Gendered Impact of HIV/AIDS on Livelihoods Among Infected and Affected Farm Households in a Selected Community in Koinadugu District, in Sierra Leone.

By

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DECLARATION

I declare that the dissertation entitled **Gendered Impact of HIV/AIDS on Livelihoods Among Infected and Affected Farm Households in a Selected Community in Koinadugu District, Sierra Leone** is my own original work. Furthermore all the resources cited or quoted are indicated and acknowledged by means of a complete list of references and that this work has not been submitted before for any other degree at any other institution.

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Date December 2015

Supervisor's Full Name : Professor Robert Pattman

Date December 2015

Dedication

This dissertation is dedicated to my dearest late sister Miss Hendretta Veronica Kumba Adama Joseph who passed away on the 9th August 2001, at the age of 36 years. She was a mother to me at a very young age. May your dear soul rest in peace and may light perpetual continue to shine on you, may God be with you till we meet again. Sleep on beloveth, sleep and take your rest.

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[1] Co-funding organisation of my study
[2] Co-funding organisation of my study

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Abstract

This study explores the impact of HIV and AIDS on farming households in Koinadugu District, Sierra Leone. There is a strong relationship between HIV/AIDS and nutrition; as poor nutrition reduces the immune system's ability to fight infections which hasten the progression from HIV to full-blown AIDS, and / or HIV/AIDS itself may lead to malnutrition. It draws on interviews with policy makers /service providers, as well as with men and women in households with farm workers infected by HIV/AIDS. Koinadugu District is predominantly agrarian, with many adults, mainly men, involved in small scale agricultural production. However, it also has the highest rate of HIV infection of all the Districts in Sierra Leone during the 2005 HIV/AIDS sero prevalence survey. Of particular interest, this study is concerned about the social and economic impact of HIV/AIDS, and the gendered forms this takes. In order to ameliorate the impact of HIV/AIDS on farming households, this study recommends the provision of labour saving devices, improved seeds and better storage and processing facilities for farmers, as well as educational and health facilities for farming and other households. It also recommends improvements in nutrition through support for enhanced food crop diversification.

- **Key words / Concepts**

HIV/AIDS, Livelihood, Infected and Affected Farm Households, and Sierra Leone

List of Figures and Tables

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
CBO	Community Based Organization
CDC	Centre for Disease Control
CDW	Community Development Worker
DAC	District AIDS Committee
DFP	District HIV/AIDS Focal Person
DHS	Demographic and Health Survey
DMO	District Medical Officer
HIV	Human Immune Deficiency Virus
IEC/BCC	Information Education Communication/Behaviour Change
NAS	National HIV/AIDS Secretariat
NGO	Non-Governmental Organization
NETHIPS	Network of HIV Positives
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
SHARP	Sierra Leone HIV/AIDS Response Project
SLDHS	Sierra Leone Demographic and Health Survey
SSL	Statistics Sierra Leone

STI	"Sexually Transmitted Infection[3]"
TB	Tuberculosis
UNAIDS	United Nations Programme on HIV/AIDS
UNGAS	United Nation General Assembly Special Session
VCCT	"Voluntary Confidential Counselling and Testing[4]"
WHO	World Health Organisation

[3]Government of Sierra Leone, (2008)
[4]Government of Sierra Leone, (2008)

Definition of terms

Infected household[5]: A household in which one or more members is /are either ill or has/have died of AIDS related causes.

Affected household[6]: A household in which household members are not HIV/AIDS positive, but have been affected by HIV/AIDS through supporting the infected or HIV/AIDS orphans.

Livelihood: Sources of income and food, which for this study, includes the agricultural and non-agricultural activities of HIV positive farmers and their food security status which refers to the availability, access and affordability of food, and their wellbeing.

Vulnerable children: Is a child under the age of 18 whose primary care-giver, i.e. their mother or father has died and they are in need of care[7]. In respect of this study, a child is termed vulnerable if they are under the age of 18 and no longer well provided for by one or both parents due to the ill health or death of one or both parents to HIV/AIDS.

Informal sector: For this study is PLWHAs engagement in non-farming activity such as petty trading as either a main or supplementary source of livelihood.

Response strategy: This is the strategy used as a temporary remedy to meet certain basic needs during a crisis period, such as HIV/AIDS epidemic, Cholera and other disease outbreak.

"**Quota-sample:**"[8] This is a small sample group of people used for research purposes who have been selected at the discretion of the interviewer, who fulfil the researcher's condition for selection; in this study, the quota-sample are the PLWHAs who are farmers.

[5] Muller, T R. (2005):18
[6] Muller, T R. (2005):18
[7]Economic Commission for Africa, (2004), R. Oladokun, et al., (2009)
[8]http://www.answers.com/topic/quotaa-sample accessed November 2010

Improved seeds: These are seeds that have better crop yield, but have a fairly short crop duration, yet are resistant to pests and diseases

Pandemic: Disease prevalent over a whole country or the world

Chapter One

Introduction

1.1 Background

While a number of Government studies have been conducted in Sierra Leone,[1] on the economic and sociological impact of HIV/AIDS, there has been little research focus on gender, and more specifically on the gendered impact of HIV/AIDS on families in agricultural communities and their livelihoods. This thesis aims to fill this gap in the research literature.

In this study I engage with HIV/AIDS as a pandemic which has affected livelihoods to the point that their sustainability,[2] is now being questioned, but, following Hanrahan (2015), my work adopts a "holistic approach" which attempts 'to situate livelihood practices within a larger social and environmental context."[3] I understand livelihood practices not simply as economic but social and gendered practices, with men and women performing different kinds of social roles in the household economy, and the effects of HIV/AIDS on the household economy being mediated by gender.

The study takes a qualitative approach in exploring, and describing in-depth the impact of HIV/AIDS on those infected and affected in households in agricultural communities. Such an approach was adopted in order to facilitate insights into the ways men and women in such households experience and understand the impact of HIV/AIDS, and how these may influenced by the roles they are expected to play as men and women. In this sense, I address HIV/AIDS in my research not just as a medical but also a social problem."[4]

[1]Government of Sierra Leone,(2013, 2008, 2006-2007, 2005a, 2004)

[2]Scoones, I. (1998):5

[3]Hanrahan, K. (2015):382

[4]Saki M et al., (2015):2

1.1.1 Impact of HIV/AIDS on farming households in Koinadugu District in Sierra Leone

Disease in this case HIV/AIDS is "an abnormal condition of a part, or system of an organism resulting from various causes, such as infection, inflammation, environmental factors or genetic defects and characterised by an identifiable group of signs, symptoms or both."[5] Some gradually build up while some are sporadic[6] like HIV/AIDS and Ebola respectively. Some can be mitigated, some are deadly. How it makes manifest can either be accommodated or lead to stigma in a household or community. In this study, I will be looking at HIV/AIDS and its gendered impact on both the infected and affected household members.

HIV/AIDS has a spatial dimension with high infection rates in areas where there are heavy convergences of people, because the population will be very fluid. This may be a contributing factor to Koinadugu District, where I am conducting my research in Sierra Leone, being ranked as the highest HIV/AIDS prevalent District in the 2005 HIV/AIDS sero prevalence survey.[7] For this District shares boarders with several other Districts and with neighbouring Guinea.

HIV/AIDS can be contracted through unprotected sex with an infected pattern, through blood transfusion, and sharing of skin piercing or cutting instruments. And interventions so far on the part of government and NGOs are to sensitize the populace on the basic facts of HIV/AIDS, and positive living. Sierra Leone is emerging from a brutal civil war from 1991-2002 and another disaster of Ebola in 2014 - 2015.[8] These had serious consequences on the health, social and economic development of people in the country, and especially those living in predominantly rural areas such as Koinadugu District. The problem has been further

[5]www.yourdictionary.com (accessed February 2017)

[6] Braak et al., (2006)

[7]Government of Sierra Leone (2005a)

[8]Bureau of African Affairs (2016)

exacerbated by the emergence and rapid spread of HIV/AIDS. The situation is such that the disease is communicable and can lead to death, therefore not acceptable in the community, which has led to stigma and discrimination.

This emphasises the importance of taking a holistic approach when addressing HIV/AIDS, since its causes and effects are not just medical but mediated by economic, social and cultural conditions, norms and arrangements. The purpose of the research is to explore the link between HIV/AIDS and the threat it poses to human wellbeing and existence using HIV/AIDS, with a particular focus on a case study on gendered impacts of the disease on infected and affected families living in agricultural communities in Koinadugu District.

1.2 Problem statement

The study aims to address the (gendered) impact of HIV/AIDS on the livelihoods of selected PLWHAs who are farmers and their households and to assess some of the livelihood response mechanisms employed.

Findings from studies on smallholder agriculture (which is predominantly the case in rural Sierra Leone) indicate that households affected by HIV/AIDS experience fall in agricultural production as compared to non-affected households.[9] And this in turn leads to food insecurity and consequently lack of proper nutrition and faster progression to full blown AIDS. It has therefore become a necessity for nutritional interventions to be a key component in living positively with the virus. ARV must be taken for life to be effective, and patient adherence to therapy, as well as good nutrition, is crucial.[10]

[9]Arrehag, L. et al., (2006):112

[10]Arrehag, L. et al., (2006):35

"The impact of HIV/AIDS on families affected by HIV/AIDS depends on a number of different factors such as their socio-economic conditions," [11]access and sources of labour, and other productive resources, as these determine the coping strategy they employ. Economic development and improvement in the material needs of life are closely linked with social wellbeing, and are key issues in enabling the coping mechanism of individuals, communities, and nations to cope with stress.[12] This research also investigates areas of intervention by institutions working on HIV/AIDS and assesses whether they have any nutritional interventions in place for PLWHAs, to enhance these people's capacity to live positively with the virus.

Of particular interest in this study, is the gendered impact of HIV/AIDS on farm households and livelihoods. "This is because women allocate their work time and manage risk differently than men for a complex set of reasons, including cultural gender roles, and access to agricultural productive resources"[13] (as is the case in many other African countries, Sierra Leone being no exception). In Sierra Leone, literature on the gender dimension of HIV/AIDS is lacking, therefore this research using a qualitative methodology will give in-depth views on the impact of HIV/AIDS from a gender perspective which will attempt to close the existing gap. The goal of this study therefore is to explore the social and economic impact of HIV/AIDS on male and female members of farm households in a selected community in the Koinadugu District.

1.3 Motivation for this study

My research focuses on the (gendered) impact of HIV/AIDS on livelihoods, which can be understood as "the dynamic social and material contexts that exert pressure on actors even as

[11]Arrehag, L. et al., (2006):17

[12]Mukuna, T. (2015):14130

[13]Ahear, M. (2010):1

those actors reshape them."[14] In their construction of livelihood, they see "livelihood as going beyond just considering material wellbeing but also considering the social wellbeing"[15] of a household at a micro level in meeting livelihood needs. "A livelihood system is an environment of human activities, which is aggregate, dynamic and integrates the opportunities and assets available to male and females as means of achieving their goals and aspirations."[16]

For many years, the HIV/AIDS pandemic was perceived only as a health issue, but the disease has spread to an extent that it has become a concern not only to the health sector but to the agricultural, development, economic, social and political sectors. Thus the need for the government of Sierra Leone to have a HIV/AIDS focal person in all line ministries and institutions. As such I am the HIV/AIDS focal person for the Sierra Leone Agricultural Research Institute.

