research topic makes it difficult to use only one model to address the research problem and the research questions. Consequently, the researcher also uses the HIV/AIDS Vulnerability Pathway as a sub-model to elude the physical vulnerabilities of the student to HIV/AIDS by understanding or identifying their susceptibility and resilience within the community that determines infection and also rate of deterioration.

By incorporating both models, the researcher is able to map out not only the unsafe condition of the student, but also to show progression of vulnerability down the line. The Vulnerability Pathways Model discussed below provides for this information.

3.6 HIV/AIDS VULNERABILITY PATHWAYS

The idea behind HIV/AIDS vulnerability pathway is to explain the individuals' process of exposure to HIV/AIDS, their levels of susceptibility and their coping resilience, which ultimately determines their vulnerability. This model was developed in 2003 by Clare Bishop-Sambrook, to provide a practical framework, which reflects vulnerability at different stages of HIV/AIDS. The vulnerability pathway model emphasises the time dimension of the epidemic as well as paying attention to the upstream susceptibilities to HIV/AIDS which influence entry into the HIV/AIDS pathway (Sambrook, 2003:1). Various concepts within the scientific field have been developed to explain the stages to which HIV/AIDS transfers and transmit within the human body, with little being done on the social science department. However, looking at vulnerability to HIV/AIDS all these factors have to be assessed to gain an insight into the root causes.

There are two one-way gates within the process of vulnerability to HIV/AIDS. Firstly, infection with HIV virus and secondly, AIDS related death of the students (Sambrook, 2003:2) as seen in Figure 3.2. The rate at which individuals or students pass through this process or even begin the process depend on various factors which are not discussed here, but determined in Chapter 4. These factors influence their susceptibility, and coping capacity to HIV in (Gate 1), and their subsequent vulnerability to HIV/AIDS through (Gate 2), tempered by their resilience.

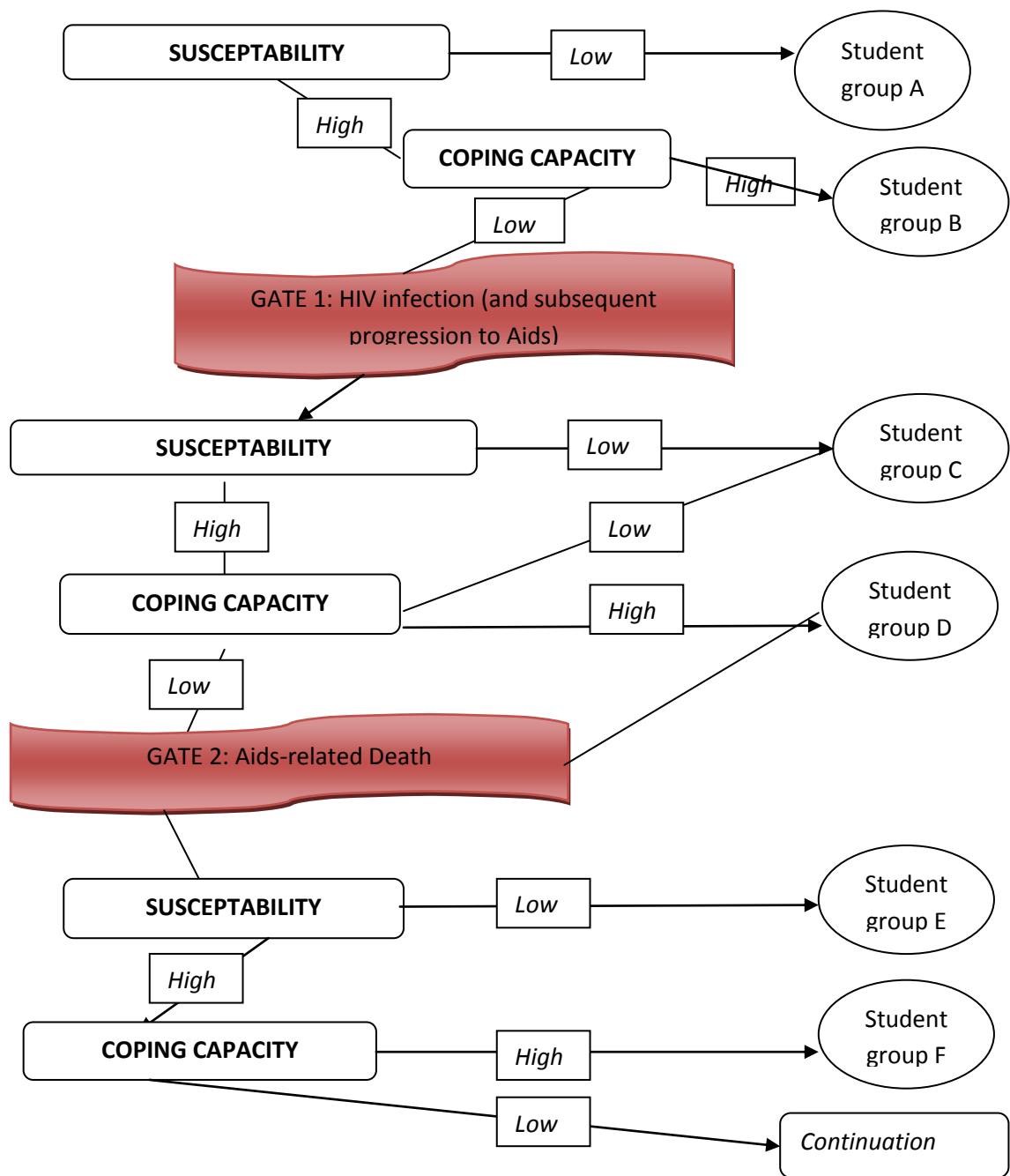


Figure 3 2: Vulnerability Pathways Model
 (Source: Sambrook, 2003).

The diagram (Figure 3.2) is used to map the progression of HIV/AIDS vulnerability among the students, with various factors interacting within each dimension. Factors like HIV/AIDS prevalence, access to services, cultural practices and beliefs, and so on contribute to the level and rate at which individuals or communities pass through Gate 1 and 2, if ever they do.

3.6.1 Gate 1: HIV infection (and subsequent progression to AIDS)

According to Sambrook (2003:4), the stage before the Gate 1, contains different contexts to which individuals are at risk of contracting HIV/AIDS within the community. This includes their decision to engage in unprotected sex, the level of morbidity, cultural practices linked to sexual activity, and so on (Sambrook, 2003:4). If the susceptibility of individual(s) is high they tend to fall away from the pathway without HIV infection (Group A), while individuals in Group B fall away due to their high susceptibility and resilience.

Within the same environment or community individual(s) with low susceptibility have a high risk of contracting HIV/AIDS. Although, these individuals are exposed to the same risk, factors like HIV/AIDS awareness and understanding, behavioural patterns (such as abstinence, number of partners, and age at first sexual encounter) can define their level of resilience. The set of individual with a high resistance follow to fall out of the pathway and become sub-group B. While, low resistance individuals continue down the pathway and contract HIV/AIDS.

After contracting HIV/AIDS, individuals can either continue down the pathway due to high level of susceptibility and low level of coping capacity within the community or they can fall away to group C and D. Even though, these groups are temporarily out of the pathway, they can within time and space, journey back to the pathway and develop AIDS. However, factors like diversity of livelihood strategies, attitude towards people living with HIV/AIDS, access to quality service and so on, affect the level of resilience and susceptibility (Sambrook, 2003:5&6).

3.6.2 Gate 2: AIDS-related Death

The level of susceptibility within and through Gate 2 is usually due to cumulative effect of factors from Gate 1. Factors such as, balance of power relation, nutritional intake, HIV/AIDS education, attitude of individuals and so on determines if the individual will fall away to Group E and prolong the inevitable death. Even though, Group E falls out of the pathway, the period at which the immune system deteriorates is only longer than that of Group F but AIDS-related death is inevitable. This model coupled with the progression of vulnerability helps to understand the factors and rate at which the NUL students are exposed, susceptible and resilient to HIV/AIDS.

3.7 HIV/AIDS VULNERABILITY ASSESSMENT OF STUDENTS

Vulnerability assessment involves first identifying all the elements which may be at risk from particularly, HIV/AIDS, which in this case are the students at NUL. Thereafter local knowledge and census data may be used to complete the inventory.

Many aspects of vulnerability cannot be described in monetary terms, such as personal loss, loss of family and friends, home, income and related human suffering and psychosocial problems due to HIV/AIDS, but these are the focus of this research as they contribute to loss of functions in the community. It is therefore important to obtain information for some elements at risk (people) based on past experience elsewhere.

Since HIV/AIDS do not have a cure as yet, much of mitigation work should be centred on reducing vulnerability to control the epidemic. Risk is compiled from hazard and vulnerability data and from the inventory of elements at risk. The importance a community places on the risk of a hazard is likely to be influenced by the types and level of other everyday risks it faces. For example, NUL staff and students living within the NUL communities are regularly afflicted by HIV/AIDS and do not perceive disaster mitigation to be a priority. The perception of peoples' risk to HIV/AIDS will contribute to their vulnerability and ultimately their susceptibility to HIV/AIDS.

Risk is perceived differently by different individuals and different groups. Those with regular access to news media are likely to be more aware of the risk in their environment that they face than others, but they may, as a result, overestimate the likelihood of uncommon risks within their community. The acceptability of a level of risk to individuals and societies appears to increase with the benefits that are obtained from exposure to it, and to be much greater where exposure to the risk is voluntary (as in sex) than where it is involuntary (Reed, 1997:12). For HIV/AIDS risks, mitigation can only be handled at the level of the community because the exposure of the community may be greater than that of the individual, and because protection often requires collective, sometimes large scale action (Reed, 1997:12).

3.8 RISK FACTORS OF HIV/AIDS VULNERABILITY AND STUDENTS

Disasters are a product of the interaction of vulnerability of a population and hazard events. The reason for a student vulnerability assessment is to help determine their vulnerability to HIV/AIDS disaster, and to identify steps that can be taken to remedy the situation. A disaster is a compound function of a hazard together with the number of students characterized by their varying degrees of vulnerability to that specific hazard, which occupy a space and time exposed to the hazard event (Blakie, 2006:49). For example, if students at NUL are under

considerable peer pressure to engage in sexual activities and have received no sexual education from school, they are most likely unaware of the risks of HIV/AIDS.

HIV/AIDS vulnerability depends on individual behaviour. Cognitively, individuals are perceived to make rational decision when presented with choices. These choices are made by rational actors depending on the expected consequences. For example, the consequences of HIV/AIDS infection, was the psychological catalyst and force behind the dramatic reduction in multiple partnership and historically unprecedented decline in HIV/AIDS prevalence in Uganda (Wilson & Halperin, 2008: 3).

On the contrary, some human decisions are influenced by dimensions of vulnerability. The social, physical, environmental and economic factors contribute to the domain in which the disease occurs. These dimensions or factors can be said to be the underlying characteristics that translate into the compromised situation. As discussed in Chapter 2, HIV/AIDS vulnerability is driven by deliberate human action that reinforces self-interest and the distribution of power in addition to interacting with physical and social systems. Hawkins and Hussein (2002:s.a), state that, vulnerability in the context of HIV/AIDS means being able to exercise little or no control over one's risk of acquiring the HIV/AIDS virus infection or for those already affected by HIV/AIDS, to have little or no access to appropriate care and support (Tango International, 2003:3).

Among these four dimensions, the social and economic factors can be said to be by far the most contributing to the epidemic prevalence within a given society. According to TANGO International (2003: 3), poverty drives HIV/AIDS epidemics, while HIV/AIDS in turn prolongs and deepens poverty, making it harder to escape from deprivation. Although, it affects both the rich and the poor, the poor face the most severe impact. The poor mostly do not have the capacity or power to access remedial solutions to the infection. Adequate nutrition to boost the immune system is usually not available; they just live from hand to mouth. Also Antiretroviral (ARV) drugs are usually given out for free by the government if one's CD4 counts are less than 250. That is given to those whose infections are worse off. Thus, an individual can reduce his/her vulnerability if he/she has enough wealth to purchase ARV drugs and eat healthily.

This is further supported by discussion in Chapter 2, where it was argued that countries such as Swaziland (38.8 per cent) and Lesotho (28.9 per cent) have one of the highest HIV/AIDS prevalence rates in Africa. In contrast in Europe, Ukraine is considered to have the highest HIV/AIDS prevalence with an adult rate of only 1.6 per cent (AIDS Epidemic, 2009: 48). Vulnerability is not synonymous with poverty, though closely related. The poor are usually the most vulnerable in adverse event, but not all those who are vulnerable to HIV/AIDS are

poor. The epidemic is more pronounced in poorer and developing countries. Therefore wealth reduces vulnerability of individuals and a nation. The resources are not purely financial: they may be access to care or a strong, cohesive and compassionate civil society (Barnett, *et al.*, 2006: 179).

Kher (2008:6), expresses that HIV/AIDS and the risk-behaviour associated with it, is mediated by socio-cultural context while the political and economical factors of a society shape sexual interactions. For instance, certain circumstances give rise to sexual interactions, the type of partners and sexual practices used, and the power relations that define these interactions (Gillepie, *et al.*, 2007: 2). Power relations within a certain society are of critical issue in determining, for example, cultural restrictions against women.

Typically most Africans have extremely poor access to public services. Therefore, National AIDS Programmes that focus on public health interventions based on functioning public services have, unsurprisingly, unimpressive outcomes. This needs emphasising, since it is yet another example where the abnormal state with respect to functioning, public services and public administration in most African countries have been woefully inadequate for many years. In part, the way forward for more relevant and effective programmes for HIV/AIDS is dependent on a generally restructured and better-funded set of public services. Yet simultaneously, the epidemic is systematically eroding human and organizational capacity, so that conditions are worsening rather than improving. Typically, key public services such as primary health care and education are characterized by extremely poor provision and low quality. This reflects overall resource constraints, as well as corruption, and the misallocation or theft of resources, and it is also an indicator of government priorities.

3.8.1 Immediate drivers of HIV/AIDS in Lesotho:

- *Multiple and concurrent sexual partnerships:* A number of cultural, social and economic factors result in high levels of multiple concurrent partnerships meaning that individuals may have two or more ongoing sexual relationships. For men, having different partners can be sign of virility. For women, different partners can assist with various social or economic needs. A high frequency of concurrency leads to highly interrelated sexual networks. Such networks are easily permeated by HIV/AIDS once one partner begins to infect another.

- *Low levels of consistent and correct condom use:* Recent work with youth (15-24 years) has shown continued reluctance to use condoms in sexual relationships, particular for adolescents who are in the early stages of becoming sexually active.

Other factors include social meanings around condom use in that it is often interpreted as signifying sexual infidelity or lack of trust.

- *Poverty and unemployment:* The search for employment and the struggle to maintain a sufficient source of income leads to high rates of migration, both across Lesotho and to a neighbouring country. Spouses spend long periods of time living apart. Women are often left in homes and villages to care for families and to search for additional income. This may involve engaging in sexual relationships in order to receive additional support for practical needs like food, transport or social protection (transactional sexual relationships).

3.9 CONCLUSION

This chapter discussed the concepts of vulnerabilities, by understanding the similarity in different models and accepting the differences. The chapter continued by illustrating the disaster management continuum and the vulnerability pathway models that will assist to determine the resilience and progression of vulnerability of the National University of Lesotho to HIV/AIDS, and to factors contributing to prevalence rate.

Relevant disaster management terms were defined for a better understanding of the concept disaster management. Owing to the fact that vulnerability models are not always 100 per cent effective in proving or disproving hypothesis, they should be used together with other models; the relevance of the PAR model was presented. For clarification purpose, factors of risk and vulnerability were also eluded. The next chapter will present the findings of the research and these findings will practically be applied to the theoretical framework

CHAPTER 4

PRESENTING THE RESULTS OF EMPIRICAL INVESTIGATION

“Each year, more and more people die from the HIV disease and it is the stigma and misinformation around HIV that is killing people” Juan Manuel Suarez del toro, president of the International Federation of Red Cross and Red Crescent Societies, 2003.

4. INTRODUCTION

The chapter provides an overview of the methods and procedure used for the empirical investigation as well as the presenting the results of the study. The empirical investigation is based on the literature study, research objectives and research questions to explore the various factors that contribute to the vulnerability of students at the National University of Lesotho, within the context of disaster management. The study investigated possible effects arising from water scarcity like development, environment, economic, health and social aspects.

This chapter focuses on the social and economic characteristics of the respondents who participated in the research, their attitude, the available resources as well as problems encountered regarding their understanding, coping capacity to the management of HIV/AIDS and particularly female students' vulnerability to HIV/AIDS epidemic.

4.1 RESEARCH DESIGN

Research design is the strategy on how to tackle the central research problem and provide an overall structure of the procedure followed by the researcher (Leedy & Ormond, 2001:91). The empirical research requires that quantitative and qualitative methods are used in order to have a full overview of the study area and the objective of the research.

4.1.1 Methodology for literature study

The nature of the study required that both national and international sources be consulted. The research looks at HIV/AIDS, which is considered to be a health problem through the disaster management perspective. The literature review was guided with the intention to identify factors that contribute to HIV/AIDS vulnerability, with the PAR model guiding relevant information. The literature was therefore organized around the vulnerability of HIV/AIDS from the global perspective to sub-Sahara Africa, and finally specifically focusing on Lesotho and National University of Lesotho.

4.1.2 Methodology of empirical investigation

For the purpose of the empirical part, both questionnaires and interviews were carried out to establish the factors that lead to the HIV/AIDS vulnerability of the students at the National University of Lesotho, and to identify the gaps that could be filled in order to make recommendation. However, due to financial and time constraints, the information that was collected was limited. Besides that, HIV/AIDS is a very sensitive and difficult issue in Lesotho, which restricted the honesty and willingness of people to freely talk. For this reason most of the empirical study was concentrated on questionnaires and complimented by interviews and secondary data.

4.1.3 Sampling technique

Sampling is defined by De Vos, *et al.* (2005:193), as taking the population and considering the sample that will represent that population. De Vos, *et al.* (2005:195) continue to say that the golden rule in sampling is that the sample chosen should be significant enough to represent the entire population.

With this in mind, the researcher administered 100 questionnaires with both closed and open-ended questions to randomly selected students. In order to fully capture the dynamics of the students within the university, the questionnaires were administered in lecture rooms, the library, leisure points of students as well as randomly identifying students on the streets. This was done in the morning and throughout the day for a period of five days. The two counsellors at the National University of Lesotho were identified and interviewed, along with the Dean of student affairs. In addition a group of five students, consisting of two males and three females were interviewed to supplement the questionnaires.

Moreover, an observation method was used, in order to analyse the environment and social activities of the students from when the researcher was a student. The local bar was visited and students observed.

4.3 PRESENTATION OF RESULTS AND DATA ANALYSIS

From the questionnaires administered, 52 per cent were males and 48 per cent females between the ages of 18-39 years old. Of the students 92 per cent were between the age of 18 – 24 while six per cent fell within the 30 -39 age group and just two per cent below the age of 18. This suggests that most of the findings will show the vulnerability of students of the 18 – 24 age group, identified as the vulnerable group.

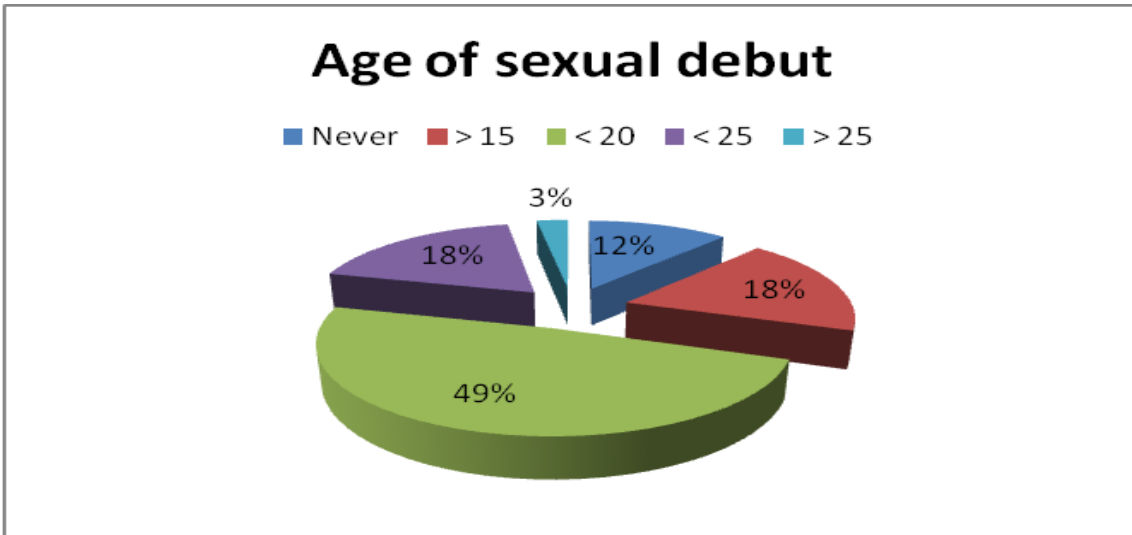


Figure 4: Age of students at the first sexual experience

The students were asked to indicate their age when they had their first sexual-experience; the earlier they started having sex the longer their exposure to sexual disease and the less likely they will fully understand the magnitude of risk involved. For example, the younger a woman begins penetrative sex, the greater her risk of infection due to the danger of tearing of the vagina (Whiteside, 2008:44). According to Figure 4, 49 per cent indicated they were less than 20 years old at the time of their first sexual experience. Since 92 per cent of the students were 18-24 years of age it suggested that the majority of the student started having sex before they started university. Only 12 per cent of the students indicated that they currently had not had their first sexual experience.

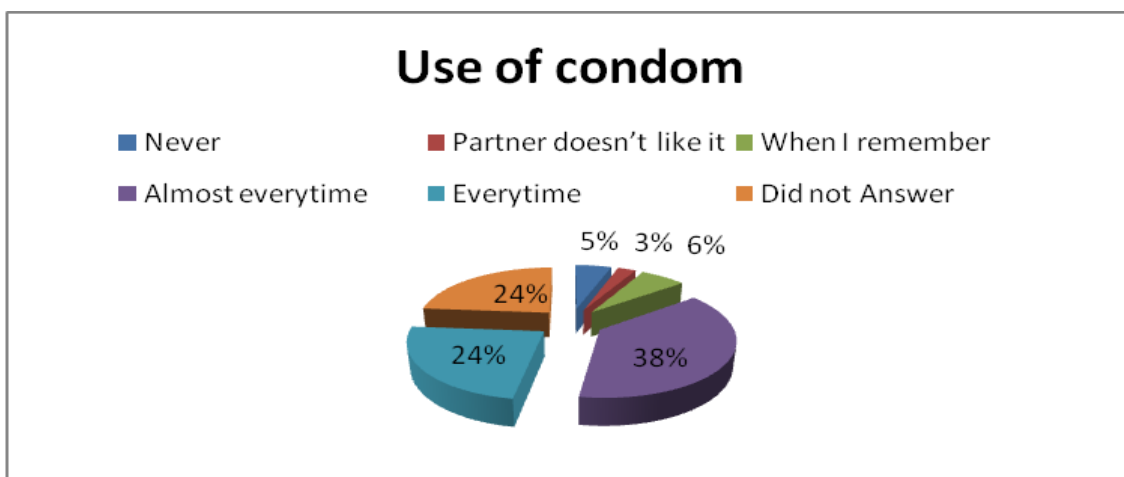


Figure 4. 1: How often students use condoms during sex.

The students were asked to indicate how consistently they use condoms during sexual intercourse (Figure 4.1) and only 24 per cent replied that they used a condom every time.

Approximately 38 per cent indicated that they used one almost every time, and only five per cent said they never did. Moreover, the students were asked, if they had ever had sexual intercourse and 83 per cent answered “Yes” and 13 per cent said “No”. However, only 30 per cent of the 83 per cent indicated that they “always” use condom. This suggested a significant number of students are exposed to HIV/AIDS.

Consequently, when asked the question if they ever had sex, 12 per cent indicated that they never had sex. Although, out of this 12 per cent who had previously said they had never had sexual intercourse, four people indicated, “My partner doesn’t like it.” When asked “How often do you use condom?” suggesting that there is an inconsistency, in the truthfulness of some of the students. However, only three per cent of the total sampled students indicated that their partners did not like the use of condoms during sexual intercourse.

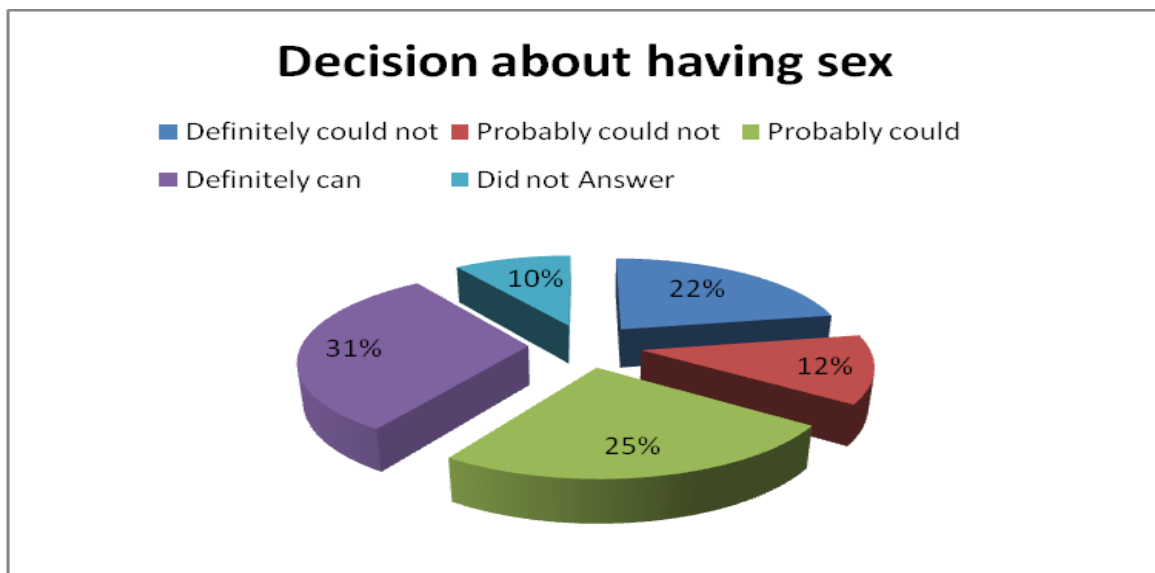


Figure 4. 2: Confidence of students to refuse sexual intercourse.

About a third of the students had the confidence to refuse sex, see Figure 4.2, if they did not want to have any – the biggest share of all the options. The ratio of male to female in this percentile is 1:1.5, indicating both sexes can refuse sex if the need arises. However, the ratio of male to female is 1:2, within the 22 per cent of students that are not able to refuse sex, suggesting that men are more sensitive when it comes to their capacity in the face of risk. The 25 per cent of the students who believed they could refuse sex were at a ratio of 1:1. Their replies could also mean they have not tried to do so in the past. The 12 per cent who answered ‘probably could not’ have a ratio of 2:3 male to female.