In 2004, the HIV/AIDS focal persons, which included myself, undertook a sensitization of women farmers in Koinadugu District on the basic facts about HIV/AIDS and in such meetings the role played by the Muslim religion and culture was quite vivid, as we demonstrated the proper use of condom on a carved penis, the women started saying "allahwakuba" meaning "Allah have mercy" and the majority of them moved out of the hall. With regards the use of condom, they categorically told us they will not even dare initiate that discussion with their husbands. It was no surprise when I read the 2005 sero prevalence report which rated the District as the highest prevalence then. It was factors such as these which prompted me to undertake this study on social (and gendered) factors which contribute to and which impact on HIV/AIDS as it is experienced by members of families in agricultural communities in Koinadugu District.

[14]Jakimow, Carr, as cited in Hanrahan, K.(2015):383

[15]Jakimow, Carr, as cited in Hanrahan, K.(2015):383

[16]Hanrahan, K.(2015):383

1.4 Objectives of the study

1. To explain the extent to which HIV/AIDS affects family structures and the livelihoods of farm families in Koinadugu District in Sierra Leone.

2. To describe the impact of the disease on the agricultural sector in terms of knowledge and skill loss from chronic illness and death.

3. To explore options available to infected and affected households, and response strategies adopted by men and women in the face of HIV/AIDS and whether these strategies are sustainable or not.

4. To explain the key social and economic challenges faced by farming households with adults infected with HIV/AIDS, and the particular ways in which they impact on household members in relation to gender, age, status, and position in the family.

5. To describe the prevalence and effects of social stigma on males and females in farming households infected and affected by HIV/AIDS.

6. To explore forms of support, if any, that are provided for HIV infected members of farming households within and outside the household.

7. To recommend to Policy makers and service providers on areas of intervention where farmers living with HIV/AIDS face greatest challenge in Koinadugu District.

1.5 Chapter outline

In *Chapter One,* I have introduced my study and discussed its rationale and my motivations for engaging in this study. I have also presented the key objectives.

In *Chapter Two,* I review pertinent literature, which focuses on HIV/AIDS and its impact on farming communities and households on local, and at global levels in sub-Saharan Africa and Sierra Leone. I focus on particular themes in the literature, relating to the (gendered) impact of HIV on farming households, and how members of households affected and infected with HIV/AIDS cope with this.

Chapter 3, engages with theoretical perspectives which influence my research. These include the Functionalist perspective of the sick role, the gendered and livelihood perspective as presented by Hanrahan,[17] which goes beyond material livelihood, to that of social wellbeing of HIV/AIDS infected and affected.[18] I elaborate on socialist feminist perspectives which influence my research.[19]

In *Chapter 4,* I discuss methods and methodology, describing my study site as well as the kinds of livelihood activities engaged in by its indigenes including research participants, and reflecting on methods of the data collection in my research and forms of analysis. Semi - structured interviews with two categories of respondents were conducted with adults living with HIV/AIDS who were members of farming households and people who worked as Policy makers and service providers for farmers in the community, and whose work brought them into close contact with members of farming households with HIV. I discuss my commitment towards establishing research relations with my participants which attempted to position them as authorities and experts in relation to themes I wanted to explore, and also to make them feel at ease with me.

[17]Hanrahan, K.(2015):383

[18]Hanrahan, K.(2015):383

[19]Hartmann, as cited in Kendall, D. (2008):375

In *Chapter 5*, I present empirical findings from my research with both PLWHAs and service providers focusing on the kinds of issues and concerns which they raised concerning the impact of HIV/AIDS on farming households and the community. I also focus on the HIV positive members of farming households whom I will interviewed about the impact of HIV/AIDS on farming households as understood and experienced by them.

Drawing on this data, I summarise some of my key research findings in *Chapter 7*, and based on these outcomes, I put forwarded certain recommendations.

1.6 Limitations

Initially my intention was to individually interview children, as well as adults, in farm households of PLWHAs in line with the contemporary interest by many researchers in understanding children as social agents and as constructors of their social worlds as being fundamental to studying their experiences and ways of addressing their health and social wellbeing of their daily existence,[20] and the research methodologies were developed around this. But PLWHAs refused consent for me to interview their household members including children, except in the situation wherein both couples were positive. This was because, in large part, they did not want their children to know they [the adults] were HIV positive.

After my proposal had been approved by the higher degrees committee and preparation to leave South Africa for data collection in Sierra Leone, my donors raised a host of suggestions and queries on the link of the project title with agriculture, this was shared and discussed with my supervisor, and as a result of this, the themes the project addresses were altered with more focus on agricultural technologies.

[20] Brady, G., Lowe, P. and Lauritzen, S.O.(2015)

My return trip back to South Africa was also delayed by donors based on funds allocation and purchase of return flight ticket.

In the field, going through all the gatekeepers proved challenging and reduced the time I had allocated for data collection but this was necessary and mandatory. Some literate respondents who were given interview guides and informed consent forms in advance of interview misplaced them.

Data collection and transcription of recorded data proved very challenging and time consuming. Also, I encountered other personal challenges among which were ill health, socio-economic, and psychological problems while in Sierra Leone when trying to write up my research (as well as a health problem my supervisor had) led to considerable delays in this study.

Chapter Two

Literature Review

2.1 Global perspectives of HIV/AIDS and agriculture/livelihood/food security

The HIV/AIDS pandemic has escalated at an alarming rate and the negative impact is increasingly felt in all aspects of human development: health, economic growth, nutrition, food security, livelihood and the environment. Out of all countries in which HIV and AIDS is endemic, those in sub-Saharan Africa (SSA) are worst hit as most agricultural operations in Africa, Asia and Latin America are carried out by human labour. HIV and AIDS is most often diagnosed in people aged between 15 and 49 years[21] because it is more likely that these people are involved in risky behaviour, than people older than 50years.

The Gross Domestic Product (GDP) growth rate in areas long associated with HIV/AIDS is being drastically reduced and the wealth produced by an agricultural workforce is lost through deaths among farmers due to HIV/AIDS. Families are forced to do auctions of their asset to raise capital for treatment of HIV and AIDS diseases. Furthermore, as I elaborate later, members of families may need to make adjustments to gender normative roles they play as "carers" and "breadwinners" in agricultural households.

Nutrition, the process involved in taking in nutrients from foods consumed, and improving nutrition by consuming a balance of: carbohydrate, fats, protein, minerals, vitamins and water can play an important part in determining the welfare of people infected and affected by HIV/AIDS and their ability to improve their livelihood.[22]

[21]Arrehag et al., (2006):16

[22]SWIHA Bulletin, (2006)

The outcome is likely to be a severe curb on domestic demand for farm produce, prolong period of low prices of farm produce, and a reduced incentive to produce more for the market.[23] The likely outcome then would be a move to extensively produce primary crops for local subsistence, with a slow economic returns and weakened prospects of reducing poverty.[24]

2.2 HIV/AIDS and agriculture/livelihood/food security in Africa

In-depth research on the socio-economic consequences of HIV/AIDS in sub- Saharan Africa was first undertaken in the late 1980s and early 1990s when the presence of the disease became visible and concerns were raised on how it would impact the world's economy.[25] Studies then mostly focused on the future potential impact of HIV/AIDS on agriculture since the actual impact had not been seen, realised and studied.

Mano and Chifupa claim that the emergence of HIV/AIDS, has led to possibilities of dissolving beneficial allowances the rural households were receiving from urban industries, and a possible transfer of sickness and its impact on rural livelihoods.[26] Against this backdrop, this research will attempt to explore the possible gendered impact of HIV/AIDS on livelihoods to gain insight into the gender roles and livelihood options before and after infection in PLWHAs.

Research has shown that by the time one person dies of HIV/AIDS, two productive years have been lost due to illness and care giving.[27] Another study states that in spite of the fact that 80% of the people in most countries in sub-Saharan Africa depend on agriculture for their subsistence, most of the response to the pandemic has come from the health sector.[28] In communities where the vast majority of the adults are dying, leaving only the elderly and

[23]Slater, R. and Wiggins, S. (2005):2

[24]Slater, R. and Wiggins, S. (2005):2

[25]White and Robinson as cited in SWIHA, (2006):102

[26]R. Mano and U. Chipfupa as cited in SWIHA, (2006):61

[27]Tempelman, D. (2007)

[28]http://www.fao.org/hivaids/(accessed September 2010)

children, the agricultural sector has had to revise the content and delivery of services, as well as the process of agricultural knowledge transfer.[29] The agricultural sector is in a strong position to assist in both the prevention and mitigation of the consequences of HIV/AIDS, as it has a responsibility to those people who depend on agriculture for their survival;[30] hence, agricultural policies need to take into account the changes occurring in society, such as agricultural practices, access to machines and agricultural inputs.

A study conducted in sub-Sahara Africa in five villages in Malawi concluded that rural households affected by HIV/AIDS are losing or have lost a large part of their assets (e.g. land, vehicles, televisions, stocks in the market) largely because of the impact of HIV/AIDS.[31] Further evidence also indicates that of selling an asset for financial, social or political goals to be higher amongst households with a HIV/AIDS-related death than for other households.[32]

However, the collaboration among various stakeholders groups; (e.g. government, civil society, and private sector) the approach with HIV/AIDS does not strongly make use of the advantages in agricultural production. The involvement of stakeholders in agriculture should focus on ensuring that they address the needs of HIV/AIDS farming households. A combination of interventions such as food aid, agricultural inputs, subsides and technical support is required to assist households affected by HIV/AIDS.

2.3 Rural- urban dimension of HIV/AIDS

When studying the impact of HIV/AIDS in the context of sub-Saharan Africa, it is imperative to consider the rural-urban dimension because migrant workers in urban areas when infected and sick with HIV/AIDS often return to their rural homes, which leads to an increased burden

[29]http://www.fao.org/hivaids/(accessed September 2010)

[30]http://www.fao.org/hivaids/(accessed September 2010)

[31]Phinder, as cited in Arrehag, L et al., (2006):61

[32]Mbaya, as cited in Arrehag, L et al., (2006):61

on rural households.[33] The impact of HIV and AIDS is of critical significance because of illness.[34] Illness prevents working, which reduces a person's pay, which restricts the amount of food / assets / medicines that can be bought / which negatively impinges on their lifestyle which causes them to be below the breadline which affects their security which impinges on their ability to get well.