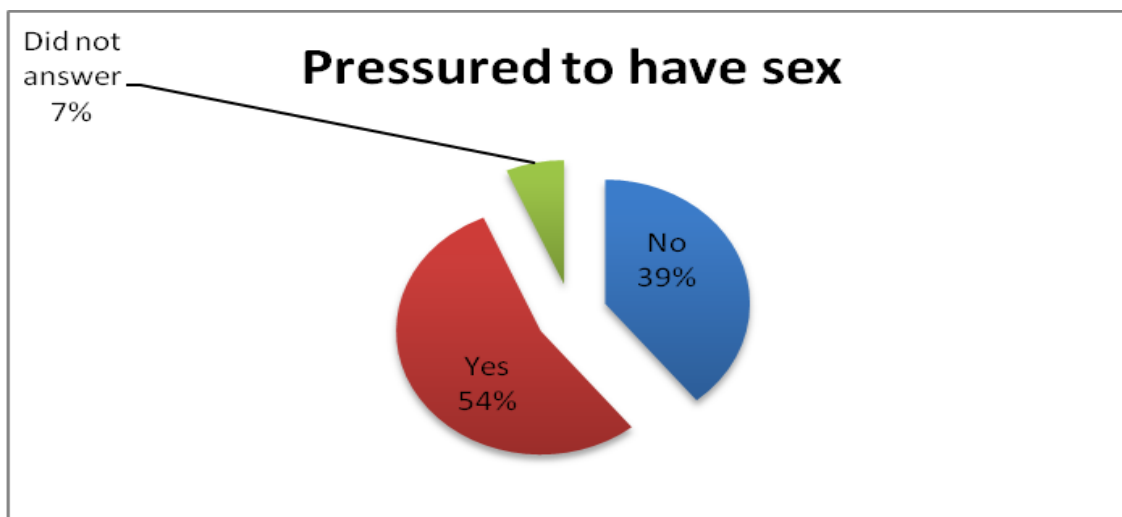


Figure 4. 3: Percentage of student pressured to have sexual intercourse.

More than half (54 per cent) - 30 male students and 24 female students - have been pressured to have sex by their friends and or sexual partners before as seen in Figure 4.3. This means that to an extent peer pressure determines when more than half of the students have sex.

Therefore it can be reasonable concluded that the students are highly exposed and susceptible, with 29 percent prevalence rate and 24 per cent of students never use condom, 22 per cent definitely could not and 54 per cent are pressured to have sex

4.4 STUDENTS' PERCEPTION OF HIV/AIDS

The students were asked if they had tested for HIV/AIDS that year and only 30 per cent had gone for tests. In addition, the students were asked if they would tell anyone if they were HIV/AIDS positive and 62 per cent replied that they would not tell anyone. That was further confirmed by the fact that they were aware of the stigma and discrimination around the disease. Furthermore, the students were asked if they knew a student at the university who was HIV/AIDS positive. Of the students, 67 per cent knew another student who had been affected, as indicated by Figure 4.4.

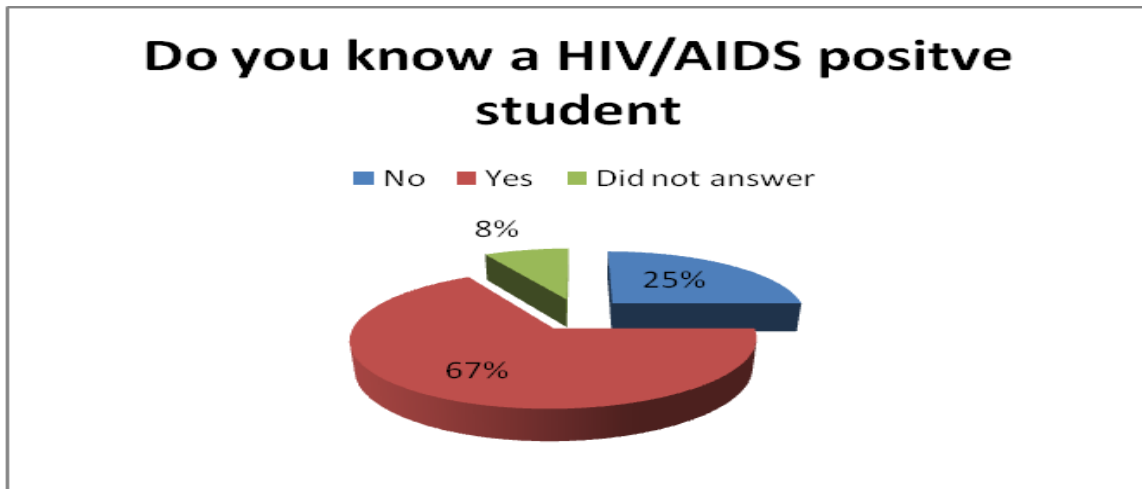


Figure 4. 4: Percentage of students who know an HIV/AIDS positive student at NUL

From the 100 students, only 37 per cent of the students said their friend or friends accepted their HIV/AIDS positive status after they had found out. These students reported their that friend(s) continued living a normal life with the support from friends and family, as well as eating healthy food and diligently taking their ARV medication.

On the contrary, all the other comments were negative, with the infected student depressed and feeling rejected by friends and society. The respondents said, their friends had lost hope in life with no possibility to get married or have children. Some of the students recorded that their friend(s) was (were) constantly emotional and ill; while others indicated that their friends had low self esteem and were always stressed. However, ten per cent of students indicated that their counterparts did not care and were on a rampage to spread the disease further.

Lack of knowledge and understanding of the disease is a problem, especially when the majority of the students feel that HIV/AIDS is a “death sentence” that will be executed within a short period of time. Regardless of the awareness and fear of HIV/AIDS presence in the university, 20 per cent of the respondents will not buy their own condoms, as shown in Figure 4.5 below.

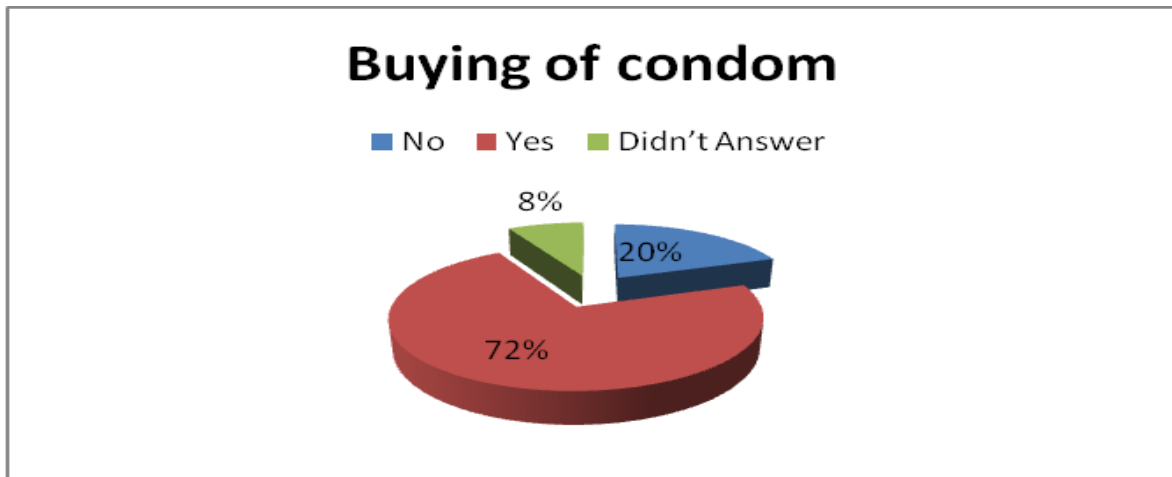


Figure 4. 5: Percentage of students that will buy their own condom.

This means 20 per cent of the students depend on their sexual partner to have a condom and 70 per cent of the students would buy their own condoms of which the majority are male students.

The monitoring of some programmes implemented is a problem. In 2002 through to 2004, free condoms were distributed and available in public toilets within the campus as well as in some hostels and the library. Owing to negligence this gradually phased out and now only occasional 'Know your Status' campaigns on the university premises provide free condoms to students.

In 2004, Lesotho became one of the first countries in the world to launch a nationwide effort to test its entire population for HIV/AIDS. The initiative was introduced as the 'Know Your Status Campaign' (KYS). The campaign's objective was co-ordinated by the Ministry of Health and Social Welfare (MOHSW), and supported by partners such as the United Nations (UN). The role of mainly WHO, UNICEF and UNDP was to ensure that all Lesotho citizens over the age of 12 years were offered an HIV/AIDS test by end of 2007. However, only 30 per cent of the students tested for HIV/AIDS and only about 40 per cent knew their status.

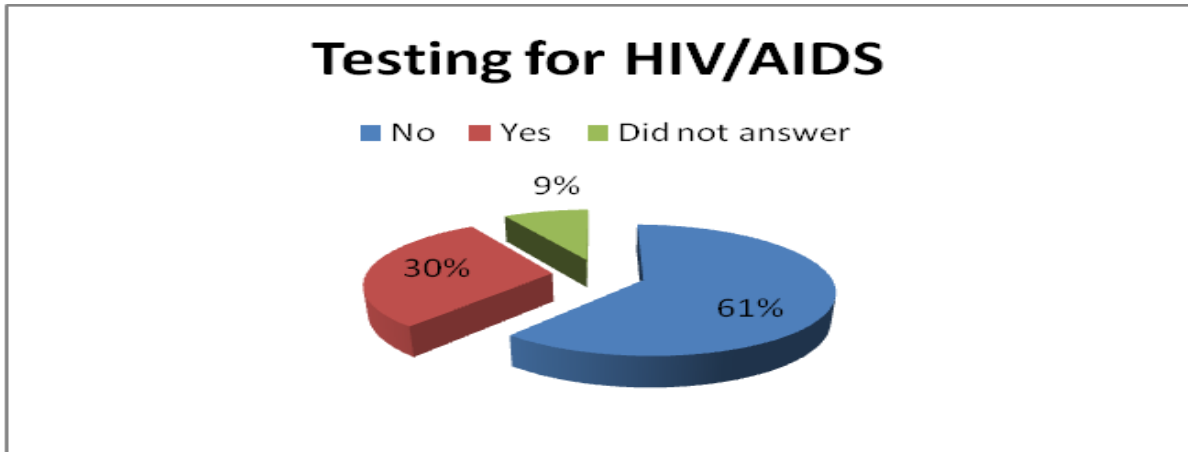


Figure 4. 6: How many students took an HIV/AIDS test

This could be due to the fact that most of the women find the counsellors at the University to be insensitive and judgmental when it comes to HIV/AIDS testing. In this regard, Kelly (2001:28) notes that members of the university community may avail themselves of other medical facilities, when these are within easy reach, fearing that information on their HIV/AIDS status might not remain confidential at the university facility. On the other hand, during an interview, the researcher found that that the interviewees are of the impression that the University students are not serious, and are reckless when it came to sexual activities, “they have sex with each other anyhow, drink and have no need to attend class the next day”.

There is a student bar within the university campus as well as right across the university gate called Casey’s, which the majority of the students visit frequently, especially over the weekend. “... *that place is the point where they all go to find who they will have sex with after drinking themselves useless*”, the other counsellor mentioned. The university clinic can be considered inadequate for the large number of students. There are only nurses in the clinic with a visiting doctor, who is hardly ever around and most of the students commented on the ineffectiveness of the clinic. When asked “How the university clinic had helped?” a significant number of students said, “paracetamol” was the only drug the nurses knew.

For example, at the National University of Lesotho (NUL), the Dean of Student Affairs’ records reported over 30 student deaths from January 2002 to March 2005 from “natural causes”. These natural causes are usually tuberculosis, the most common HIV/AIDS-associated opportunistic infection in Lesotho, and often considered a double epidemic in cases of infected people. However, in Lesotho, as a result of a general unspoken or documented rule, people do not mention HIV/AIDS in a health file as cause of death. The counsellors reported three student deaths due to AIDS-related causes over the past year.

The health centre's administrative or management records were often, when available, incomplete or did not mention HIV/AIDS. The aggressiveness met by the staff members in collecting data was also partly due to lack of HIV/AIDS information availability and management.

Most of the students, when asked whether the HIV/AIDS programmes within the university had helped, gave a negative response and 11 students did not even have any knowledge of HIV/AIDS programmes at the university. Twenty-three students reported not being interested in available programmes or activities. The attitude of some of these students could be associated with the denial of the presence of HIV/AIDS at NUL. Even though the regular distribution of condoms had phased out due to poor management, at the entrance of the university there is a billboard sign with "Know your status", campaign orchestrated by the MOHSW, see Figure 4.8.



Figure 4. 7: A billboard in front of the NUL gate to promote safe sex

In addition, about 32 of the students suggested that the available programme created awareness on HIV/AIDS and helped them to make a more informed decision about sex being monotonous, made them test for HIV/AIDS and to be more cautious about having sex. Consequently, some students noted the ineffectiveness of the activities and programmes, and the lack of creativity of the activities. "They come and sit in a tent and ask people to come and test for HIV, I don't want to find out in front of everyone that I am HIV positive"

said one of the students interviewed. The stigma and discrimination within the university, has made some students reluctant to test and find out their status.

4.5 NATIONAL UNIVERSITY OF LESOTHO HIV/AIDS MANAGEMENT

According to one of the interviewees, the University's HIV/AIDS budget in the 2010 academic year was not met, due to uncoordinated efforts and lack of motivation. The NUL University has a *Wellness and Counselling Centre*. The ineffectiveness of the centre led to an establishment of NUL HIV/AIDS Coordinating Committee in 2002, and to implement the efforts of this committee the former Vice-Chancellor, Dr. Tefetso Mothibe, established a HIV/AIDS office at the institution in June 2003. From the outset, however, the Committee's activities were hampered by the voluntary status of its members. A new committee was constituted in 2004. Thereafter nominations were sought through faculties, departments, and Student Representative Council (SRC), and the response was more positive. Yet NUL has not yet fulfilled a coordinated and purposeful HIV/AIDS response.

Since 2003 the NUL HIV/AIDS Office, somewhat hampered by a lack of resources, has managed to initiate training for peer educators and has organized HIV/AIDS workshops for students and staff. NUL has also been in negotiation with staff from the Centre for the Study of AIDS (CSA) at the University of Pretoria, to initiate the expansion of the CSA's Future Leaders @ Work (FL@W) peer education programme to NUL under the Beyond Borders regional initiative. One of the counsellors noted that students could participate in HIV/AIDS related activities by enrolling in any of the student group activities coordinated by the NUL HIV/AIDS Coordinating Office. However, only a few students did.

The anti-AIDS student groups (The NUL HIV/AIDS Coordinating Committee, Peer Guidance Educators) are active on the NUL campus and had taken the lead in organising events commemorating World AIDS Day, a successful event transpired in 2004. The 2004/2005 orientation programme included a brief component of HIV/AIDS information, and it was planned for more life skills information to be included in the orientation programmes of subsequent years. However, NUL offers no VCT or HIV/AIDS-specific counselling and treatment services, although there is a clinic situated on campus staffed by three nurses, focusing on the general health of the students. The Centre provides health care services geared towards preventive and curative treatment as well as health education and counselling (National University of Lesotho, s.a). The students are offered sick leave and it is usually recommended by the campus nurses. Sick leave recommendation should be communicated in writing to the Dean of Student Affairs. The consultation fee (R15) is relatively affordable for the students. The centre is known to the majority of the students.

However, the unfriendliness of the staff seems to be a drawback and discourages most students, especially when it comes to HIV/AIDS related issues.

The Counselling Centre is tasked with disseminating information based on life and decision-making skills, and support to the students. The Counsellor's role is to help students gain control of their lives, and strengthen their ability to react in a responsible, constructive manner in order to support their development and well-being without being destructive to their peers.

4.6 SOCIAL ACTIVITIES AT THE NATIONAL UNIVERSITY OF LESOTHO

The students usually gather every Friday after classes at the local bar, restaurant and club, for social interaction, during which the student eat, consume alcohol and on occasion have loud music which often creates a party atmosphere. From observation, there were a lot people at the Casey bar, some eating, others eating and drinking beer, while some are having conversations without beer or food and others were there to have their alcoholic beverages. The bar is only about 50sqm, with a counter to order food and beverages, there is currently a stage and dance floor being built to cater for music festivals and reduce the crowd inside the bar.

During the day, right after classes at about 6pm or 7pm, Casey seems to be more or less empty. Although as the night progressed more and more students arrived and even friends from the capital city, Maseru, arrive to spend the night with their University friends. This occurs often when there is a festival or a local band at the university campus. The small Casey bar becomes overcrowded and even runs out of alcoholic beverages.

In 2006, in the effort to reduce the alcoholic consumption of the students, NUL banned the sale of alcohol within the university campus. The student bar called Muzalas was prohibited from selling alcohol. Even before then, students were restricted from taking alcohol into the university premises. If caught, the content is seized and reported to the school authorities. However, some students' seldom take unauthorized alcohol into the university premises. The Dean of Student Affairs suggested that its lack of effectiveness is due to the fact that there are shops about 500 meters to one kilometre from the NUL campus, including Caseys that sell alcohol to students.

Although alcohol drinking and gathering of students is not illegal nor an indicator of exposure, the two counsellors and the dean seem to think, it has a significant influence on the sexual behaviour of NUL students.

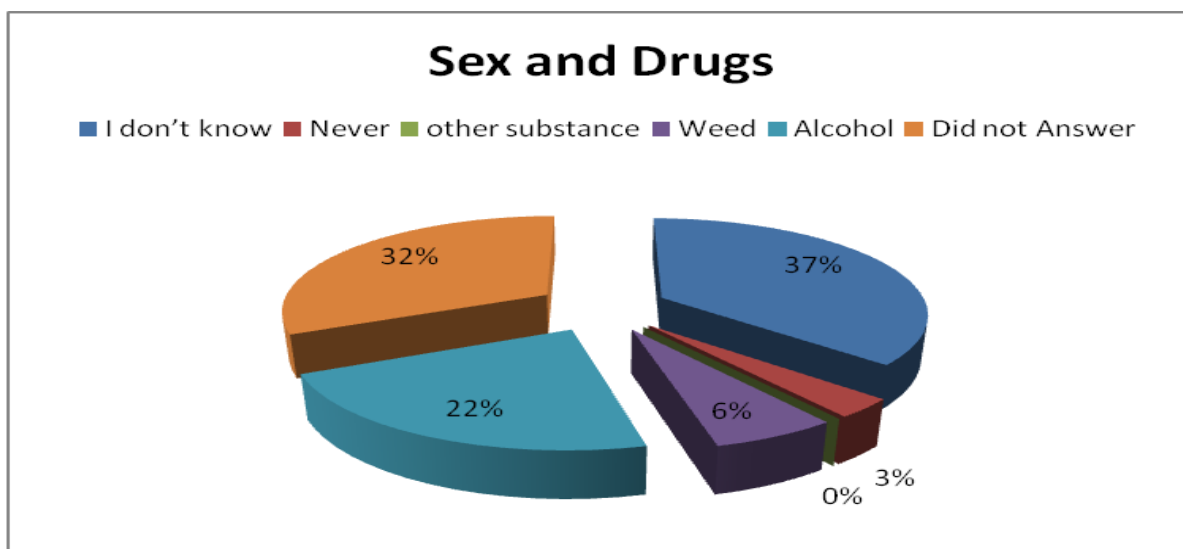


Figure 4. 8: Correlation of Sex and Drug use among students.

The students were asked if they have more sex when they use the drug called weed, drink alcohol or other drug-like substances. 22 per cent of the students agreed to have the desire to have more sex after drinking alcohol and six per cent say they do when they take weed and 3 per cent never see a change. 32 per cent of the students did not answer the questions and 37 per cent were not sure whether they saw a correlation between sex and alcohol or drug use.

These social activities of the students are mostly concentrated during the weekend and more importantly when the students get the quarterly stipend from the government of Lesotho, a bursary called “Manpower”.

4.7 GOVERNMENT BURSARY: ‘MANPOWER’

‘Manpower’ is the general term used for Lesotho National Manpower Development Secretariat (NDMS), a government department that sponsors tertiary students at school in Lesotho. Owing to the unique position National University of Lesotho holds, as the only institution offering degrees and postgraduate qualifications in Lesotho, nearly all of accepted students are sponsored by a 100 per cent bursary programme in place.

The application applies to candidates willing to further their studies with universities locally and those outside Lesotho. The Lesotho government has given the NMDS the task with the mammoth responsibility of administering scholarships to multitudes of Lesotho citizens willing to further their education at tertiary institutions, both locally and abroad.

The renewal process is done until the beneficiary's programme of study is completed as per the admission letter from the institution concerned. Upon completion, the contract stipulates that repayment of the loan bursary should commence. According to Sekhonyana (1978), "Loan bursary fund agreements shall provide for the repayment of bursaries by equal monthly instalments over a period of five years commencing as from the end of the first month of employment subsequent to the completion of the course" (Nchaka, 2009: 26-29). The repayment scenarios are categorised as follows:

- For students who do not return to Lesotho and those who fail to serve the country for a minimum of five years upon completion of their studies have to repay the full cost of their bursary.
- Those students who work in the private sector or parastatal organisations repay 65 per cent of their bursary.
- A student who after completion of his or her course works for the government of Lesotho repays 50 per cent of the national cost of his or her bursary.

However, recent reports about the NMDS from a number of newspapers highlighted the nature of complaints put forth by NUL students and clients. The first instance was reported in a newspaper called *Moeletsi oa Basotho* (translated as the Advisor of Basotho) on 23 March 2008, under the heading "Manpower ha e na boiphihlelo" meaning "Manpower lacks efficiency". It is reported that the coalition of students from various institutions of higher learning in Lesotho, including NUL, are not satisfied with the services of Manpower. In 2010 November last year the students went on a three weeks strike due to the fact that Manpower delayed payment, and threatened to pay only half of its overdue instalment. It is important to mention that the NMDS pays its beneficiaries through a bank, Standard Lesotho Bank, where students who were awarded scholarships would have opened personal accounts for ease of payment of stipends.

Over the years due to the economic situation in the country the number of students sponsored has been reduced with erratic instalment payment and constant change in the rules and regulation of how students receive their stipend. The fluctuating financial status of students and their family render them powerless if they do not receive the money.

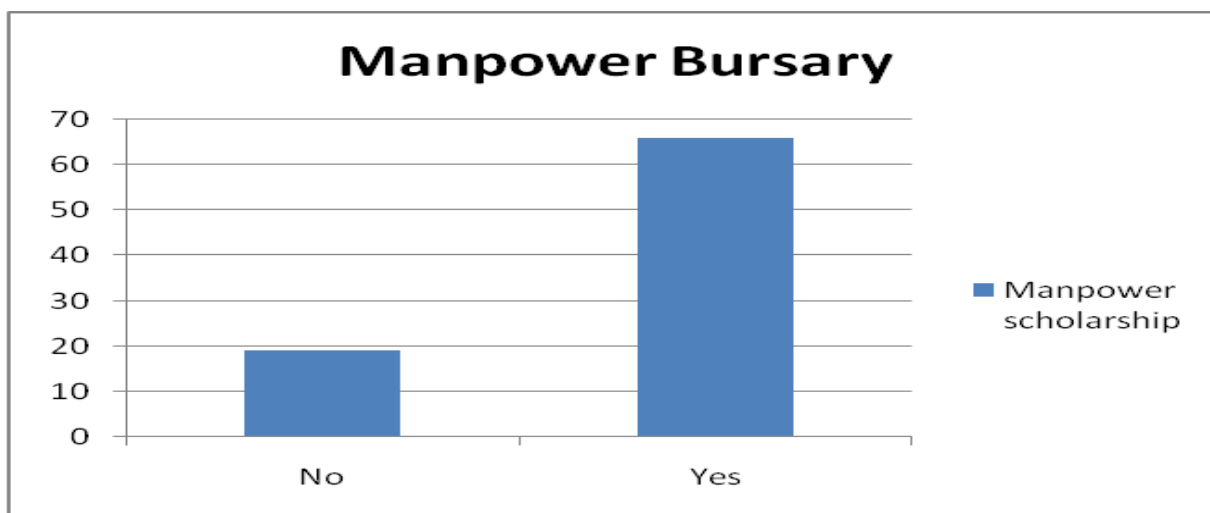


Figure 4. 9: Number of students receiving local government bursary

More than 60 per cent of the students receive Manpower bursary and they are fully dependent on the instalment. Some of the student help out their family as well as provide for their own basic needs with this money. This shows the economic status of NUL students with over 60 out of 100 relying on bursary for tertiary education. It also attests to the fact 65 per cent of Lesotho population are below poverty level.

4.8. CONCLUSION

This chapter analyzed the socioeconomic determinants of HIV/AIDS infection and related sexual behaviours using the data and information gathered from the empirical investigation. This is the first study to look at HIV/AIDS from the disaster vulnerability perspective using indications that will suggest exposure, sensitivity and resilience.

The study also identified and discussed the use of condoms and the number of times the students use condoms during sex. The management of HIV/AIDS programmes and activities both locally and nationally by the university, and the levels of satisfaction were discussed. Social activities at NUL and their relation to HIV/AIDS were identified and also the coping capacity of NUL.

From the questionnaires, focus group discussion and observational studies, HIV/AIDS programmes and activities at NUL are not enough and accessible to all. Health aspects, and problems caused by the HIV/AIDS is a national issue that filters down to the university environment. The national WHAT impacts on students' social well-being, production, social activities and economic development? The students coping capacity regarding HIV/AIDS are positive and negative, for example having a peer group committee team, which is mainly

composed of students, is available. Unfortunately the university does not attach any significance to such a group which leaves them ineffective. The lack of creativity of programmes leaves the student feeling saturated with the autonomous and monotonous HIV/AIDS activities. However, the national campaign in the capital city, just about three kilometres away from the university creates awareness for some of the students. The progression of vulnerability (PAR) model and the Vulnerability Pathway model are then integrated with the presentation of findings in the following chapter.

CHAPTER 5

SYNTHESISING THE RESULTS INTO THE PRESSURE AND RELEASE MODEL AND VULNERABILITY PATHWAYS

*“Education is the most powerful weapon you can use to change the world”
Nelson Mandela, Global Campaign for Education (GCE), 2004.*

5. INTRODUCTION

The HIV/AIDS epidemic has effects on social, political and economic life in an unprecedented scale, so that all developmental activities, including those relating to security at national, regional and international levels, have to explicitly address the implications of what is evolving as a huge humanitarian disaster in Lesotho. The demographics of Lesotho are changed drastically by the prevalence of HIV/AIDS with the youths and young adults being mostly affected. This chapter will synthesize the results from the questionnaires and interviews into the pressure and release model and the vulnerability pathways model in order to show the progression of vulnerability of students before HIV/AIDS infection and thereafter at the National University of Lesotho.

5.1 PRESSURES AND RELEASE MODEL

5.1.1 Root causes

According to Blaikie (2006:52-53) root causes reflect the exercise and distribution of power in a society. Root causes are the most remote influences of vulnerability; the most unnoticeable and often neglected, but the most dangerous that slowly destroys the resilience of the community or society, if not addressed. These root causes include: limited access to power, structures and resources, regressive and ideologies, political system and economic systems (Birkmann, 2006:30).

Viewed in another way, these root causes operate in the form of economic, demographic and political processes, which affect the allocation and distribution of resources among different groups of people and are a function of economic, social, and political structures, legal frameworks and the enforcement of human rights, gender relation and elements of ideological order (Wisner, *et al.*, 2004:52). Root causes are usually seen as either the

function or the dysfunction of the state, nature of control by the police and military, good governance and the rule of law (Wisner, *et al.*, 2004:53).

The root causes are treated in this research as those distant and sometimes neglected factors but form the foundation of HIV/AIDS vulnerability of students at the National University of Lesotho. Only the root causes which are relevant to the students' vulnerability to HIV/AIDS are discussed. Prominent among others are economic factors such as the level of poverty in Lesotho, limited natural resources, and a weak and undiversified economy. In addition, socio-cultural issues like traditional beliefs and ideologies are also discussed while the political factors that revolve around the issues of lack of access to power structure and the instability of the political system of Lesotho are all highlighted below.

➤ **Political factors**

Besides the lack of an effective central government, incompetence and corruption creates weak organisational structures and deficient welfare programmes, which all increase vulnerability of the society to external shocks such as HIV/AIDS (Smith & Petley, 2008:19). Therefore directly or indirectly, political factors are linked to HIV/AIDS. The HIV/AIDS response was late, only establishing 'National Aids Commission' in 2002. This is as a result of Lesotho's policy makers, looked at HIV/AIDS as a clinical-medical problem and only realized later that HIV/AIDS required a much broader perspective, and that it even had to do with human rights (Barnett & Whiteside, 2006:76-78). Political views on HIV/AIDS from prominent politicians like former president Thabo Mbeki of South Africa, who argued that HIV/AIDS did not cause AIDS but poverty did, could only increase the vulnerability of people to the pandemic (Whiteside, 2008:89). The researcher believes that though poverty increases people's vulnerability to HIV/AIDS, however, poverty is to an extent as a result of a breakdown in the national government system.