Many people who live in rural areas have to leave their families to work in urban areas. People that have migrated to urban areas often assist their families by sending money to them to aid their families in paying school fees, purchasing food and clothing items. Urban workers, particularly men, return to their homes on holidays especially over the December holidays or during periods when they are unemployed.[35] Rural households and communities may also suffer from the impact that the disease has on the wider economy. Sicknesses and death in family members living in urban areas can lead to loss of remittances, impose additional costs in terms of caring for the ill person, if the person returns to the village for the final stages of the disease and subsequently this may also cause serious impact on the rural family's financial position as there is less money to purchase goods.[36]

2.4 HIV/AIDS impact on rural livelihoods

When studying the impact of HIV/AIDS in the context of sub-Saharan Africa, one of the most important areas to consider is how the epidemic affects agriculture and rural livelihoods. The impact of HIV and AIDS in connection to rural livelihoods facilitates the understanding of the epidemic as not only affecting individual households but also on livelihood options.[37]

[33]Muller, T R. (2004):21

[34]Topouzis, as cited in Muller, T R (2004):22

[35]Carson, as cited by Muller, T R. (2005): 46

[36]Slater, R. and Wiggins, S. (2005):2

[37]Beuma; Barnett &Haslwimmer; NAADS as cited in Muller, T R (2004):31

To understand the dynamics between HIV/AIDS and rural livelihoods more broadly, some writers looked at the impact HIV/AIDS has on the context of rural people's livelihoods.[38] They analysed how the disease affects human, financial, social and physical ability in so far as it strips individuals, households, networks and communities of assets.[39] Comparative case study research has also shown that household group members respond differently to the additional costs of HIV/AIDS related illnesses and death, based on their asset or resource bases, these groups may cause a family to become more vulnerable and even destitute or even more vulnerability among household members. The more diversified the latter, the more options are available.[40]

With their increased vulnerability, members of households may resort to dangerous response strategies which may further undermine the future survival of the households infected and affected by HIV/AIDS;[41] like the distress sale of productive resources, withdrawal of children from school, and a switch from commercial to subsistence farming, producing crops just for household consumption. More generally, it has been argued that what should be of utmost importance in responding to the HIV/AIDS pandemic are strategies such as, awareness creation, avoid unsafe sex and proper hygiene that will enhance the resilience of livelihood systems to any disease outbreak, which will at the same time reduce susceptibility and vulnerability of the households to the HIV/AIDS epidemic.[42] Another study argues that this crisis should not be analysed as an emergency at household level, but as a livelihood crisis at community level which requires an integrated approach that addresses the underlying causes of vulnerability.[43]

[38]Haddad & Gillespie; Seeley; Stokes as cited in Muller, T R (2004):31

[39]Haddad & Gillespie; Seeley; Stokes, as cited in Muller, T R (2004):31

[40]Muller, T R (2004):32

[41]Haddad & Gillespie, as cited in Muller, T R (2004):32

[42]Chopra, as cited in Muller, T R (2004):32

[43]Devereux, as cited in Muller, T R (2004):32

2.5 HIV/AIDS impact at rural household level

The impact of the epidemic on rural households practicing small holder agriculture impinges negatively on their food security. Food security is a basic need without which survival itself is put into question. It has been shown that HIV/AIDS has affected, and will continue to affect the ability of households to food access in the quantities and quality necessary for household members to live a healthy life.[44] HIV/AIDS has led to the breakdown in social solidarity and bonds also contributing to food insecurity.[45] Research in West Africa has shown that the most immediate problem for many AIDS- afflicted female headed households is not medical treatment and medicine, but food and malnutrition.[46] Food security is generally considered to be in danger when women are no longer able to produce the same amount of supplementary food crops especially cassava and potatoes.[47]

With the important role played by the agricultural sector, the loss of work might not in every case be the single most important impact,[48] but rather the loss of money to pay for hired labour, thus, households will have to depend only on household labour and this leads to a drop in food crop and animal production.

There is also an increase in the dependency ratio, wherein a higher number of dependants rely on smaller numbers of productive household members, and this may result in: (1) altered values within the community when young farmers for example, have been observed not to be interested in farming anymore;[49] (2) changes in age structure and quality of the agricultural

[44]Muller, T R (2004):33 -34

[45]Barnett, as cited in Muller, T R (2004):34

[46]Black- Michaud, as cited in Muller, T R (2004):34

[47]Timbaituka, as cited in Muller, T R (2004):34

[48]Ellis, as cited in Muller, T R (2004) :34

[49]Muller, T R (2004):46

labour force as more elderly people and children assume greater roles in farming; and (3) an increase in child/orphan headed and grandparent headed households.[50]

2.6 The global mirror of gender and HIV/AIDS

The HIV/AIDS pandemic has raised concerns about a crisis of gender inequality.[51] Women's subordinate position in society as well as limited access to income generating activities (agriculture, trading and education) makes women dependent on their male counterparts both in the household and workplace settings.[52] Low condom use by women may also reflect women's overall subordinate position in society, which implies powerlessness to negotiate abstinence or condom use.[53] For instance, in many communities a woman may not request condom use from her partner for fear of being accused of unfaithfulness and consequently violent retribution from her partner.[54] Underlying most of these factors are the crucial issues of gender inequality and male domination in economic and sexual relationships.[55]

Gender based violence is both a cause and a consequence of HIV/AIDS.[56] This means it does not only reinforce the subordination of women, but it is also connected to physical and social factors and individual thought and behaviour. Fear of violence stops women from accessing HIV/AIDS information, seeking and receiving treatment, disclosure of status when they are aware of their positive status and the consequences of divorce with their husbands. At the same time, AIDS may cause violence and worsen the situation for women who are already suffering from gender based violence and in most cases it is intimate partner violence, and husbands are

[50]White & Robinson, as cited in Muller, T R (2004):46
[51]Arrehag et al., (2006):42
[52]Arrehag et al., (2006):42-43
[53]Arrehag et al., (2006):49
[54]Arrehag et al., (2006):49
[55]Arrehag et al., (2006):49
[56]White et al., as cited in Arrehag et al., (2006):43

the main perpetrators.[57] Research also indicates that in some cases violence is also perpetrated by the in-laws.[58] Under these circumstances, marriage is therefore a woman's primary HIV risk factor since they have little or no power at all within their marriage to abstain from sexual intercourse or to negotiate safer sex.[59]

The culture of silence surrounding sex in many cultures dictating that so-called 'good women' are expected to be ignorant about sex and passive in sexual interactions makes it difficult to inform women about risk reduction and negotiating safer sex.[60] Gender norms also determine what women and men are supposed to know about sex and sexuality, and hence limit their ability to accurately determine their level of risk and to acquire accurate information and the means to protect themselves from HIV/AIDS.

Women's economic dependency also increases their vulnerability to HIV as it may lead to transactional sex for money or goods.[61] This imbalance of power between men and women curtails female sexual autonomy and expands male sexual freedom, thereby increasing the risk and vulnerability of both genders to HIV.[62]

2.7 Social stigma and HIV/AIDS

Stigma is another important issue in the context of gender and HIV/AIDS. Stigma is a set of negative and often unfair beliefs that a society or group of people have about something e.g., HIV/AIDS. Stigma and discrimination arise from and reinforce unequal social relations, as illustrated in studies of discrimination in relation to HIV/AIDS which situate this in the context

[57]Arrehag et al., (2006):43
[58]Arrehag; L et al (2006):43
[59]Arrehag et al., (2006):43
[60]Gupta as cited in Minke et al., (2006):18
[61]Minke et al., (2006): 18
[62]Minke et al., (2006): 19

of institutionalised gender power relations..[63] In some communities, HIV/AIDS is seen as a sign of sexual promiscuity and in such communities, stigma is much higher for women than for men who are much more likely to be expelled from their homes and families.[64] Stigma is not only discrimination expressed by individuals but also a social phenomenon which builds on and reinforces existing differences. It is also used by dominant groups to justify and perpetuate inequalities such as those based on gender, age, sexual orientation, class, race or ethnicity.

Therefore, HIV/AIDS organizations need to intervene to educate men and women, from areas in which HIV and AIDS is wide spread, about the dangers of stigmatisation and to support infected and affected people who may be stigmatised because of HIV/AIDS. What we have learnt from HIV/AIDS is that the involvement of the community is crucial for successful interventions,[65] at all levels: household, community, national and international.[66]

About half of the women (49%) and nearly three quarters of men (73%) respondents said that they were willing to take care of a family member who was HIV positive in their household,[67] while about 60% of both men and women said they would not want to keep secret that a family member was HIV positive.[68] Empowering persons living with HIV/AIDS is a critical programme area as this survey shows that only 20% of women and 40% of men would buy fresh vegetables from a shopkeeper who is HIV positive, while 31% of females and 53% of men said that an HIV- positive female teacher should not be allowed to continue teaching.[69] Stigma is an issue with PLWHA and this research attempted to explore the gender dimensions

[63]Parker and Aggleton as cited in Minke et al., (2006):19
[64]Wegelin – Schuringa, as cited in Minke et al (2006):20
[65]Minke et al (2006):20
[66]Government of Sierra Leone, (2008):191
[67]Government of Sierra Leone, (2008):191
[68]Government of Sierra Leone, (2008):191
[69]Government of Sierra Leone, (2008):191

of stigma at both household and community levels with focus on discordant couples if any, self-stigma and effects on livelihood options and response strategies.

2.8 The gendered impact of HIV/AIDS on farming households in Africa

The gendered dimension of HIV/AIDS is taking a lead in interventions geared toward addressing the pandemic because women are responsible for between 60 and 80 percent of food production in developing countries.[70] Gender inequality and socio-cultural norms determine women's roles in producing and securing food for the family as well as what resources they have at their disposal to produce food, what food they can produce and who consumes the food that they produce.

Women are disproportionately burdened with having to secure food, as well as most other aspects of household tasks including securing water, fuel and firewood, processing crops and preparing food. Despite their central role in providing food for the households and heavy workload incurred, women have relatively little control over the resources needed to conduct these tasks.[71]This research explores the consequences of gender inequalities in the face of HIV/AIDS and the effects on widows and orphans with regards to access, ownership and use of productive resources using the socialist feminist theory of gender inequality. An understanding of gender inequities and inequalities in the household and elsewhere is essential when studying the impact of HIV/AIDS on affected households and livelihoods.

Many women are caught in a cycle of economic dependency on men who are often not equal partners in relationship with them. Furthermore, many lack property rights and will often lose property when their husbands die,[72] and in some cases they are even part of the husband's property that gets inherited by his family. Factors such as these clearly have important

[70]FAO; Mehra and Rojas, as cited in Doss, C. (2011):3

[71]http://www.actionaid.org/what-we-do/food-rights/women-farmers (accessed June 2011)

[72]Kasiram, M. et al., (2006):35

implications concerning the impact of HIV/AIDS on members of households and their livelihoods when a male or female member becomes sick with HIV/AIDS.(this is elaborated in Chapter 3).

Some studies have shown that Swaziland has the worst HIV epidemic in the world, with a lot of contributing factors, amongst which are the cultural practices like; role of women and how they are perceived by men and polygamy which is a major issue.[73]Many women lose their rights to matrimonial land upon the death of their spouses. When this situation arises, women employ a range of coping strategies to ensure continued access to land. Such strategies include remarriage to gain access to a new piece of land, never re-marrying in order to secure the permission of in-laws to continue to access late spouse's land through a relationship with the late spouse's brother (wife inheritance). This is relevant to this research since one of the theories informing this research is feminism which discusses issues of female exploitation.