➤ **Wars**

This creates not only vulnerable situations, but also produces a very vulnerable group of people who are exposed to all forms of hazards including HIV/AIDS.

There has been no recent war in Lesotho, but the 'Basotho Wars' in the 19th century led to the loss of much arable land to the Free State (Tylden, 1950:13-20). This has resulted in the general lack of arable land in Lesotho, and is partly responsible for the food insecurity in Lesotho. Food insecurity is documented as one of the drivers of HIV/AIDS in Lesotho (GOL, 2006: x), which could be inversely related to the poverty status in the country and therefore affect student's family economic status.

➤ **Natural resources**

Lesotho has few natural resources. Apart from water and a shallow diamond deposit at Letsie-La Terre in Mopotlong district, the country generally lacks natural resources unlike the immediate neighbour, the Republic of South Africa (RSA). About 75 per cent of the total land surface is mountainous and is covered by hard sedimentary rocks with only ten per cent arable for agriculture (World Bank, 2005:2). Lesotho lost most of its arable lowland to the Free State dwellers, a sub group of the Trekkers in the mid 19th century during the Basotho Wars.

These wars were fought between King Moshoeshoe I (the founder of the Basotho Nation, which is today called the Kingdom of Lesotho) and the Trekkers (a group of Afrikaners who formed part of the Orange Free State province in Southern Africa) displaced from the Cape Colony by the British settlers (Tylden, 1950:13-18). Meanwhile the piedmont area in Lesotho is seriously ravaged by erosion leading to a lot of wasteland in the form of dongas. The problem of soil erosion resulted lack of arable land for agricultural production. The lack of arable land partly explains the problem of food insecurity in Lesotho, and when people are poorly fed or have no food, their immune system is affected rendering them vulnerable to HIV/AIDS. Besides, lack of arable land is documented as a push factor, the rural-to-urban migration process with all its attendant risks including being vulnerable to diseases like HIV/AIDS (Weeks, 2005:460-461).

➤ **Socio-economic factors**

The socio-economic vulnerability of people in a country can be decided by the state of governance in the country. The level of governance in Lesotho influences the ability of a country to mitigate and manage HIV/AIDS (DFID, 2006:7). Lesotho inherited the capitalist economic system from its history and the national wealth is concentrated within a small portion of the population while the majority live below the poverty line (MOSH, 2008:5; Phamotse, 2008:2). The role of poverty regarding the vulnerability of HIV/AIDS is encapsulated in the statement by Whiteside (2008: i) who believes that HIV/AIDS is a disease of the poor, be it poor countries or poor people living in rich countries, this was elaborated in chapter 2. It compared HIV/AIDS around the world, and literature revealed that the highest HIV/AIDS prevalence is in the poor nations. In DFID (2006:3) most disasters affect poor countries and poor people the most, due to that lack of resources to mitigate, respond and recover from impact of hazards. The lack of resources in the country is affecting training of peer educators and workshops for students and staff at the NUL.

➤ **Economic factors**

The high level of poverty remains the main cause of vulnerability to HIV/AIDS in Lesotho. From the population of 2.3 million in 2003, 948,310 were “poor”, 621,610 “middle class” and a dismal 238,080 labelled “better off” (LVAC, 2004:4). In the 2006, UNDP ranked Lesotho 149 out of 177 in the Human Development Index of the UNDP. The food deficiency and chronic malnutrition conditions, classifies Lesotho as a Least-Developed country, and one of the poorest countries in the world. Lesotho’s weak capacity for governance and service provision in relation to HIV/AIDS (FAO, 2007:1), increase the populations’ vulnerability while reducing the resilience of the society to HIV/AIDS. The prevailing conditions in the society regarding the population’s vulnerability determine the susceptibility, coping capacity and ultimately resilience of the population to loss or damage (UNISDR, 2002:13; DFID, 2006:5). In Chapter 3, Bogardi, *et al.* (2010: 2), it was argued that vulnerability is to an extent is inherent, therefore due to factors of root causes that has been examined above, it can reasonable be concluded to an extent, that students in Lesotho is pre-vulnerable regardless of HIV/AIDS.

➤ **Socio-cultural root causes**

Culture has a role to play in the vulnerability of the population of Lesotho to HIV/AIDS. Gender inequality, diminished equity, gender-based violence and the attitude of men towards heterosexual relationship create vulnerable conditions to HIV/AIDS (UNDP, 2006:47). Gender inequality, gender-based violence, the low socio-economic and legal position for women and lack of empowerment of women to make decisions, all of which are common in Lesotho, are all factors fuelling women’s vulnerability to HIV/AIDS (GOL, 2006:X; MGYSR, 2006:12).

Although, there is a new act that liberates the minority status of women, the fact that it is fairly new means women in practice cannot negotiate safe sex, and are often subjugated in marriages with no legal independence (UNDP, 2006:47). Cultural perceptions of women’s sexual and reproductive obligations increase their vulnerability to HIV/AIDS. For example, the African culture of paying “lobola’ gives men the impression that they own their wives and therefore their wives cannot negotiate when and how to have sex, thus increasing women vulnerability to HIV/AIDS (UNDP, 2006:47). This practice, though changing, was not empowering the women in Lesotho. It rather compromised their socio-economic status and made them more vulnerable to HIV/AIDS.

This translates down to the couple relationship in NUL, where 31 per cent female students answered “No”, with the question “Do you think female students are equal to

male students?” Although, according to the recent law enacted that women are equal to men, customary practices are instilled in the minds of people. It will take some time for this belief to be rectified by law.

The practice of widow inheritance where a woman is inherited by the deceased’s brother, sometimes with the cause of death not clear is a factor that leads to the spread of HIV/AIDS (Whiteside, 2008:46). Besides the practice of “dry sex”, where herbs and other agents are used to dry out the vagina with the belief that the practice increases men’s pleasure during sex (Barnett & Whiteside, 2006:46; Whiteside, 2008:46) not only increases the vulnerability of women to HIV/AIDS infection but again testifies to the weak position of women when it comes to negotiating sex with men. This can also be due to the fear and intimidation of the family structure in which the students grow up. This usually then is translated to male students forcing their sexual partners to have sex without condoms. According to Owusu-Ampomah (2009:37), in the 15-24 age cohorts in Lesotho, 71 per cent of those infected are females. The research found that this is not necessarily the case in NUL, where 30 per cent of students whom have been pressurized into having sex are males. However, of the 24 percent female students whom have been pressurised to have sex, majority (80 per cent) indicated that their partners doesn’t like using condoms, Never use condom and Almost every time.

To add on, historical demographic imbalance in the sex ratio in Lesotho with more female and fewer men (BOS, 2007:6) plays a role in the vulnerability of the nation to HIV/AIDS as it predisposes the culturally minded few men to having multiple sex partners. Having multiple sex partners is an important factor that fuels the spread of HIV/AIDS (GOL, 2006:8). Multiple and concurrent or overlapping sexual partnerships have long been identified as a major risk behaviour leading to the spread of HIV/AIDS, and the underlying factors of HIV/AIDS prevalence being culturally and geographically associated. A survey conducted in 2005 showed that more than 20 young people over the age of 20 would have more than one sexual partner if given the chance (Owusu-Ampomah, 2009:37).

Another common practice is intergenerational relationships, which is an important phenomenon driving the epidemic in Lesotho, “sexual intercourse between very young girls and much older males is one of the most important factors influencing the spread of HIV/AIDS among young women” (Owusu-Ampomah, 2009:45). These older men are more predisposed to HIV/AIDS by virtue of their age. The intergeneration sex practices are also encouraged by transactional sex where young women may be driven to seek relationships with older men out of financial necessity. Older men may also have strong motivations for their relationships with younger women; there is a strong tendency for older males to prefer

sex with young women, because of the fear that older women are probably already infected with HIV/AIDS (Owusu-Ampomah, 2009:45-46). However, in NUL, there is a ratio of 1:2 male to female students whom have had sex with a partner ten years older than them. The practice of intergenerational sex between older men and younger women occurs in NUL, with mostly financially stable men from Maseru, however, it has also transpired to intergenerational sex between older women.

The culture of silence and parents in general not explaining sex to their children, leads to them finding out from friends or other sources with little knowledge; and 54 students indicated they have had sex due to some kind of pressure or curiosity. It is important to say, although sexual debut of students in NUL could be considered as “normal”, but the vulnerability (exposure, susceptibility and coping capacity) involved makes the difference. In a country with low HIV/AIDS prevalence rate, students are less exposed to infection, whereas the higher the rate of prevalence the more exposed the population.

Consequently, the HIV/AIDS impact may be felt longer and harder than anticipated at NUL. This opinion is supported by studies, which observed that despite high level of awareness, there has been little or no change in attitude towards HIV/AIDS in NUL or Lesotho in general.

5.1.2 Dynamic pressures

Dynamic Pressures are factors that channel root causes into particular forms of insecurity that have to be considered in relation to the type of hazards facing vulnerable people in society (Twiggs, 2001:4, 5). Such dynamic factors include:

- Lack of local institutions
- Lack of training and appropriate skills
- Lack of local investment and lack of local market
- Lack of press freedom and poor ethical standards in public life.

Dynamic pressures also involve macro forces such as:

- Rapid population growth and changes
- Rapid urbanization
- Decline in soil productivity (Wisner, *et al.*, 2004: 51-55).

Disaster impacts are exacerbated by dynamic pressures (DFID, 2006:6). Though there are different dynamic pressures in the model, for the purposes of this study, only the lack of local institutions and appropriate skills to handle HIV/AIDS, lack of local investment and weak local market, rapid population change, rapid urbanization, wars and decline in soil

productivity are discussed under this sub section with reference to vulnerability of students to HIV/AIDS at the National University of Lesotho.

➤ **Lack of local institutions and appropriate skills**

To reduce vulnerability to HIV/AIDS involves serious institutional implications; such as the establishment of disaster risk reduction department in all government institutions and a disaster management centre as a central coordination body. However, Lesotho did not establish such an institution until year 2000. Lesotho AIDS Programme Coordination Authority (LAPCA) which was established to help formulate the first policy framework on HIV/AIDS and could have increased the vulnerability of NUL students to HIV/AIDS, due to the fact that the first HIV/AIDS case was reported in 1986 (MOHSW, 2008:2; GOL, 2006: xiii).

On a national level, the Lesotho National Disaster Management Authority was established in 2007 and currently lacks both human and financial resources for its operations. As identified in Chapter 4, the health centre at the University lacks appropriate human skills with only nurses available for students and just two counsellors for over ten thousand students. The reason could be due to the health system in Lesotho that has been in shambles for years and this has forced many nurses and doctors to either leave the public service or migrate to other countries especially to the United Kingdom (Moeti, 2007:23). Poor access to health services increases the vulnerability of students to HIV/AIDS.

In addition, the lack of therapeutic methods at NUL, contributes to HIV/AIDS vulnerability. There is no psychology programme within NUL or the country, and even if there were psychologists, the demand for such services is low or close to zero.

➤ **Lack of local investment and a weak local market**

There is a general lack of local investment in Lesotho. This is partly caused by lack of access to micro finances and loans, lack of entrepreneurial skills in Lesotho or due to poor work ethics and fear of risks involved in business. Lesotho is basically a consumption economy of imported goods with even the most basic goods and services imported from Republic of South Africa. This leads to perpetual deficits in balance of payment. Such deficits are only corrected by either borrowing or from foreign aid. The latter has created dependency problems in Lesotho for even basic needs like food supply. Over reliance on relief supply even in normal situations results in the perpetuation of existing risks, and creates a cycle of recurrent disaster (DFID, 2006:9). Such over reliance on foreign aid does not build societal resilience and therefore

increases the impact of hazards such as HIV/AIDS. It was observed during the empirical research, that the few businesses that exist in Roma are mostly shops, especially small supermarkets and liquor stores and are owned by foreigners mainly from China and India. Foreign investment dominates Lesotho's economy and this does not empower a nation to become resilient to external shocks like HIV/AIDS. Consequently, the locally owned businesses are mainly small side road restaurant, typical to Africa.

Therefore students are not encouraged to become entrepreneurs needed at this point to help Lesotho economy neither are there adequate businesses or organisations with sufficient resources to employ students on a part-time basis. Students are forced to solely rely on their bursary stipend and those that do not receive a bursary cannot get a job to earn extra income.

➤ **Rapid population increase**

The population of Lesotho, like in many other developing countries was increasing rapidly before the advent of HIV/AIDS. The rapid population increase was mainly due to high birth rates, which were close to 30 per thousand (PRB, 2008:8). The total population of Lesotho increased from 1.8 million people in 1976 to 2.3 million in 2003, before dropping to about 1.9 million in 2006 (BOS, 2007:2). This drop in population is strongly linked to the effects of HIV/AIDS (GOL, 2006: i). However, the rapid population increase before the advent of HIV/AIDS mounted to considerable pressure on environmental, economic and social infrastructure and resources with negative consequences.

The rapid population growth, coupled with lack of environmental awareness produced a seriously negative impact on the environment in Lesotho. Lack of vegetation cover exposes the land surface to various agents of erosion resulting in dissected surfaces with a fall in agricultural productivity and shortage of food supply, which is documented as one of the drivers of HIV/AIDS in Lesotho (GOL, 2006: x). However, the PAR model talks of rapid population change in terms of population increase, in relation to a hazard. The impact of HIV/AIDS has instead reduced the population of Lesotho.

Nonetheless, the situation at NUL is different, because to the University's position, many high school graduates still desire to attend the University. This has resulted in an increase in the number of students attending. The Manpower scholarship is an additional incentive to attend the university. Subsequently, the university is located in the capital district of Lesotho and therefore considered more prestigious, including the volume of international expert expatriates that lecture within the university.

Consequently, the location of the university, located at the capital city, leaves it exposed to various international and local migrations.

➤ **Rapid urbanisation**

Natural increase in cities and rural exodus (due to hardship in rural areas), have led to rapid urbanization in Africa (Pelling & Wisner, 2009:39). Rapid urbanization is a major factor in the growth of vulnerability especially for low income households who live in squatter settlements (UNISDR, 2002:70). Lesotho faces rapid urbanization with the main focus being the city of Maseru. Urban population has increased from 10.5 per cent in 1976 to 23.8 per cent in 2006 (BOS, 2007:4). Rapid urbanization in Maseru puts pressure on available land as the new settlers meet already crowded land and therefore foster close encounters of sexual relationships.

With the case of the NUL campus, year after year the number of students applying for school increases which leads to an ever increasing in-take of students. This then puts pressure on the university management to increase lecture buildings, offices and hostels on a limited land available in Roma. The rapid growth in student population and limited space also forces the students to squat with their friends or sexual partners.

Because of NUL location (30km from the capital city) and its position in Lesotho, it seems to be a major attraction for social events like local and South African artists to perform. It also attracts different kinds of people from all over Lesotho during this period which then creates a hub for sexual activities. It should be borne in mind that though similar events may occur in other countries in other regions, the HIV/AIDS prevalence rate and other factors determine the vulnerability of the individuals. As said in Chapter 3, the vulnerability of a student in Western Europe will be less than that of a student in Southern Africa.

➤ **Global economic pressures**

The fall in prices of agricultural and mineral products linked with a corresponding increase in prices of technical, manufactured and energy products in the 1980s coinciding with the first HIV/AIDS reported cases in sub-Saharan Africa. The fall in prices of these primary products resulted in serious indebtedness for the Less Developed Countries (LDCs), and the servicing of these debts take up as much as 50 per cent of their GDP (UNISDR, 2002:76). Attempts to pay these debts have led to over exploitation of natural resources leading to environmental degradation with corresponding health risks.

The Structural Adjustment Programmes (SAP) prescribed by the International Monetary Fund (IMF) and the World Bank have led to cut backs in social services including health services and the privatization of state owned corporation, reduced market prices and have instead increased the vulnerability of the very poor in society (World Bank, 2005). Lesotho like many African countries is implicated in global economic pressures.

For example the recent world crisis has led to a reduction in funding for HIV/AIDS treatment in developing countries especially in the Eastern and Southern Africa region (UNAIDS/World Bank, 2009:1-3). Reduction in funding for the treatment of HIV/AIDS can exacerbate the impact of HIV/AIDS in developing countries like Lesotho. In addition, the reduced Gross Domestic Profit (GDP) in Lesotho and the growth of competing claims could lead to fewer public resources being available for the education sector (Kelly, 2001:10) and higher institution like NUL will be affected, especially when it comes to resources.

This impacts on household economies, that is families and individuals tend to will have fewer cash resources at their disposal, whether for education or for other purposes. As a result, students are constraint and limited to the government bursary they receive, to which some students support their family with their stipend.

The dynamic pressures explained above translated the root causes discussed under sub section 2.1.1 into unsafe conditions. In the next sub section, we look at some of the unsafe conditions in Lesotho.

5.1.3 Unsafe Conditions

Unsafe conditions are the specific forms in which the population's vulnerability is expressed in time and space in relation to a specific hazard (Blaikie, *et al.*, 2004:55). Unsafe conditions include lack of protection by the state, engaging in risk livelihood such as concurrent multiple sexual partners, low income levels and its uneven distribution, lack of disaster preparedness and prevalence of endemic diseases (Wisner, *et al.*, 2004:51, 55).

➤ Behaviours and risk environment

It should be noted that "risk" is not an attribute of an individual, but reflects in the environments in which people live their lives. In this case, the environment is NUL which in turn can affect who the students are, who they become, what they do with their bodies. The environment is shaped by the inhabitants' histories (Barnett & Whiteside, 2006:88). The environment becomes a "risky environment", defined by behaviours and practices such as intergenerational sex and casual sex practices, drug and alcohol abuse, and the

practice of multiple sex partners are some of the practices that create very unsafe conditions in the face of HIV/AIDS at NUL (Barnett & Whiteside, 2006:88). According to Whiteside, *et al.*, (2004:88), students are compelled to make rational decisions based on their own view of its impact in the long term. The major problem is that students do not see themselves as being at risk of the infection.

People whose livelihood strategies expose them to a high risk of infection are, precisely because they are impoverished, less likely to take it seriously or able to take the risk of the threat of an infection seriously (Barnett, *et al.*, 2006: 358). A survey conducted in 2005 showed that over 20 per cent of young people over the age of 20 would have more than one sexual partner if given the chance (Owusu-Ampomah, 2009:37). The researcher found this to be true in the case of the students at the University.

➤ **Differential of students' well-being**

Students who have multiple concurrent sexual partners are more susceptible to HIV/AIDS infections than those who are monogamous. Within the community of NUL, students have differential levels of vulnerability to infection, as shown in the Vulnerability Pathway model in Chapter 4. Their level of knowledge also has an impact on how to prevent infection as well as what to do to prevent the rapid deterioration of their immune system once infected. In addition to this, their level of vulnerability is influenced by relative wealth of the student (Barnett, *et al.*, 2006: 179). Students from a reasonably wealthy background are probably more likely able to afford ARVs and other nutritional necessity to maintain a healthy immune system.

➤ **Discrimination and stigmatization**

Discrimination and stigmatization of people living with HIV/AIDS (PLWHA), remains one of the prominent unsafe condition facing many societies that are implicated with the effects of HIV/AIDS. These two problems are cited by almost every researcher on HIV/AIDS (ILO/USDOL, 2005; Whiteside, 2008:4, 9, 112; UNGASS, 2008). In the case of HIV/AIDS, stigma is as a result of shame and fear. Shame because sex which is the main route of HIV/AIDS transmission in Lesotho (UNDP, 207:46) is still surrounded by taboo and moral judgment, and fear because HIV/AIDS is a relatively new phenomenon and deadly (UNAIDS, 2002:7).

Stigma, discrimination, denial and silence are the factors that undermine most students' judgement to seek confirmation and treatment. Stigmatisation is another unsafe condition in Lesotho for PLWHA due to the link of HIV/AIDS positive to sexually promiscuity. Discrimination in social networking has forced many people not to go for

HIV/AIDS testing or not to disclose their HIV/AIDS status. This spoils the efforts the government have taken for prevention, care and treatment. Thus the impact of HIV/AIDS on individuals, families, communities and nations is increased (United Nations, 2002:6) and presents unsafe conditions especially for PLWHA.

➤ **Gender roles and discrimination**

Women in Lesotho are more educated than men; female enrolment exceeds that of males at all levels of education. A sexual violence survey found that women hold many negative attitudes and myths which reflect the power relations within the couple and the family cross-generational or intergenerational sex. According to Leclerc-Madlala, S., Simbayi, L.C. & Cloete, A. (2009), studies in Southern Africa have consistently found that the larger the age disparity, the lower the probability of safe sex (UNAIDS. 2009:36). Leclerc-Madlala. *et al* (2009) also argues that the stereotype of 'sugar daddies' is too limited for Southern Africa, and that 'sweet mammas' is a growing phenomenon. (UNAIDS. 2009:36). This is apparent at NUL; there is a ratio of 1:2 of male to female students who have had sex with a partner who was ten years or older than they were. Again, this is confirming the growing intergenerational sex situation in the country.

Inequities in gender run parallel to inequities in income and assets. It is well established that young women are both physiologically and socially more vulnerable to HIV/AIDS than young men (ICRW, 1996:6.7). Low incomes, disinvestment, constrained cash flow all place economic pressures on women. These pressures push a number of women into situations where sex is coerced (Collins & Rau, 2000: 29), where a ratio 1:2 male to female students could not refuse sex with their partner.

➤ **Fragile institutions**

The Lesotho Disaster Management Authority (DMA), is not well equipped with both personnel and equipment to handle disasters of even average magnitude. This lack of capacity creates ineffective education, training and information dissemination on matters related to disasters are generally lacking in Lesotho. Despite mass education and awareness campaigns on HIV/AIDS in Lesotho, the majority of the students have not made significant change in their sexual practices of having multiple and concurrent unprotected sexual relationships (GOL, 2004:17). This type of attitude is one of the main drivers of HIV/AIDS in Lesotho. Besides, the government responded late to HIV/AIDS (Kimaryo *et al.*, 2004:19), and it is only recently that the government started integrating disaster risk reduction into her national development programmes.

Despite support from the government of Lesotho to promote VCT (Voluntary Counselling Testing), HIV/AIDS testing has not yet been systematically established on campus. The inadequate style of management, silence and denial among the staff and students, relinquish the University's *ad hoc* and uncoordinated efforts to promote VCT. This is partly due to the lack of autonomy and inadequate staffing of the university's HIV/AIDS office, and the temporary nature of the key positions of the University. NUL still has no institutional HIV/AIDS policy; formal HIV/AIDS planning and teaching programmes have not been integrated into the formal curricula; student care and support services have not been established and there is little coordination of student activities related to HIV/AIDS; and a culture of silence persists on campus in terms of HIV/AIDS. Moreover, recent attempts at addressing this state of affairs have been hampered by the unstable management structures of the university.

5.2 VULNERABILITY PATHWAYS

Because of the long period between the initial HIV/AIDS infection and the development of full-blown AIDS (and subsequent death) these impacts are still in process of making themselves felt in NUL and not covered by this study. However, their vulnerability pathways will provide factors within lapse of time between each of the waves and within the National University of Lesotho among students in the same time frame. In the context of the HIV/AIDS vulnerability pathway, indicators need to capture information at three levels in order to understand the nature of the epidemic within NUL.

5.2.1 Gate 1: HIV infection (and subsequent progression to AIDS)

According to Sambrook (2003:4), the stage before Gate 1 contains different contexts in which individuals are at risk of contracting HIV/AIDS, more than others within the university community. This included their decision to engage in unprotected sex, the level of morbidity, cultural practices linked to sexual activity (Sambrook, 2003:4).

According to the research done at NUL, 38 per cent of sampled students indicated that they used a condom *almost* every time and five per cent said they never did. In addition, 22 per cent of the students were not able to refuse sex and 20 per cent of the respondents would not buy their own condom. These students will have a higher susceptibility to these and may journey down the pathway to Group B fall away, due to their high susceptibility to HIV/AIDS if corrective action or behavioural adjustment is not made. Students who have never had sex amounted to 12 per cent and 24 per cent said that they used condoms every time they would tend to fall away from the pathway without HIV/AIDS infection (Student group A). This shows the level of susceptibility within the same university environment or community.

Although, these individuals are exposed to the same risk factors like the HIV/AIDS awareness programme, their attitude will determine the group to which they will fall. Moreover, understanding HIV/AIDS, behavioural patterns such as abstinence (only 12 per cent), number of partners and age at first sexual encounter, can define their coping capacity. According to the questionnaire carried out 36 per cent of the students indicated that they had more than four partners, and one student said he had 33 sexual partners. The availability and use of health services, such as Voluntary Counselling and Testing (VCT) and condoms, increase the students' coping capacity. The set of students with a high coping capacity follow to fall out of the pathway and become sub-group B. These students are able to avoid HIV/AIDS infection. Therefore sub-group A and B can be considered resilient to HIV/AIDS infection; however, the number and percentage of these types of students are not many at NUL.

At the same time students with low coping capacity continue down the pathway and contract HIV/AIDS. For example, the 12 per cent of students who never had sex were more resilient and less susceptible to risk of infection as compared to students who had sex and had been exposed to STIs for a longer time period. Additionally, lack of consistency in condom use and multiple sexual partners, and attitude towards HIV/AIDS awareness campaign, determine the group in which students will fall. The students' sample percentages to susceptibility and factors of coping capacity were discussed in Chapter 2. Although, most of the indicators were lower than the 50 percentile, the percentage value signified a point of concern when administered to the whole population.

5.2.2 Entry to Gate 1

After contracting HIV/AIDS, students can either continue down the pathway due to high level of susceptibility and low level of resilience within the university or they can fall away to group C and D. The level of stigma, discrimination, income, access to quality service and general attitude of the individual will determine if the individual journeys down the pathway through Gate 2 or not. Investigation shows that about 14 per cent indicated that their infected friends were living a normal life due to support from facilities, friends and family. For example, improving the nutritional status of students living with HIV/AIDS not only improves their quality of life, but also improves their coping capacity to secondary infections, thereby enabling them to lead a normal life and contribute to economic activities for a longer period.

Whereas a different scenario can play out with factors like *life expectancy*; in 2003, an estimated 29,000 Lesotho citizens died of HIV/AIDS, and life expectancy at birth in Lesotho has fallen below 40 years largely due to HIV/AIDS (HIV/AIDS Policy fact sheet, 2005:2). De Waal (2003) suggests that adult life expectancy will serve as a more useful measure of the

demographic impact of HIV/AIDS. If this is taken by students, they may lose the motivation to continue with studies and live. This reflects in the answers of the students during empirical data gathering, 32 per cent of the students reported that their friends were emotionally depressed, with no hope for life and self-esteem after the discovery that they were HIV/AIDS positive. The access to HIV/AIDS services was also a reflection of how resilient the students would be.

5.2.3 Gate 2: AIDS-related death

The level of susceptibility within and through Gate 2 is usually due to cumulative effect of factors from Gate 1. Factors such as balance of power relation, nutritional intake, HIV/AIDS education, attitude of individuals and so on determine if the individual will fall away to Group E and prolong the inevitable AIDS-related death. Even though, Group E falls out of the pathway, the period at which the immune system deteriorates is only longer than that of Group F, but AIDS-related death is inevitable.

However, there are some factors within the community, in this case of NUL that can help increase the coping capacity of students and delay the progress down the line. That is, the drivers of their vulnerability include the following variables noted below, which determine the vulnerability of a household to the impacts of HIV/AIDS (before death):

- The attitudes of students and staff towards HIV/AIDS and PLWHA, can have a major psychological impact towards the infected, including the perceived stigma and discrimination, (see Chapter 4).
- The care practices and support for PLWHA and caregivers is practically non-existing in NUL. There is no support programmes for students living with HIV/AIDS at the university.
- There is a considerable ease of access to health clinics, but the service is not of quality and the use not conducive to the satisfaction of students. In addition, access to medication is not yet automatic and depends on your CD4 count.
- There is access to educational material, the billboard outside the university gate is an example, but the educational materials and programme is considered insufficient and lacks maintenance and coordination from the management section of NUL.
- The students' social life without HIV/AIDS can be said to be 'thriving', however HIV/AIDS complicated the social network, where some of the students notice a negative impact on their friends and 75 per cent of the students will not tell anyone if they were HIV/AIDS positive.
- The balance of power relations within the university, according to questionnaires and interview seems to be relatively the same among the both sexes, although culture

does play a role in the decision of certain students the general impression is that there is some kind of balance in power.