Moreover, young women or orphaned girls also often enter into marriage at the expense of their education. For female orphans, marriage becomes a rescue mission in the sense that they will use it as a way of escaping the hardship of dealing with the loss or chronic ill health of their parents as this may have caused them the low status of being an orphan.[74] Unfortunately more often than not their situation gets even worse. In a similar process, orphan girls who are already made vulnerable by AIDS face an even higher risk of contracting HIV.[75]

Some of the most commonly reported gender dimensions of HIV/AIDS include: access to land and other productive resources as the epidemic reinforces the problems women face with regards to property and inheritance rights. After their husband's death, women are often left without control over land or other means of production, making it very difficult if not

[73]Whiteside et al., (2006):18-20

[74]Arrehag et al., (2006):71

[75]Bryceson et al., as cited in Arrehag et al., (2006):71

impossible for them to support their children and their own livelihoods. Property grabbing is the order of the day in most African countries, mostly by male relations from the deceased husband's side and they abandon their common customs and traditional practice of providing and caring for their deceased relative's immediate family: wife and children.[76] Unfortunately, and in most cases these assets are the productive assets which go a long way in addressing the livelihood and other needs of the surviving family. Property grabbing is also said to be increasing with increasing levels of poverty within a specific geographical setting.[77]

Wife inheritance is another impact, as it is seen as a culture of creating social security and safety nets for widows who have limited access to land and property. In most African traditions, wives and children become the property of the husband's clan, in particular in societies where the man pays a bride price to the family of his future wife. This practice ensures that the clan keeps the widow and her children as part of 'its wealth'. It comes in many different forms and more often than not includes sexual relationships between the widows and one of the deceased husband's brothers. Such practices have survived because they have a vital social and economic function, but might become a death sentence if the deceased husband died of HIV/AIDS. HIV/AIDS is in effect transforming extended family kinship systems that provided a critical welfare function and turning them into self-destructive and unsustainable institutions.[78]

HIV/AIDS weakens women' land and property right and thereby contribute to the eviction or dispossession of widows from their marital homes and access to their late husband's property in several ways. These are normally the justifications for not giving them any of their deceased husband's property; accusations that the widows have bewitched the husbands that died of AIDS, that the woman is the one that has brought the disease in the family, that they do not

[76]Muller, T R. (2005):43

[77]FAO; as cited in Muller, T R. (2005):44

[78]Topouzis, as cited by Muller, T R. (2005):44

require large tracts of land because they too are sick and will soon die, and also that they have started having a sexual relationship with another man.[79] This is the situation whether the marriages are registered or not. Some widows stand their ground, but the majority of them give up and go back to their parental homes.[80]

Widows and vulnerable women that are faced with these situations have extremely limited livelihood options. No single clear path has proved helpful to the victims of dispossession/eviction.[81] The problem is exacerbated because many families are still steeped in kinship ties and ideologies according to which only members of the kin group can inherit from each other, so wives cannot inherit from their husbands because they are not members of the kin group. This continues to happen despite laws to the contrary. In such cases even the female relatives might discourage a woman from claiming her dues as a widow.[82]

"Culture has also impacted and still continues to impact on widow's willingness to use legal channels to enforce their rights especially when a couple has had children,"[83] as they will want the husband's family to support them when any of the children are sick or getting married because the latter brings in much more respect. Some give up because of veiled threats issued against them. Whilst some women are submissive and therefore do not stand up against their in-laws, others believe that they did not bring anything into the marriage, and therefore are not entitled to take anything out of it.[84] So it is for these reasons that some widows rather prefer to lose the property to maintain peace in the family.[85] The situation is even worsens if the woman

[79] Kaori, I. (2006): 25
[80] Kaori, I. (2006): 41
[81] Kaori, I. (2006): 36
[82] Kaori, I. (2006): 36
[83] Kaori, I. (2006): 42
[84] Kaori, I. (2006): 42
[85] Kaori, I. (2006): 36

is illiterate, as "limited education means limited livelihood opportunities and skills, rendering the women even more vulnerable."[86]

"Gender has been identified as the key cross-cutting issue in addressing the HIV/AIDS epidemic in sub-Saharan Africa and beyond, visible in the growing body of literature on '*gender and HIV/AIDS'*[87]. "More generally, sexual behaviour and the attitudes of men "combined with deep rooted gender inequality are regarded as a principle force driving the epidemic worldwide."[88] In terms of female infection rates, "sub-Saharan Africa in general is in the epicentre of the pandemic worldwide."[89] In 1985 "roughly half a million men and women were living with HIV/AIDS in sub-Saharan Africa, since then the number of women relative to men has increased every year. In 2004, 57 percent of infected adults aged 15-49 years were women."[90] This makes sub-Saharan African the only region in the world in which overall HIV infection "rates are higher for women than for men."[91]

It has been argued that gender roles and a gender understanding which equates masculinity with sexual prowess, multiple sexual partners and a general dominance over women, often coupled with reluctance to access health and or emotional support services poses equally a burden on men and makes them prone to engage in sexual behaviour that carries a high risk of HIV transmission.[92] "Simply by fulfilling their expected gender roles, women and men are likely to increase their personal risk of HIV infection,"[93] which in no part of the world is more obvious than in sub-Saharan Africa, because heterosexual intercourse is by far the predominant

[86] Kaori, I. (2006):42

[87] Seeley et al.; Smith & Cohen; Whelan; du Bruyn; Panos, as cited in Muller, T R. (2005):23

[88] Scalway; UNAIDS, as cited in Muller, T R. (2005):23

[89] UNAIDS, as cited in Muller, T R. (2005):23

[90] UNAIDS, as cited in Muller, T R. (2005):23

[91] UNAIDS, as cited in Muller, T R. (2005):23

[92]Scalway; UNAIDS, as cited in Muller, T R. (2005):24

[93] UNAIDS, (2004) as cited in Muller, T R. (2005):25

mode of transmission. This is so because of the cultural rules and norms governing sexual relationships between men and women.[94]

Also the focus on individual behavioural change leaves aside sexual behaviour which is deeply culturally embedded and has to do with the persistence of a masculine culture that encourages men to continue with multiple sexual relationships even with the advent of HIV/AIDS.[95] In the context of sub-Saharan Africa, the institution of marriage and its cultural specifications have been identified as major risk factors for women.[96] "It has been estimated that between 60 and 80 percent of HIV positive women were infected by their husbands or stable partners."[97] Married women are in majority of the circumstances in Africa due to cultures and tradition, unable to either negotiate safer sex or be in a position to influence their partners' decision not to have multiple sexual affairs. Traditional patterns of polygamous relations always promote male superiority and female subordination.[98]

Generally, the major root causes and effects of increased HIV infection in women as opposed to men reflect differences not only in biological factors, sexual behaviour, cultural norms and social attitudes that all work to the disadvantages of women, but equally women's often weaker economic power leading to greater livelihood vulnerability[99] and women's active responses to structural subordination and dependency on men for access to means of production as well as their increasing economic marginalization in most African countries.[100]

[94]UNAIDS, (2004) as cited in Muller, T R. (2005):25
[95]Kaler, (2004) as cited in Muller, T R. (2005):25
[96]Kaler, (2004) as cited in Muller, T R. (2005):26
[97]Kaler, as cited in Muller, T R. (2005):26
[98]Colvin, as cited in Muller, T R. (2005):26
[99]UNAIDS/UNFPA/UNIFEM, as cited in Muller, T R. (2005):27
[100]Muller, T R. (2005):27

Notwithstanding these, there are regional differences. "It has been argued that in western Africa, women have"[101] more control over sexual relationships including the refusal of sex in certain instances within marriage, because they are more economically dependent, and do not lose the support of their lineage family upon marriage. They can thus decide more easily to leaving their husbands as they can still continue to have "access to resources to secure their own livelihoods"[102] and that of their children. One may then have the tendency to hypothesis that the reason why HIV/AIDS is less severe in western Africa is related to women being in a position to exercise their power and livelihood options even though other factors no doubt play a crucial part in different patterns of the epidemic in sub-Saharan Africa. In most African countries, the position of women is strongly characterized by subordination, and dependence on husbands or other male relatives to support their own livelihoods and that of their children.

The structural features that are common in most African societies if not all are the cultural norms and traditions guiding sexual behaviours in the context of many livelihoods, and these are the reasons behind gender specific constraints based on femininity and masculinity.[103] There are also gender intensified constraints that on the other hand are related to unequal access to resources based on societal norms; and gender imposed constraints in the form of lack of power to access productive resources at community and societal levels.[104] These constraints exist because of the unequal gender power relations in all spheres of life: socio-cultural, economic, political and sexual. Thus the crisis of HIV/AIDS and its gender dimensions is a crisis of wider inequality.

[101]Muller, T R. (2005):27

[102]Orubuloye et al.; as cited in Muller, T R. (2005):28

[103]Muller, T R. (2005):32

[104]Muller, T R. (2005):29

Women and men have a vast difference in access to income and productive resources, different economic behaviours and are also subject to different legal arrangements[105] with HIV no doubt aggravating the situation. Ideologies on "masculinity and femininity which make it seem natural that men should have the upper hand when it comes to economic decision making, opportunities for advancement, expressing their sexual desires and satisfying their sexual need."[106]

"Most women are at risk because of their powerlessness relative to men in the overall organization of society and this subordinate position undermines their livelihood options."[107] Even though women are more susceptible to infection, there has been a tendency in many communities to stigmatize women with AIDS and perceive them as the main transmitters of the virus. This emanates from women's inferior position in their communities[108] and unfortunately also "the consequences of HIV infection and the burden of care that is considerably higher for women than men."[109]

More generally, "changing opportunities for constructing a livelihood"[110] potentially alters gender relations. Households may act as a unit in the face of crisis, or such crisis may increase pressures on households to fragment and at times even dissolve.[111] Gender -intensified or -imposed constraints are rife with regard to productive assets such as land and livestock. With land specifically, the problem starts with access before even thinking about ownership in some

[105]Smith & Cohen, as cited in Muller, T R. (2005):37

[106]Heise& Elias; Rivers &Aggleton, as cited in Muller, T R. (2005):37

[107]Muller, T R. (2005):37

[108]Muller, T R. (2005):37

[109]Nyblade et al., as cited in Muller, T R. (2005):37

[110]Francis, as cited in Muller, T R. (2005):41

[111]Francis, as cited in Muller, T R. (2005):41

cultures. This is compounded by women's lower human, productive and capital resources in comparison to men, as well as the high illiteracy rate amongst women relative to that of men.[112]

Literature on "HIV/AIDS has been centred on the gender specific impact" [113]of the epidemic and also equally determines impact mitigation. "Women as individuals and in their central roles as wives, mothers and care givers are disproportionately affected by HIV/AIDS"[114] as they are less able than men to negotiate sex and livelihood options.[115] With regard to rural livelihoods, gender attributes are very important in addressing the impact of the epidemic generally and on agriculture specifically, as rural livelihoods depend on on- and off-farm activities to meet their livelihood needs, and these activities are highly gender sensitive.[116] If the status of women is not transformed, the impact of the epidemic will deepen the already deplorable conditions of women and men living in already critically stressed societies and will thus lead to the disintegration of such societies.