- At Gate 2 stage the nutritional intake of student will also determine the acceleration down the pathway. To some extent the educational information on what nutrition to take depend on the health centre, a major part of lifestyle change depend on the individual who will make decisions based on his/hers economic status.

Within these sub-groups certain students are much more vulnerable to the aftermaths of HIV/AIDS. However, their capacity to withstand the effects after infection is likely to be eroded by the cumulative effects of various coping strategies within the university and possibly around the capital city, Maseru.

The pathway is a continuum, with students being at risk of re-entering the pathway after existing to a previous subgroup, for example students with limited livelihood options may seek financial support through the wrong channels of sugar daddy or sugar mummy. Nevertheless, whether students were infected before entering the university or whether they become infected during the course of their studies, the majority of HIV/AIDS positive students will not succumb to AIDS until after they have completed their studies and left the institution.

5.3 CONCLUSION

This chapter applied the progression of vulnerability to HIV/AIDS of students to the National University of Lesotho. It also analysed the factors that expose the students to HIV/AIDS. The PAR model illustrated all the different stages that led to the vulnerability to HIV/AIDS of the students of NUL. This chapter brought to light the discussion of the Pressure and Release model discussed in Chapter 4. This chapter systematically identified and analysed the problems experienced regarding HIV/AIDS. The susceptibility to coping capacity and resilience of students was discussed. Moreover, the chapter looked at the vulnerability pathways in order to separate the types of students, and show how individual factors and

factors within the university contributed to the overall vulnerability of students to HIV/AIDS infection and subsequently death. The following chapter will discuss the possible recommendations and conclude the study.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

Institutionalising HIV and AIDS as a university response is far more complex than offering counselling services or establishing research programmes. It involves turning the whole University around to recognise the threat of HIV/AIDS both to the University and the Roma in which it is located, and to respond to it in a holistic and complete way. It involves addressing the essence, culture and power of the institution and it challenges the relationship between the institution and the society.

Anonymous

6. INTRODUCTION

In this chapter the researcher comes to a conclusion and makes relevant recommendations. It is therefore necessary to revisit the research problem, the objectives and research questions. An overview is first given on what transpired in the previous chapters.

The study initially examined existing literature available and the vulnerability of students to HIV/AIDS at the National University of Lesotho was subsequently investigated. However, this required a general overview of the HIV/AIDS situation in Africa and the rest of the world before funnelling the literature study down to the specific situation at the National University of Lesotho.

The literature study was carried out from a disaster risk reduction point of view, using the concept of exposure, susceptibility and resilience background, and using the progression of vulnerability in (PAR) model as the main conceptual framework for the study. However, the vulnerability pathway was explored to complement the PAR model in the study. In this study, the PAR model was used to explain the progression of vulnerability of the students to HIV/AIDS at the National University of Lesotho by starting at the source of the problem; root causes. These then translated to dynamic pressures and unsafe conditions that led to HIV/AIDS vulnerability of the students at the NUL. Meanwhile to understand the differential vulnerability status of the students and the specific contributing factors within NUL, the vulnerability pathway model was used. Additionally this model examined the possibility of students' progression toward AIDS-related death due to factors in place or lack thereof.

In order to collect information needed for the study, and to substantiate or disprove of factors in the literature study, a supplementary empirical investigation was undertaken (Chapter 4). For the purposes of empirical investigation, closed-ended and open-ended questionnaires

were used and interviews were conducted. Within the overall study, from the literature study to empirical investigation, the researcher's objective was to outline and explain the vulnerability of students to HIV/AIDS disaster at the National University of Lesotho. The conclusions and recommendations that emerged from the literature study and empirical investigation are presented in this chapter.

6.1 THE PAR MODEL AS A CONCEPTUAL FRAMEWORK

The PAR model clearly showed the progression of HIV/AIDS vulnerability at NUL the economic, social, cultural and political factors that increased the vulnerability of students to HIV/AIDS were examined under three headings;

- Root causes
- Dynamic pressures
- Unsafe conditions.

From this conceptual framework, it was observed that the root causes such as cultural aspects like sex being a taboo, transformed dynamic pressures such as inadequate resources or commitment to sexual programmes produced unsafe conditions such as risky behaviours in the face of high intensity (29 per cent prevalence rate), long duration (from 1986 to date), large coverage (NUL) and high exposure (NUL students) of the HIV/AIDS hazard. The PAR model and its application showed the progression of vulnerability to the impact of HIV/AIDS in Lesotho.

In the study, the PAR model could not be used to explore and describe the phenomenon of HIV/AIDS and how the students were vulnerable to HIV/AIDS, particularly at the National University of Lesotho. Therefore the Vulnerability Pathway Model had to be used as a supplementary and secondary model. The vulnerability pathway model showed the susceptibility to HIV/AIDS, before and after infection, of the students at NUL.

Based on the vulnerability pathways it was clear that factors that influence the level of students HIV/AIDS infection is high within NUL. The vulnerability pathways show the different categories in which different subgroup of students may fall, using factors that determine infection and subsequent progresses down the pathway. However the utilisation of both the PAR model and the vulnerability pathways model in this research made the researcher realise at the most proximate level, that the chances of HIV/AIDS transmission might depend on biological determinants. The real challenge was to change behaviours of students to reduce risk (Whiteside, 2008:53). The biological behaviour of students is determined by how the society operates at the micro level: the culture, social and economics

as unfolded in Chapter 5, with the PAR model. The main issue is how students treat and see one another which are influenced by the greater perspective of the Lesotho society. In Chapter 5, it is clear that the students are significantly vulnerable to HIV/AIDS infection, and even more so after infection. Because the epidemic has gained a hold over Lesotho (with 23 per cent HIV/AIDS prevalence rate), the more people with the infection, the greater the chance of a student having sex with such a person and being infected, and that is where the vicious cycle develops (Whiteside, 2008:42). However, NUL is at its current stage of HIV/AIDS prevalence rate among students, due to past behaviour. Although, the behaviour of the students is important in determining susceptibility of students, the university and government commitment determines the coping capacity of the students and subsequently their vulnerability.

Take note that the above conclusion was drawn by addressing the research problem, which necessitated the use of a combination of research approaches and theoretical frameworks or models when carrying out the research in a disaster management context.

6.2 REVISITING THE RESEARCH PROBLEM

The research focus was on discovering factors that were contributing to the HIV/AIDS prevalence rate at the National University of Lesotho, and the vulnerability of the students to the epidemic, through the social, economic and political impact of HIV/AIDS in Lesotho. This study was carried out to determine the contributing factors to HIV/AIDS prevalence rate among young people at the university, and to inform students, non-governmental organisation, NUL, and other governmental organisations.

The research problem was addressed in the different chapters of the literature review, the chapter on global perspective of HIV/AIDS. Moreover the different vulnerabilities of young people within different regions around the world were discussed and finally, literature of student vulnerability to HIV/AIDS was examined. There were issues of risky sexual behaviour of students that related to the case of NUL. The issue of rampant HIV/AIDS prevalence rate between men to men sex did not significantly apply to the case of NUL. Although the research noted that there were cases of men to men romantic relationships at the University, the numbers were not currently significant enough to warrant mentioning.

Globally, the literature study indicated that a student's vulnerability to HIV/AIDS is not just linked to the sexual behaviour of the individual, but the social, economic and political activities within the society of the students that contributed to their vulnerability. Students were not secure in their social needs (that is they do not have variety of social activities at

their disposal), inadequate management coordination, poor quality and limited health services applied strongly to the National University of Lesotho. The students' experience regarding HIV/AIDS was highlighted when asked if they had a friend from the university who was HIV/AIDS positive, and how the disease had affected the person. All students knew at least one HIV/AIDS infected student and most of them reported a negative feedback, associated with the stigma and discrimination on campus, as well as lack of adequate support from the institution.

The discussion on the National AIDS Commission Act of 2005 is supported by the Legal Capacity of Married Persons as well as the Sexual Offence Act of 2003. These improved women's access to power and decision-making regarding their sexual life. There was a discussion on the activities and programmes envisioned to be implemented as a draft document, 'National University of Lesotho HIV/AIDS policy'. The chapter continued to identify women as particularly vulnerable due to their biological make up and position in the society.

Moreover, HIV/AIDS was discussed as a hazard, followed by how students were at risk and vulnerable to HIV/AIDS. The clear definition of vulnerability was given in order to understand the intricacy of the HIV/AIDS vulnerability. The element of exposure, susceptibility and resilience of students was also discussed in this chapter. The fact that HIV/AIDS was able to affect every aspect of the society and slowly disrupt all developmental activities including disaster management was discussed. The chapter continued by examining those factors including human decision and other dimensions that left the students vulnerable to infection and deterioration thereafter. Thus far we can conclude that students' exposure to HIV/AIDS does not determine their vulnerability, but it is their social interactions that affect their susceptibility and coping capacity that render them vulnerable or resilient to the disease

In Chapter 4, presentation of findings indicated that the majority of the students knew about HIV/AIDS, but did not pay much attention to the occasional programme on campus. For example even though they knew of the presence of HIV/AIDS, and that it was the major contributor to the increase in deaths in NUL and the country as a whole the majority of students still did not take enough precautions.

Nevertheless, the behavioural change of youth cannot begin at the university; it has to begin in high school, as most of the students have already engaged in sexual activities during their high school time. Sexual debut, sexual practices, number of partners and concurrent partners and intergenerational sex are key behavioural factors that put students at risk of infection. It should be noted that although frequent change of partners is a hazard, the real

danger lies in concurrent partners, when people have more than one partner with overlapping relationships for months or years.

There is further evidence from the empirical study and the literature review that HIV/AIDS has caused significant prevalence rate in the 15–24 age cohort around the world and affects the students at NUL. However, because HIV/AIDS affects mostly this age cohort, women within this group are particularly at higher risk of infection. The empirical research proved that most of the students who would not buy their own condoms were women and the correct, consistent condom use was a behaviour aspect that reduced the chances of HIV/AIDS infection. How students behaved, determined their risk of infection but behaviour of students resulted from the local and wider environment in which they lived and operated (Whiteside, 2008:50). The hope of not losing all the students to the epidemic in the near future lies in effective prevention measures.

Educational institutes like NUL need to take a more proactive and coordinated action to HIV/AIDS. This requires the implementation, coordination and monitoring of HIV/AIDS programmes. However, it should be taken into account that the lack of programmes and activities is not the problem as the empirical investigation has shown. Rather, the problem is the lack of motivation for implementation and coordination of activities, as well as the monitoring of goals and programmes in order to achieve the vision of reducing the prevalence rate within the university and beyond.

It will be premature, however, to come to any definite conclusion on the current HIV/AIDS prevalence rate in NUL, because the sample in the empirical study was not large enough and all the students were not included, due to financial and time constraints. The empirical investigation suggested that the main cause or source of students' vulnerability to HIV/AIDS was the underlying culture about sexual activities in the country as well as lack of motivation, commitment and implementation of relevant programmes from NUL management section.

Finally, the research questions and the research hypothesis were sufficiently covered by the empirical study that was supplemented by the literature review. The research problem was therefore addressed. This research has found that cultural factors have a big role to play in the vulnerability of students at NUL to the HIV/AIDS. Through, the inherent culture in Lesotho, the sexual behaviour of the students is shaped, decision on sexual intercourse, sexual interaction. The culture is also playing a role in the implementation of policies as well as attitude of people towards up scaling their economic status (dependency ratio of the country).

6.4 RECOMMENDATIONS

The recommendations made in this study are consistent with the current HIV/AIDS situation at the National University of Lesotho, the existing resources in the university, the international shift in paradigm from disaster response to disaster risk reduction (DRR) and the commitment of the government including NUL and students to fight against the HIV/AIDS pandemic. It takes a long time to change deeply-rooted cultural norms and practices.

6.4.1 Practice

HIV/AIDS was considered a disaster in 2002, because it was identified that its presence will overwhelm existing resources of the country. However, it needs to be practiced as a disaster by the Disaster Management Authority, in order to prevent or mitigate the impact of the disaster without neglecting the response, recovery and rehabilitation of the affected community. In the case of HIV/AIDS in NUL, all these five facets of the disaster management continuum should be engaged. Like any other disaster, HIV/AIDS posed several risks and any disaster risk has three components - the vulnerability, the hazard and the risk.

HIV/AIDS should feature more prominently among the topics for students' orientation programme. Students should receive some factual information about the disease, Sexual Transmitted Diseases (STDs), and the avoidance of unwanted pregnancies. Information should also be given about available health and counselling services and condoms provided on a regular basis. It is critical that new students are alerted from the outset to be HIV/AIDS-vigilant, especially when the warning bells are sounded by senior university administrators. However, in the absence of continuous follow-up activities, these once-off communications are likely to have very little or no impact where it is most urgently needed, on students' behaviour.

There clearly seems to be a need at NUL to establish on-going HIV/AIDS education programmes that provide students with training in psycho-social life-skills such as assertiveness, effective communication, and decision-making, when it comes to sex before and after infection. These are needed in order to equip students to resist peer pressures in such high risk areas as alcohol abuse, drug-taking, multiple and concurrent partners and casual sex activities. It must also be remembered that the majority of students profess that they already know a great deal about HIV/AIDS when they first arrive on campus. Many see the orientation presentation of the topic as being little more than a formality. The majority probably learn something about the provision of clinical counselling and condom services, but little that will stimulate them to adopt or maintain more responsible sexual behaviour (Kelly, 2001:21).

Key elements of resilience include the continued access to, and control over resources (HIV/AIDS information) and the health centre services; acquisition and development of life and livelihood skills; the strength of safety net; and the provision of psycho-social support for students.

The University, government and non-governmental organizations should sponsor a systematic HIV/AIDS programme and follow-through on student orientation through an annual university-wide HIV/AIDS awareness week. During this week, debates, discussions and guest speakers provide ample opportunity for deepening knowledge and awareness of the disease on campus and in society. This will also forms part of university outreach to the community on HIV/AIDS (Kelly, 2001:21). Radio broadcasts, theatre presentations, and awareness-raising meetings for secondary school students, the latter, being youth to youth, are of particular value for both university and school students.