"When women fall ill themselves, they continue to care for others"[117] in the household, while often nobody is left to care for them when they are in need and at the same time they are less able to seek treatment outside the household due to lack of resources. It has also been reported that men secretly buy medicine and hide it from their wives.[118] A lot of gender issues are coming up with regards HIV/AIDS. If among HIV/AIDS positive couples a decision has to be taken on who should be given the treatment, the men are often preferred because of the gender constraints to productive use of resources - especially land.[119] Men may however, also have

[112]Quisumbing et al., as cited in Muller, T R. (2005):42
[113]Seeley, as cited in Muller, T R. (2005):29
[114]Tallis, as cited in Muller, T R. (2005):29
[115]UNAIDS/UNFPA/UNIFEM, as cited in Muller, T R. (2005):29
[116]Francis, as cited in Muller, T R. (2005):41
[117]UNAIDS, as cited in Muller, T R (2005):56
[118]Human Right Watch, as cited in Muller, T R (2005):56
[119]UNAIDS/UNFPA/UNIFEM, as cited in Muller, T R (2005):56

difficulties accessing HIV/AID services as they are often located in health facilities that primarily serve women, such as antenatal and family planning clinics.[120]

2.9 Orphaning due to HIV/AIDS

One of the main issues in looking at the longer term "impact of HIV/AIDS in sub-Saharan Africa is the large number of orphans"[121] as a result of premature death of members of the parent generation due to AIDS related causes. Sicknesses and death from HIV/AIDS often provokes "migration from urban to rural areas (birth places of PLWHAs)."[122]

"There have always been high number of orphans in Africa,"[123] and AIDS has however, "increased the number of orphans to unprecedented levels and traditional support mechanisms are struggling to cope with the increasing demands for care and support."[124] AIDS orphans suffer from stigma and marginalization in their communities, and therefore need targeted interventions.[125] "Gender and orphan challenges overlap because orphaned girls are the ones mostly sexually exploited, as well as standing the risk of dropping out of school, thus increasing their vulnerability to HIV infection."[126]

Another study on HIV/AIDS shows that maternal relatives became the main carers for AIDS orphans which are contrary to tradition that demands paternal relatives to be the main source of orphan care.[127] Thus, the socio-economic impact falls on the maternal nuclear family, often the mother's mother (the child's grandmother) or the mother's sister (the child's aunt). Generally, it has been found that mothers are more likely to be responsible for their orphaned

[120]Sy, as cited in Muller, T R (2005):56
[121]Muller, T R (2005):59
[122]Muller, T R (2005):59
[123]Economic Commission for Africa, (2004):14
[124]Economic Commission for Africa, (2004):14
[125]Economic Commission for Africa, (2004):14
[126]Economic Commission for Africa, (2004):14
[127]Mutangadura, as cited in Muller, T R (2005):60

children than fathers, and if fathers look after orphans at all, it's mostly sons, [128] thus making daughters more likely to grow up in insecure conditions or with poorer grandparents.

In grandparent-headed households, a high percentage of them are headed by grandmothers due to female longevity. This may result in grandmothers becoming overburdened by the additional role of parenting[129] instead of being supported by their own children in old age. In such cases they not only have to support themselves but also their grandchildren, leaving most orphans unable to attend school. As a response strategy, many elderly women who end up being care givers are "pushed back into the labour force as they have to step up their roles as producers and providers."[130]

In parts of Kenya, orphan girls are more easily lured out to relatives in urban areas with the promise of either being educated or in search of domestic labour and need up being abused and exploited on the one hand. On the other hand, in contrast to the male orphans, it is common for them to continue residing in their rural home and continue having access to land.[131]

Looking at the bigger picture however, too little is known about the gender implications of the increased incidences of orphaning, with regards to the orphans themselves and for the households caring for orphans. Orphans seem to live in poor and non-poor households. It is rare for poorer households to provide care and support for orphans in most African countries especially in sub-Saharan Africa. This is partly due to traditional coping mechanism where those with better resources take in orphans.[132]

With regards to orphaned girls dropping out of school, there has been a lot of controversy surrounding this. Some writers observed that gender gaps in the enrolment of orphans vary, but

[128]UNICEF, as cited in Muller, T R (2005):60

[129]Ayieko, as cited in Muller, T R (2005):60

[130]Obbo, as cited in Muller, T R (2005):61

[131]Ayieko, as cited in Muller, T R (2005):61

[132]Ainsworth & Filmer, as cited in Muller, T R (2005):62

are not necessarily different from gender gaps in enrolment among non-orphans.[133] On the other hand, another study shows a sharp difference in enrolment between children in poor and non-poor households, leading to the conclusion that orphans are not universally in need of assistance, but that poverty is the main reason why children are not in school.[134] Another writer also states that there are cases of orphans who feel embarrassed to go to school because they fear the stigma of other children knowing that their parents died of AIDS.[135] There have been cases where care givers have prevented such orphans from going to school.[136]

Orphans in rural settings marked by poverty and high HIV infection rates, especially if "girls, belong to the group of the most vulnerable and therefore need assistance, are mostly exposed to violence and exploitation."[137] This is because there is increased responsibility in caring for other siblings and time required to do household chores. In fact, some might even need care before they actually become orphans as they might start these roles even before the death of their parents and have to take care of a seriously ill parent and at the same time fulfilling other household duties.[138]

Another gender specific dimension of orphan hood is the pattern of orphaning and at present maternal orphans out number paternal orphans. In a study conducted in five of the most affected African countries, 60 percent of orphans have lost their mothers.[139] There is a need for research to be undertaken in order to better understand the implications of a child losing his or her mother compared to one losing his or her father. Based on findings from a household survey from 40 sub-Saharan African countries, results showed that the epidemic has caused a rapid

[133]Ainsworth & Filmer, as cited in Muller, T R (2005):62
[134]Monasch & Boerma, as cited in Muller, T R (2005):62
[135]Ayieko, as cited in Muller, T R (2005):61
[136]Ayieko, as cited in Muller, T R (2005):61
[137]Muller, T R (2005):61
[138]Muller, T R (2005):62
[139]UNAIDS/UNICEF/USAID, as cited in Muller, T R (2005):63

increase in the prevalence of orphan hood but there is no evidence yet that existing child patterns in the extended family safety net are not absorbing that increase to a large extent.[140] The researchers base their findings on "the fact that the majority of sub-Saharan African countries"[141] have for decades evidenced comparatively high incidences of orphan hood due to war and other unrest, and child fostering is generally a common practice in many communities and societies.[142]

2.10 Gender inequalities in Sierra Leone

"Women constitute an estimated 51.3 percent of the population but their low status is deep – rooted and is perpetuated by discrimination entrenched in traditional customs and law."[143] Various interventions have been done to address some of the challenges encountered by women through especially empowering them economically.[144] For sustainable national development, it is but fitting if steps are taken to support women in Sierra Leone in order to enhance their effective contribution.[145] For instance in the agricultural sector, "it is recognized that women do the bulk of the farm work, yet they remain marginalized with limited access to productive resources such as finance and training."[146]Therefore in my research I will be looking at the gender roles among household members of "infected and affected"[147] farm households.

2.11 The status quo of agriculture in Sierra Leone

[140]Monasch &Boerma, as cited in Muller, T R (2005):63
[141]Monasch & Boerma, as cited in Muller, T R (2005):63
[142]Monasch & Boerma, as cited in Muller, T R (2005):63
[143]Government of Sierra Leone, (2005b):24
[144]Government of Sierra Leone, (2005b):24
[145]Government of Sierra Leone, (2005b):24
[146]Government of Sierra Leone, (2005b):24
[147]Muller, T R. (2005):18

The main thrust in the agricultural sector in Sierra Leone is putting money into the pockets and purses of farmers[148] by adding value to their produce and taking care of post-harvest losses nationwide. In order to achieve this, various agencies among which is the Sierra Leone Agricultural Research Institute (SLARI), which has embarked on the training of farmers on how to produce multiple food recipes from the food crops they produce in their respective communities and has also been able to teach farmers the skills necessary to cultivate yam through minisett technologies. For instance, for industrial and other purposes, the following production technologies are being taught on gari, foofoo, starch, glues, alcohol, paper and textile industries, adhesives, sweetners and pharmaceutical dustings processing.

Farmers are also trained on how to apply what they have learnt in a business-like and profitable manner. They are told how to develop a business plan, how to adapt the business to a sizeable and manageable one and the need to discuss and bring on board the ideas of others that have considerable knowledge and experience in similar business ventures. They were also trained on recommended good practices on nursery preparation, planting and weeding on time and other farm management technologies including control and prevention of diseases and pests. This is relevant to this study, as it will also determines the impact of HIV/AIDS on farmers' knowledge and available technology adoption and transfer to household members as well as on availability and access to market and marketing constraints if any faced by farmers that are HIV/AIDS positive.

2.12 Secondary information on the agricultural situation in Koinadugu District

CARE Sierra Leone has a Sustainable Agriculture Development project in Koinadugu District (SADev).[149] Approximately 12,600 people in the District were beneficiaries.[150]The project aim

[148]SLARI bulletin June (2010)

[149]http://www.care.org/careswork/projects/SLE044.asp (accessed April 2010)

[150]http://www.care.org/careswork/projects/SLE044.asp (accessed April 2010)

was to "increase the income and farm productivity of members of the 60 Farmers' Associations in five Chiefdoms of which 45% are women and 70% are young people."[151] CARE implemented this project through a local partner, MADAM, with capacity building support provided by VSO[152] and Ministry of Agriculture for project sustainability. Lots of crops, among which is the staple food (rice), of Sierra Leoneans are grown in the valleys of the region and other remote parts of the country, but most of the crops grown including rice, goes to waste every year due to postharvest losses and factors such as bad roads and storage problems.[153]

This chapter has dealt with the global perspectives of HIV/AIDS and agriculture/livelihood/food security, HIV/AIDS and agriculture /livelihood /food security in Africa, the impact of HIV/AIDS on productivity, HIV/AIDS in Sierra Leone, the rural-urban dimension of HIV/AIDS, HIV/AIDS on rural livelihoods, HIV/AIDS at a rural household level, the global mirror of gender and HIV/AIDS, Gender and HIV/AIDS in Africa, orphaning due to HIV/AIDS, Gender Issues in Sierra Leone, the status quo of agriculture in Sierra Leone and secondary information on the agricultural situation in the District. These are the main themes on which this research is based.

Chapter Three

[151]http://www.care.org/careswork/projects/SLE044.asp (accessed April 2010)

[152]http://www.care.org/careswork/projects/SLE044.asp(accessed April 2010)

[153]http://www.madam-sl.org/?Projects:SADev (accessed June 2011)

Theoretical Perspective

3.1 Introduction

This Chapter discusses the theoretical perspectives on which this study is built, in order to give a better understanding of the issues under review from different dimensions. Various theories and notably those put forward by the functionalist perspective of the sick role, backed by the livelihood perspective,[154] and other discourses on the issues of livelihood which go beyond material livelihood, to that of social wellbeing.[155] The work is also influenced by the theory of feminism;[156] specifically the socialist feminist perspective which inform this study.

3.2 Functionalist perspective of the sick role

Talcott Parson's initially defined "the sick role as the set of patterned expectations that defines the norms and values appropriate for individuals who are sick and for those who interact with them."[157] "According to the functionalist approach of the sick role which believes that if society is to function as a stable system"[158] (which here can be the family, community or the nation at large); "it is important for the people to be healthy and to contribute to their society."[159] Parsons believe that "illness is dysfunctional for both individuals and the larger society. Those who assume the sick role are unable to fulfil their necessary social roles."[160] Similarly, those that are "ill loose days from their productive roles in society, thus weakening the ability of individuals, groups and organizations to fulfil their functions."[161] The present research relates to this school of thought in the sense that, it also looks at the gendered impact of HIV/AIDS on livelihoods of affected households. This research describes how HIV/AIDS affects various

[154]Hanrahan, K. (2015):383
[155]Hanrahan, K. (2015):383
[156]Hartmann, as cited in Kendall, D. (2008):375
[157]Kendall, D. (2008):611
[158]Kendall, D. (2008):611
[159]Kendall, D. (2008):611
[160]Kendall, D. (2008):611
[161]Kendall, D. (2008): 611

roles in the households and the supportive role/s provided by members of the households, community and the nation at large. It further explores how HIV/AIDS affects the contribution of both the infected and affected to their households and community sustenance. The theory of the sick role in this research was useful in describing the impact of HIV on the lives and livelihoods of both the "infected and affected" with regards to meeting their daily needs and the coping mechanisms employed when HIV/AIDS sets in.

AIDS "affected households" are said to spend less time on work due to ill health and because of this, there is less income and less food in the household. "Studies have shown that sub-Saharan Africa remains one of the regions in the world that is predominantly rural, and agricultural food production remains a primary source of household and national food security."[162] And if farmers are being infected with HIV/AIDS, this will have serious consequences for rural food production, productivity and security.[163] This can result in the disintegration of the family, community and the nation as food is a political commodity. Many AIDS-"affected households" currently cannot farm their lands because they do not have enough labour and they are also unlikely to rent out their land because of the fear of losing their land rights.

Globally 17,800,000 women aged above 15 years are living with HIV/AIDS and out of this 14,200,000 which is 80% of the global figure lives in sub-Saharan Africa.[164] Worldwide, there are at least 1.6 billion women who live in rural areas and depend on agriculture for their livelihoods-more than a quarter of the total world population.[165] "Women farmers produce more than half of all the food that is grown in the world, specifically, up to 80% in Africa and

[162]UNAIDS/WHO (2002):28

[163]UNAIDS/WHO (2002):28

[164]UNAIDS, (20016):14

[165]IFAP and Women Farmers.(accessed February, 2017):1

60% in Asia."[166] And now that they are the most vulnerable to HIV/AIDS, this is therefore a threat to food security.

AIDS "affected households" are said to spend less time on work due to ill health and because of this, there is less income and less food in the household. This can result in the disintegration of the family, community and the nation as food is a political commodity in Sierra Leone, and its scarcity, will lead to the disintegration of the 'whole' which parson says is necessary for the function of the human being as well as the household and society. Many AIDS-"affected households" currently cannot farm their lands because they do not have enough labour and they are also unlikely to rent out their land because of the fear of losing their land rights.

Various researchers on HIV/AIDS[167] have presented a picture on the disintegration of families and a total breakdown in the extended family system which as compared to the functionalist perspective of the 'whole' has in the past acted as a very strong support system that has kept families together, and the very existence of which is now questioned by HIV/AIDS.

HIV/AIDS contributes to food insecurity, especially in rural areas where the main occupation of majority of its inhabitants is agriculture, which depends mostly on manual labour especially in Serra Leone. Therefore the loss of an adult member due to HIV/AIDS, "poses a significant challenge for agricultural production"[168] especially during peak farming season when there is great need for more household labour source, as every household will be occupied with their farming activities. This will consequently lead to the cultivation of either smaller farms or less labour intensive crops, which will lead to food insecurity at household, community and national level depending on the level of infected farmers and available labour saving technologies.

[166]IFAP and Women Farmers.(accessed February, 2017):1

[167]Susser, I. (2009)

[168]Mazzeo, J. (2011):409

3.3 The livelihood perspective

Scoones "defines livelihoods as comprising the capabilities, assets (including both material and social resources) and activities required for a means of living."[169]Livelihoods are '*sustainable'* he argues, when they are able to "cope with and recover from stresses and shocks and maintains or enhances its capabilities and assets both now and in the future, while not undermining the natural resource base."[170] Some scholars think that "livelihoods analysis have largely been reduced to economic decision-making, with material outcomes being accorded primary importance and social life relegated to an instrumental position."[171]

Hanrahan in her work in rural Ghana[172] and as the case of many other scholars focus on some of the limitations of livelihood perspectives which do not adequately engage with the significance of gender and the very complex ways in which this shapes and influences everyday experiences of the social wellbeing of individuals, families and the community.[173] She "stated that livelihoods approaches are one of the various approaches applied to understand the ways in which people support themselves and others."[174]

In my study in as much as consideration will be given to material wellbeing in meeting the needs of HIV/AIDS infected and affected households, critical attention to social wellbeing of both the infected and affected as they interact and take decisions to cope with their stress is considered as well.

HIV/AIDS is the major driver to livelihood insecurity. AIDS through the death of the active and economically viable groups of the human race leads to the disintegration of social networks, and kinship relationships, which strengthens and supports the livelihoods of

[169]Scoones, I. (1998):5

[170]Scoones, I. (1998):5

[171]Jakimow; Carr; as cited in Hanrahan, K.(2015):383

[172]Hanrahan (2015)

[173]Hanrahan, (2015)

[174]Hanrahan, (2015):282

especially vulnerable rural communities.[175] This research explores how HIV affects various roles in the households and the supportive role/s provided by members of the households, and the gendered dimensions they take. It further explains how HIV/AIDS affects the contribution of both the infected and affected to their households and community sustenance.

The theory of livelihoods and how these could be made sustainable in the face of HIV/AIDS was useful in describing the impact of HIV on the lives and livelihoods of both the "infected and affected"[176] with regards to meeting their daily needs and the coping mechanisms employed when HIV/AIDS sets in. With regards livelihood perspectives, I also wanted to explore with these Policy makers and service providers how PLWHAs are affected in the following areas: inputs and technology adoption, access to and control over productive resources, knowledge and information pathways.

"AIDS remains to be the leading cause of death among Black women between 25 and 35 years and the second leading cause of death in Black men between 35 and 44 years of age."[177] Statistics on gender considerations in agriculture and rural livelihoods "continue to lack significant visibility"[178] and making it difficult if not impossible for generalization. The main consequence of HIV/AIDS is that it affects people in their prime who play major roles in contribution to the wellbeing of their households, in sub-Sahara Africa mainly through agriculture. Rural livelihoods especially in Sierra Leone depend greatly on manual labour for their farming activities, so the loss of a productive household member to HIV/AIDS affects the household needs, especially food for its members.[179]This leads to food insecurity at household,

[175]Dawson, H. (2013):1

[176]Muller, T R. (2005):18

[177]Black AIDS Institute, as cited in Susser, I. (2009):19

[178]Ahear, M. (2010)

[179]Institute of Development Studies, (2003)

community and national level depending on the level of infected farmers and available technologies.

When the situation continues "with less labour and capital, and in some cases having sold off household assets, affected households have to modify their farming systems;"[180] either by tilling less land or cropping patterns may shift towards food crops with less labour intensive activities to assure survival while cash crops are particularly in most cases abandoned.

Drawing on this perspective, this research investigates the social and economic impact of particular members of the household becoming sick with HIV/AIDS on the household. These include fathers, mothers as well as children who carry particular responsibilities and obligations. This depends on the asset and resource availability within households and this relates to the material circumstances of the particular household and the kinds of roles members of households (children and adults, males and females) are able and are expected to play.

With regards to the effects of HIV/AIDS, especially in chronic and persistent poverty stricken households, affected household members and the reliance on safety nets is gradually weakening. Therefore, there are concerns in some quarters that there should be a shift from reliance on these safety nets to promote "interventions that enables synergies between protecting and promoting people's livelihoods."[181] This seems quite possible through interventions that will meet livelihood needs on a sustainable basis regardless of a person or households HIV status. The impact of HIV/AIDS on individuals, communities and Institutions is strongly connected to their ability to cope[182] with the stressful condition of being sick with a disease that there is no cure for now, on the part of PLWHAs, and on the household members through provision of care and support.

[180]United Nations Office of the Special Adviser on Africa(OSAA); June (2003):22

[181]Devereux; Farrington et al., as cited in Slater, R. and Wiggins, S. (2005):1

[182]Scoones, I. (2009)

For any livelihood to be sustainable, gender analysis is a must because one can "better understand the cultural realities"[183] of all genders and age categories whose lives are being impacted by HIV/AIDS. "Gender analysis is the process of examining why disparities if any are there, and how they can be addressed, if they are of concern.[184] "Principally it is about understanding culture, expressed in the construction of gender identities and inequalities, and what that means in practical terms is that it is also political."[185]

The livelihood needs and access to these livelihood resources, and interventions to address issues that may arise between men and women are likely to differ,[186] so attention must be paid to overcoming such barriers. With gender analysis, researchers or Policy makers will be able to identify the needs of both males and females which are critical to help them achieve more sustainable livelihood strategies. This will also highlight the "different roles and responsibilities of males and females that might constrain their participation in a livelihood project."[187]

Furthermore, it is important "to determine the different ways in which men and women,"[188] boys and girls may or may not benefit from a particular livelihood intervention. It can also be used to raise awareness of gender issues; to inform and influence policy interventions[189] "All aspects of livelihood analysis should explore gender issues. This can be done by gender disaggregation of broad based livelihood data"[190], narrowed down specific gender analysis,[191]

[183]Pasteur, K. (2002):1
[184]Pasteur, K. (2002):1
[185]Pasteur, K. (2002):1
[186]Pasteur, K. (2002):1
[187]Pasteur, K. (2002):1
[188]Pasteur, K. (2002):1
[189]Pasteur, K. (2002):1
[190]Pasteur, K. (2002):1
[191]Pasteur, K. (2002):1

and this is particularly relevant to this study to better understand the impact of HIV/AIDS on affected households and the roles which different members of the households take up when a particular member of the household becomes sick.

3.4 The socialist feminist perspective

"Feminist theory aims at understanding the nature of inequality and focuses on gender politics, power relations and sexuality."[192] "Feminist theory also focuses on analysing gender inequality and the promotion of women's rights, interests, and issues".[193]

The socialist feminist perspective advocates for equality between men and women,[194] and further suggests that "women's oppression results from their dual roles as paid and unpaid workers in a capitalist economy."[195] "In the work place socialist feminists argue that women are exploited by capitalism, at home they are exploited by patriarchy."[196] This research specifically elucidates information on exploitation in the home and community.