The National University of Lesotho should form groups such as Student Welfare Societies, AIDS Societies, or Anti-AIDS Clubs which include students, lecturers and other relevant stakeholders designed to sensitize students to HIV/AIDS issues, provide peer support, and promote HIV/AIDS awareness in nearby secondary schools.

The severity of the impact of any disaster (in this study HIV/AIDS) depends on the degree of the vulnerability of the affected community, the coping capacity of that community as well as the nature of the hazard itself (as measured by the intensity, duration and magnitude of the hazard). The golden thread therefore is to tackle the disaster risks of HIV/AIDS in NUL in an holistic way. For example, it is vital to put measures in place that will reduce the vulnerability of the students to HIV/AIDS such as poverty eradication policies being included in the disaster management act. In addition, increase the coping capacity of the population to build strong social network by addressing the cultural issues and misconceptions on HIV/AIDS with nation-wide programmes. Moreover, the University needs to adopt policies and practices that will reduce the intensity, duration and magnitude of HIV/AIDS. It is equally important to put in place effective manageability measures like improvement on health centre in the University and coordinated efforts by the local clinics in Roma area.

6.4.2 Theory

The Progression of Safety Model (see Appendix 1) as a theoretical framework is recommended in this study for purposes of addressing the vulnerability of student to the HIV/AIDS (Wisner, *et al.*, 2004:291,344) because it provides guidelines on reversing or addressing the root causes, and reduce dynamic pressures of vulnerability so that safe conditions are created that will prevent or reduce the vulnerability to HIV/AIDS. The

progression of safety theory is the antithesis of the progression of vulnerability theory (PAR model) which has been used in this study as a conceptual framework. The application of the progression of safety theory to tackle vulnerability to the impact of HIV/AIDS in Lesotho will imply the following:

- Address the root causes of vulnerability of the students to the impact of HIV/AIDS. For example, address the issue of poverty in the country. Tackle ideologies and cultural practices that perpetuate the vulnerability of the people of Lesotho to the impact of the HIV/AIDS hazard.
- Address the dynamic pressures that translate the root causes into unsafe conditions.

For example, the institute should increase the number of staff members so that there will be a fair balance between the resources available and the number of students that depend on these resources. That is, the University should have a psychologist and qualified social workers at the health centre that is trained to deal with a delicate situation such as HIV/AIDS. The HIV/AIDS situation in Lesotho should be treated like the any other hazard or disaster such as flood and drought with experts from the field. However, institutionalising HIV/AIDS as a university response is far more complex than offering counselling services. It involves turning the whole university around to recognise the threat HIV/AIDS poses, both to the University and the society in which it is located, and to respond to it in a holistic and complete way. It involves addressing the essence, culture and power of the institution and it challenges the relationship between the institution and the society.

In addition, controlling sexual behaviour of the students is to increase good parental upbringing with the topic of culture and tradition addressed in a critical and sensitive way. This can be done through sound moral education promoted in households and primary school through Christian education, as Lesotho is a Catholic oriented country. This will also translate to the sexual decision the students make as young adults.

The public language of HIV/AIDS is too narrow and too tightly focused. It circulates powerfully in the HIV/AIDS community, so powerfully that outsiders can seldom find a way into it. The broader public, of whom some of the staff and students are part, do not communicate with outsiders. This leaves a huge gap between people on the inside and those on the outside, which can only be as a result of stigmatization. The complete lack and inadequate educational programmes in Lesotho affects the situation at the National University of Lesotho. Therefore, the Institution and the government in general have to address this problem by not just giving preventive educational measures, but also a

complete overview of the HIV/AIDS epidemic in rural areas. This may also require putting in place tough measures and policies to combat any form of discrimination and stigmatisation against people living with HIV/AIDS (PLWHA) and making health facilities more accessible to the people as well as increasing the coverage of ARV drugs to PLWHA.

Another important fact is to redress the problem of rural-urban migration by putting in place, rural development programmes that will stabilise the rural population since HIV/AIDS prevalence rates are lower in rural areas. This will reduce the number of people relocating to the capital city, Maseru, and reduce the risk the female and male university students face with the incentive of “sugar daddy”.

- Create safe conditions for the students. For example, tackle the problem of women inequality in Lesotho in general. It is not enough to enacting laws and legislation without implementation. Therefore, promoting activities that educate community.

However, the culture and tradition that sexual activities should be among married people can explain the silence and stigma around young unmarried adults’ sexual activities, and this need to be addressed. The research does not suggest that the culture should be ignored but a more outspoken and practical approach should be used. The prevention measures of contracting infection should by far continue, as it is the only way in which the HIV/AIDS prevalence rate can be reversed.

All the above-mentioned measures could be exploited to address the problem of HIV/AIDS at NUL. The popular campaign slogan ‘Know your Status’ that calls on Lesotho to abstain from sex, to be faithful to their partners or to use condoms is too narrow as it focuses only on sex needs to be revisited and updated with more in-depth information at the University. At its current stage, the slogan seems to have become a cliché, and is therefore falling on deaf ears as there is still no positive behavioural change at NUL regarding HIV/AIDS (Moeti, 2007:14; UNGASS, 2008:42). It is high time therefore for the University, government and other stakeholders in Lesotho start exploiting other measures to upscale the vulnerability to HIV/AIDS in Lesotho as a whole, for example make the study on HIV/AIDS a compulsory and examinable subject in primary, secondary and high schools in Lesotho as part of education and awareness campaign. More research is needed particularly by social scientists on ways to effect positive behavioural change especially among young adults who are the most affected by HIV/AIDS in Lesotho.

However, the principal response to HIV/AIDS on the NUL campuses should be carried out through the health faculty and clinics. These will increase medical attention regarding the

needs of students and staff, initiated condom distribution, promoted awareness-raising through posters and other educational materials (for instance, articles in university newsletters and newspapers or broadcasts on campus radio), and augment their capacities to provide counselling (Kelly, 2001:22).

6.4.3 Training, Education and Research

The government should, through the Disaster Management Authority (DMA), initiate education and training of the students on disaster risk reduction that will include information on the risk of infection and spread of HIV/AIDS as a new approach in national planning for sustainable development. The government of Lesotho and partner organisations in Lesotho should intensify the training of educators, social workers, community based organisations and cultural organisations on the prevention and management of HIV/AIDS in the country in general but for NUL specifically as it will empower the student to influence the younger generation.

Such wide-ranging educational measures will change culture (like the culture of denial and silence). More resources should be tailored to high schools as these programmes hold a bright future for pupils and a sound foundation against the HIV/AIDS epidemic. As well as identifying the aspect within the inherent culture that render the current and future generation vulnerable to HIV/AIDS infection. This information can be broadcasted on NUL local radio station called "Dope FM". This also can be used as a forum for discussion that involves students' leaders as well as some NUL staff members.

More systematic and improved methods should be made on HIV/AIDS data capturing and management that will include data captured by all health facilities including private clinics in the country. This recommendation is made because, from some of the returning comments in the empirical study, it seemed that data captured on HIV/AIDS is scattered not consistently and definitely not coordinated by health facilities at the university and beyond. Further research is needed especially from the social sciences on how to tackle the social dimensions of the impact of HIV/AIDS. A good example in this domain will be to have more research done on how to effect positive behavioural changes regarding HIV/AIDS in Lesotho without offending the culture and norms of the society.

It is recommended that further research be conducted on the vulnerability of HIV/AIDS on other young pupils in school in Lesotho for both urban and rural area in order to monitor vulnerability factors and probably develop strategies for specific cases. This will also inform policies to be included in education. In addition, a broader study sample should be done at

NUL including medical personnel need, counsellor, and some lectures within the university campus.

6.4.4 Policies

It is recommended that a national disaster management policy be formulated that will take care of all disasters, whether natural disasters or human induced disasters. Such a policy should be consistent with the national constitution and other government acts such as the *Lesotho Disaster Management Act of 1997*.

In direct relevance to NUL the draft institutional policy and strategic plan produced in 2002, need to be approved and implemented as so as possible.

6.5 CONCLUDING REMARKS

HIV/AIDS is a serious problem in Lesotho and affects all aspects of the society. A core lesson from this study is that when a country or community faces serious social, economic, political and even physical vulnerability which is coupled with a general lack of coping capacity, then such a society is highly exposed to hazards and its impact. Such an impact especially in a high institution like NUL may overwhelm the resources of that society or community and thus produce a disaster. The above statement explains why HIV/AIDS has become a disaster in Lesotho, reinforced by the fact that is not managed as such and this could be an explanation for the lack of commitment and the almost nonchalant approach the NUL has towards the epidemic.

From this study, it is also clear that HIV/AIDS has affected all the components of all the students either directly or indirectly, and although a change of behaviour has been determined by some students it is in varying degrees. The changes in behaviour have to be of a high percentage than it currently is. The behaviour toward HIV/AIDS is largely due to the cultural practice within the country, rendering students highly vulnerable to HIV/AIDS. The current situation poses a challenge to decision-makers and managers (including disaster managers) on how to contain and reverse the negative effects of HIV/AIDS on the students and population in general.

The institute and the government are not solely responsible for this change, especially since it is more of a cultural, moral and economic perspective. Parents of these students are supposed to be the primary source of information and support systems, and the students should be well informed about sex and associated risk, especially HIV/AIDS. The likelihood of acceptance and behaviour modification will be more conducive if these students are

raised in an open environment, where they will accept the warm, comfort and guidance from their parents. This parental care is very vital for the physical and psychological development of children, who will later use this as background knowledge to make future sexual decisions. Sexual intercourse topic is a taboo between children and parents in Lesotho, and therefore many of these students cannot talk to their parent about sex. In fact, the challenges facing students in NUL about HIV/AIDS should be addressed and investigated in another research.

In conclusion, the world especially developing countries like Lesotho, is facing serious challenges because of increase in HIV/AIDS prevalence rate and population vulnerability, due to social, economic, political and economic factors. However, NUL cannot solely address the problem; there need to be continuous monitoring, improvements on strategies to combat the effects of the epidemic and the reallocation of national resources by the government of Lesotho and partner organisations to areas that will minimise these vulnerabilities and ultimate risk of HIV/AIDS. Although, the first step to reducing HIV/AIDS at NUL can only start with implementation of previously developed programmes and policies.

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APPENDIX 2

Good day I'm **Kehinde Balogun** and am working for (*DiMTEC*) and also conducting a research for my **Master's dissertation**. I am conducting a survey vulnerability of students to HIV/AIDS at the National University of Lesotho, purposes of this is to find out how vulnerable students are and make recommendation to address the problems in order to plan future higher education programs in Lesotho.

The information you provide will be kept strictly **CONFIDENTIAL**. You and your fellow students will not be identified by name or address in any of the reports written.

PLEASE BE HONEST IN YOUR ANSWER for precise and relevant solutions. **THANK YOU**

1. Age: _____ and; Sex (M/F): _____

2. Year of Study: _____

3. Are you on Man Power scholarship?

NO		0
YES		1

4. Do you get money from anywhere apart from Man power?

NO		0
YES; specify		1

5. How would you classify family?

VERY POOR		0
POOR		1
JUST OK		2
RICH		3
VERY RICH		4

6. How many of your parents are still alive?

ONE		1
TWO		2
NONE		0

7. Do you have friends in Roma or Maseru area?

YES		1
NO;		0
SPECIFY		

8. Do you have a partner?

YES		1
NO		0

9. Do you consider your partner's wealth (amount of money) to be?

LESS THAN YOURS		0
SAME AS YOURS		1
MORE THAN YOURS		2
A LOT MORE THAN YOURS		3

10. Have you ever had sex?

YES		1
NO		0

LESS THAN 15		1
LESS THAN 20		2
LESS THAN 25		3

11. At what age did you first have sex?

MORE THAN 25		4
NEVER		0

12. When last did you have sex?

MORE THAN 1 YEAR AGO		1
WITHIN 6 MONTHS AGO		2
IN THE LAST MONTH		3
LAST WEEK		4

13. Did you use a condom?

NO		0
YES		1

14. How often do you use a condom?

NEVER		0
MY PARTNER DOESNT LIKE IT		1
WHEN I REMEMBER		2
ALMOST EVERYTIME		3
EVERYTIME		4

15. Do you think you have MORE sex when you used

I DON'T KNOW		0
NEVER		1

OTHER SUBSTANCES		2
WEED		3
ALCOHOL		4

16. If you did not want to have sex, how confident are you that you would be able to refuse it?

DEFINATELY COULD NOT		0
PROBABLY COULD NOT		1
PROBABLY COULD		2
DEFINATELY COULD		3

17. Have you ever been tricked or pressured to having sex by friends/partner or both?

NO		0
YES		1

18. About how many of your friends do you think have had sex?

NONE		0
A FEW		1
ABOUT HALF		2
MOST		3
ALL		4

19. How many people have you had sex with in the past year?

0		
1		

2		
3		
OTHER (please specify)		

ONE		0
TWO		1
THREE		2
FOUR		3
OTHER (please		4

20. Within the last 2 years have you had sex with a person

2 YEARS OLDER		1
3 YEARS OLDER		2
5 YEARS OLDER		3
10 YEARS OLDER		4
OLDER THAN 10 YEARS		5

21. How many people did you have sex with this year?

specify)		
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22. Did you get tested for HIV/AIDS this year?

NO		0
YES		1

23. If you found out were HIV positive, would you tell anyone?

YES;		1
Specify		
NO;		0
Specify		

24. Would you buy your own condoms?

YES		1
NO;		0
State why		

25. Do you know an HIV positive person?

NO		0
YES		1

26. If **YES** to question 26; how do you think it has affected their lives?

27. Women are treated as being equal to men in NUL or Lesotho in general?

YES;		1
Explain		
NO;		0
Explain		

28. How do you think the HIV/AIDS programmes on campus and Lesotho helped you?

29. What do **you think** should be done to improve the HIV/AIDS programmes for students like yourself?

THANK YOU, for your time.

If you will like to know more about Masters in Disaster Management in Bloemfontein, Please feel free to talk to me.