A socialist feminist perspective raises questions about gender power relations in households and in (paid) work place outside the home and this is particularly relevant to this study to better understand the impact of HIV/AIDS on affected households and the roles which different members of the households take up when a particular member of the household becomes sick, and the difference reactions from husbands and even community members when it is the wife/woman that is first diagnosed positive, and how this affects status disclosure due to stigma and discrimination.

[192]http://en.wikipedia.org/wiki/Feminist_theory (accessed April 2010)

[193]http://en.wikipedia.org/wiki/Feminist_theory (accessed April 2010)

[194]Ferrante, J. (2008):290

[195]Ferrante, J. (2008):290

[196]Kemp, as cited in Kendall, D. (2008):375

Much of the published work on women and AIDS, especially medical and scientific publications,[197] has concentrated on women as care givers of people with AIDS and possible transmitters of the HIV virus, with the focus highly on prostitutes and pregnant women. Influenced by feminist concerns, a number of writers[198] have raised concerns about gender inequalities as they frame popular discourses and representations about AIDS which particularly stigmatise women, or as they are manifested in processes of negotiating sex or in expectations that girls and women bear the responsibility of caring for sick people or for taking precautions when it comes to sex.

It is one thing to say AIDS is a women's issue or a feminist issue. As feminists demand that we should "not only be concerned about how HIV/AIDS affects women in particular, but also how women's subordination influences their risk status and experience of HIV/AIDS"?[199] In the AIDS crisis, women are often invisible, and "face severe and sometimes insurmountable obstacles to coming out with a positive HIV status."[200]They are rarely provided with adequate care, and are expected to take care of others.[201]The development of health and social services to care for and support people with AIDS or other HIV-related illness, demands an understanding of women's unpaid work in the home, in particular their responsibility for the care of family members.

Within feminist theory sexuality is defined as a site of struggle in which men exercise power over women, although important differences exist between feminist in "the significance attributed to sexuality in understanding women's oppression."[202] Acknowledging the power

[197]Doyal, L. et al., (1994):45
[198]Doyal, L. et al., (1994): 45
[199]Doyal, L. et al. (1994):45
[200]Doyal, L. et al., (1994): 45
[201]The ACT UP, (1990) :243
[202]Holland, J. et al., (1990):5

relations embedded in sexual relationships helps to explain both how and why women can find the process of negotiating safer sex difficult. Most public education campaigns around AIDS/HIV, in assuming individual choice and personal responsibility do not address the issue of relative power in sexual relations.

We need to address gender power relations, gender roles and gender expectations. Taking a socialist feminists perspective view, a look at the economy of households, and how this is sustained by particular gendered arrangements and roles is examined in this research, and the particular ways in which these impacted on household members across gender, status and position, as well as how household members responded to these.

In addition the impact on households when particular male and female household members become sick, such as male adult breadwinners who may be the main source of household incomes or female adult and child members who may be responsible for domestic duties including provision of care for the sick people was explored. Furthermore, the household dynamics in terms of response strategies employed in relation to gender, as well as to the general gender situation in the country or more specifically in the study area was explored to link the impacts these have on HIV infection and mitigation efforts.

Feminist perspectives of households, thus, are highly critical of structural functionalist perspectives for justifying and legitimating the polarisation of gender roles and power relations, along the lines of husbands and fathers as breadwinners and wives and mothers as unpaid carers who provide emotional support and care for family members and are responsible for domestic tasks as well as other activities. While functionalists, such as Parsons, present these gendered roles as complementary feminists such as Hanrahan, argue that these are exploitative, in large part because the role of women is unpaid which in effect renders their contribution to the economy and dynamics of the household invisible as well as undermining their status in the

household and contributing to patriarchal notions of women as being subordinate to men. However while the structural functionalism of Parsons and others has been highly critiqued by feminism for presenting an idealised view of families and households in men and women complement each other to function positively as an economic and social unit to contribute to the benefit of the family members and the wider community, the questions posed by functionalism about roles men and women play in families are also posed by feminist writers even if these are configured in very different ways. Thus feminists pose questions about the subservient role of women in the family and how this ensures that the family functions in a particular way.

Drawing on feminism, I also pose such questions in my research, which focuses on how HIV/AIDS impacts on households which are mediated by unequal gendered relations in which caring is feminised and unpaid and the breadwinning role is masculinised. What happens when HIV/AIDS infects male "breadwinners" and/or female "carers"? How does this affect the dynamics of the households and the roles which men and women play?

Chapter Four

Research Methods and Methodology

4.1 Introduction

This chapter reports on the description of study location and research participants, research design, sources of data, sampling procedure and size, data collection and analysis, ethical concerns and highlights contingencies employed during field work.

As elaborated in the first chapter, my research is concerned to explore the sociological impact of HIV/AIDS on farming households in Koinadugu District, the support available, if any, for members of such families infected by HIV/AIDS either from within or outside the family, the coping and adjustment mechanisms of people in such families "affected and infected" by the virus. Influenced especially by concerns raised by socialist feminist writers about the exploitation of women in patriarchal and capitalist societies as unpaid care givers at home and as constituting a reserve army of labour in paid work, as well as the tendency for women, unlike men, to be judged and stigmatized according to perceived standards morality, I am particularly interested in the gendered impact of HIV/AIDS in farming households in which one or more members were HIV/AIDS positive.

4.2 Description of study location

My research is conducted in an agricultural community of Koinadugu District, in Sierra Leone. This District is selected because according to the 2005 sero prevalence [203]survey in Sierra Leone, it emerged as the one with the highest HIV/AIDS prevalence rate in the country. This District is located in the northeast of Sierra Leone. Koinadugu District is said to be the poorest[204] and largest District in the country.[205] It borders Guinea in the north, Kambia in the northeast, Tonkolili in the south and Kono in the east.[206] It has eleven Chiefdoms and, with Chiefdoms and villages situated miles apart.[207] It occupies a total area of 12,370.8 Km^2 It has

[203] http://en.wikipedia.org/wiki/Seroprevalence (accessed July, 2009)

[204] http://www.seed-narsarah.org/theneed.html (accessed May 2011)

[205] http://koinadugu-District.co.tv/ (accessed May 2011)

[206]Government of Sierra Leone, (2009):22

[207]Government of Sierra Leone, (2009):22

an estimated population 265,765[208] according to the 2004 census and according to the 2005 sero-prevalence survey 3% of this population (7,973) is infected with HIV/AIDS.[209]

The community is Muslim dominated and practices a lot of cultures and traditions like polygamy and early marriage which are very strong factors with regards the spread of the disease. Vegetables, other cereals like millet, wheat, sesame and tree crop production of fruits and palm fruits processing are the main focus areas in terms of agricultural production. There is also a lot of animal husbandry in terms of cows, sheep and goats. Rice production is done at a minimal level, as the farm sizes for rice are very small, and there have historically been disputes between cattle rearers and rice farmers as the cattle are always damaging their rice farms and because the herders are economically stronger than the crop farmers. At one stage rice farmers also started killing the animals, that was when action was taken and this is to some extent, another discouraging factor for rice production.

The District headquarter is Kabala town. The main ethnic groups are Limba, Madingo, Kuranko and Yalunka,[210] with Kuranko being the main dialect.[211] The District is referred to as a land of 'Powerful Mixture' due to its ethnical and cultural diversity. Main economic activities include mining of gold and diamonds, cattle rearing and palm oil production.

[208]http://koinadugu-District.co.tv/ (accessed May 2011)

[209]Government of Sierra Leone, (2005a):26

[210]Government of Sierra Leone, (2009):22

[211]Government of Sierra Leone, (2009):22

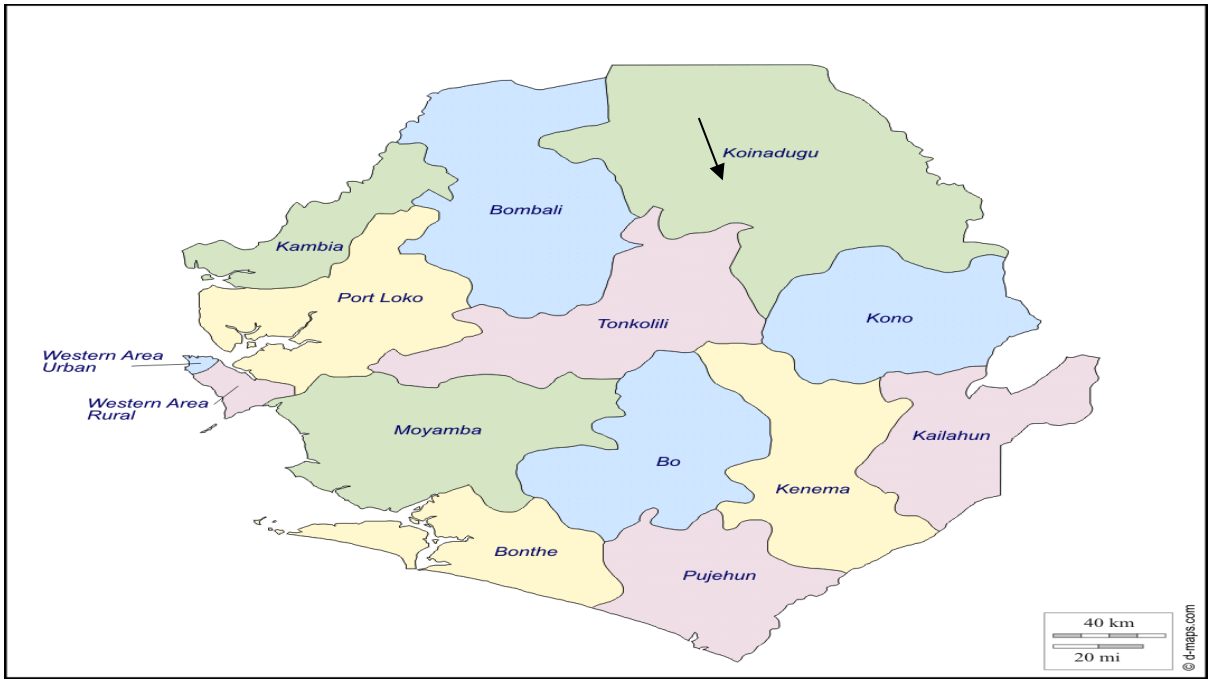

Figure 1: Map of Sierra Leone showing study area

4.2.1 HIV/AIDS prevalence and impact in Koinadugu District, Sierra Leone

There is no denial that the causes of HIV/AIDS have a rural and urban divide. The main risk for people contracting HIV in rural areas is because they become involved in HIV risky behaviour, mostly through unprotected sex with an infected person who may continue with this behaviour and infect many other people. This poses a big threat in countries like Sierra Leone that is hugely dependent on agriculture and cannot even feed its citizenry. In the course of rural-urban migration either for schooling or jobs, youths meet high-risk persons who coerce them into sexual encounters. As the culture is not to discuss sex and sexuality with household members, these youths receive limited information on the seriousness of these encounters.

Koinadugu District is predominantly a rural and a relatively poor District, with many of its population engaged in subsistence farming.[212] The 2005 Sero prevalence survey, rated Koinadugu District as having the highest HIV sero prevalence in Sierra Leone,[213] and based on

[212]Government of Sierra Leone, (2009):23

[213]Government of Sierra Leone, (2009):23

this information, Koinadugu District was selected for this study to research on the effects of HIV/AIDS on affected households.

A study conducted in 2009,[214] identified the following as most wanted by families that have HIV/AIDS infected members: emotional support, psychological support, education, treatment, and other training needs for individuals and support groups. In part, these wants have been taken into account as a support group has been set up in the District headquarter town of Kabala. This group comprises approximately 50 members (20 men and 30 women). The group meets once a month but they have no funding source and offer no services.[215]

4.2.2 HIV/AIDS sensitization programmes in Koinadugu District

Many organisations who are working to help HIV/AIDS infected people in the District have components of HIV/AIDS in their programme of activities but are engaged mainly in sensitizing people about the disease and its causes and effects, rather than providing support either to PLWHAs or their households (Figure 2).

These institutions are trying to educate people in the District to address the issue of stigmatization and to protect positive women/wives against abuse by either their husbands and or other household members, but it was cautioned that this depends on the woman making her status known to her husband and/or other household members, which HIV/AIDS positive women may not easily do. It was mentioned that cases have been brought to relevant authorities of husbands sending their wives away because they are "HIV/AIDS positive". These cases were referred to the counsellors in the hospitals, but the intervention of the counsellors did not make any difference.

[214]Government of Sierra Leone, (2009):23

[215]Government of Sierra Leone, (2009):22

Figure 2: One of the numerous HIV/AIDS sensitization programmes in the District

4.2.3 Agricultural activities in Koinadugu District

Koinadugu District produces large quantities of food crops especially vegetables, rice and fruits, as well as meat.[216] But, with the advent of HIV/AIDS and its relatively high prevalence in Koinadugu District,[217] it impacts negatively on the workforce which in turn negatively affects agricultural production because there are fewer people who are able to work. Agricultural activity forms the main income earning activity that the targeted respondents are involved in; either as a main or supplementary livelihood. Agricultural activities, including crop and animal farming, form part of the livelihood options that are available to the inhabitants of this community (Appendix14). Other work options include timber cutting, mineral and sand mining activities.[218]

4.2.4 Agricultural trainings and knowledge transfer in Koinadugu District

Before the HIV/AIDS pandemic rice was plentiful in Koinadugu District and it was cheap but now, even during harvest time, locally produced rice is much less in abundance. There is lack of mechanized farming, which is at a very low scale in the District as not many farmers are

[216]Government of Sierra Leone, (2005a)

[217]Government of Sierra Leone, (2005a)

[218]Primary data collection, July (2010)

able to meet the hiring cost and conditions of the tractors/ power tillers that are provided to help them produce more. Therefore they have to continue using manual labour with hoes and cutlasses.

In modern agriculture, there are lots of new technologies; insect control method like the methods used to catch the insects that were damaging the fruits especially mangoes in the community. There has been series of practical training sessions on the farms of PLWHAs blending modern techniques with the indigenous knowledge of the farmers, in a bid to improve on their agricultural production. Disease control, and postharvest loses which are normally huge in this District were part of the training package. PLWHAs were encouraged to use local pest control method on their farms by killing the pests in a container of water and splash it in the insect infected areas of the farm, and this drives the others away.

The transfer of this knowledge is limited by the legal requirement for all children to attend primary school, though they join their parents or caregivers in the farms either after school or during weekends and or holidays. Since primary school education is free and available for all, there is huge enrolment, as much importance is attached by parents to care for their children even in the remotest villages. Rather than learning farming skills, children of the farmers, according to my respondents, are generally sent by their parents to engage in petty trading when they are not at school. However, some do follow their parents to the farms during holidays, weekends and some after school and contribute to the source of labour. But in the surrounding area, after school most of the children go to evening lessons.

There was a consortium programme organized by other agencies in the District and it was difficult for some farmers to be able to adopt the new technologies that they were taught but with time they began to see the differences in terms of production levels and many of the

farmers have adopted them. But it really depends on the kinds of technologies and how those advocating for their use, apply them.

Another organization introduced ridge/line transplanting, but farmers all over Sierra Leone including those in Koinadugu District have been accustomed to round bed planting in swamps or hilly places but with the farmer field school they introduced them to ridge/line planting which the farmers saw as a waste of their time, and initially most farmers opposed to the technology, although few opted for the training and are practicing it. Seeing its profitability, more farmers adopted the technology in the community. Also initially farmers in Koinadugu District were not planting Irish potatoes, they were bought from shops in the city, but many farmers are engaged in planting Irish potatoes, and they are no longer called Irish potatoes, but "Koina" potatoes.

4.3 Description of research participants

4.3.1 People living with HIV/AIDS who were interviewed

PLWHAs were identified via clinics and or support groups, as in Sierra Leone, all hospitals/clinics have trained counsellors assigned to HIV/AIDS programmes, and these were very helpful during field work. With regards to PLWHAs who are farmers a purposive quota sampling was taken[219] to interview those who were most willing to participate. These formed the research sample size. (Quota sampling is a non-probability sampling technique where the assembled sample has the same characteristics, traits or the phenomenon under investigation.[220]

All the PLWHAs who were interviewed were farmers or were living in households which relied on farming as their main source of livelihood and grew mostly vegetables which they sold to get money for feeding and the education of their children as this was less labour intensive than other forms of farming. Some grew rice and tubers, and were engaged in alternative sources of

[219]http://www.answers.com/topic/quotaa-sampling (accessed November 2010)

[220]http://www.answers.com/topic/quotaa-sampling (accessed November 2010)

livelihood like petty trading in crops, fuel wood, palm wine "poyo"[221] tapping and sales, with an average age of 36 years, and average household size of 10 persons.

They included:

Table 1: Description of people living with HIV/AIDS who were interviewed

Pseudonyms of PLWHAs	Sex	Age (years)	Household size (persons)	Livelihood activities
Margaret	Female	40	7	Vegetable farming and petty trading
Hawanatu	Female	39	12	Vegetable farming and petty trading
Musu	Female	36	8	Vegetable farming and petty trading
Kamarakai	Male	35	10	Root and tuber and livestock farming
Bintu	Female	33	8	Vegetable farming and petty trading
Mansaray	Male	41	8	Rice, vegetable, and livestock farming
Fatou	Female	16	8	Vegetable farming and petty trading
Jamiru	Male	43	9	Vegetable farming and livestock
Yayah	Male	32	6	Root and tuber and livestock farming
Marie	Female	30	15	Vegetable farming and petty trading
Batu	Female	32	19	Vegetable farming and petty trading
Momodu	Male	55	8	Petty trading
Saidu	Male	33	16	Volunteer of the Red Cross as a security guard
Joseph	Male	36	8	Carpenter, rice and root and tuber farming
Average		36	10	

4.3.2 Policy makers and service providers who were interviewed

Nine Policy makers and service providers (two women and seven men) with an average age of 45 years were interviewed individually. These included:

Table 2: Policy makers/ service providers who were interviewed

Pseudonyms of Policy makers/service providers	Sex	Age (years)	Occupation
Marian	Female	35	HIV/AIDS counsellor
Felicia	Female	48	Secretary
Sylvester	Male	45	Development worker
Dennis	Male	40	District Programme officer

[221]A local beverage brewed from palm tree.

Saffa	Male	44	District counsellor
Johannes	Male	40	Health manager
Mohammed	Male	43	Social worker
Mathew	Male	52	Development officer
David	Male	58	Teacher/farmer and member of Network of HIV Positives (NETHIPS)
Average		45	

4.4 Data collection and analysis

4.4.1 Data collection

Data collection was conducted using qualitative methods. The key benefit of qualitative methodology is that it 'takes its departure point from the insider perspective on social actions."[222] It entails in-depth studies of small groups of people, and results obtained are descriptive. These methods allow the researchers to get close to 'social actors' meanings and the interpretations they are involved in.[223]

I chose these qualitative research approaches because I was interested in understanding how people in farming households "affected and/or infected"[224] by HIV/AIDS, experience the impact of HIV/AIDS, and the issues and concerns this raises for them. I was also interested in exploring Policy makers and service providers working in the District and their perspectives and interpretations of the impact of HIV/AIDS on farming households and the social problems this was raising for members of these households and what could be done, in terms of policies and support to address these.

[222]Babbie and Mouton, (2001)

[223]Blaikie, N. (2009) :234

[224]Muller, T R. (2005):18

In order to pursue these research questions my main methodological approach was to conduct semi-structured individual interviews (14) with people (men and women) living with HIV/AIDS (PLWHAs) in farming households, and (9) with relevant Policy makers and service providers in the District, and (1) focus group discussion with PLWHAs who were willing to discuss their issues in a group.

This meant developing methodological approaches which prioritized the interpretations and meanings which my research participants attached to the social and economic problems for farming households generated by HIV/AIDS, but also engaged with participants, to some extent, as experts and authorities on this topic, and encouraged them to set the agenda in the interviews and focus group discussions by making them conversational, putting open ended questions to them and picking up on issues which they raised and posing new questions in response to these.

As interviewer I was free to formulate other questions (not included in my initial interview schedule, "as judged appropriate for a given situation"[225] and "respondents were free to choose their own definitions, to describe a situation or to express their own views on the issues under investigation."[226]

While there were certain themes I wanted to cover in the "semi-structured interviews and focus group discussions"[227] I conducted with them, I was keen to encourage my research participants to raise and elaborate on concerns and issues which I had not necessarily anticipated. In this sense I tried to engage with my research participants as active agents, and to encourage them to influence the pace and direction the interviews and focus group discussions took by asking

[225]Bless, C. et al. (2006):116

[226]Bless, C. et al. (2006):116

[227]Bless, C. et al. (2006):116

questions I had not necessarily anticipated in response to issues they raised. (For an outline of these semi-structured methodological approaches, using interviews and focus group discussions, see Frosh et al.[228]

One of my concerns when conducting the research interviews was to engage with my participants as authorities about issues which affected farming households with adult members and breadwinners who were HIV positive, and to give them time to develop their contributions.

Another was to develop a relationship with my research participants in which they felt free and able to talk about being HIV positive in a context in which HIV may be highly stigmatized.[229]For both these reasons I chose to conduct semi-structured individual interviews (appendix 1 and 7) as well as focus group discussions (appendix 2), with those that were willing to participate in the group discussion. With regard to PLWHAs in particular, I assumed that they might find it easier to speak about their experiences and the impact of HIV/AIDS on their households and their relations with household members if they were interviewed individually. Not only would they have more time to do this, but also they might feel less restricted to do so than in a group. It is unlikely, I argue, that they would have been able to reflect upon their experiences in such engaged ways if they had been interviewed in a group, so I decided to do a blend of both individual as well as group interviews with PLWHAs.

Interviews with PLWHAs, and Policy makers/service providers were in-depth and lasted for roughly 90 and 60 minutes, respectively. Summary notes were made immediately after each data collection process in order to outline some of the key themes that emerged during these processes and also reflected on the group dynamics[230] and diary keeping of daily research activities throughout the data collection process. Interviews were tape recorded, transcribed

[228]Frosh, et al (2002)

[229]Pattman & Chege, (2003)

[230]Pattman, R. and Chege, F. (2003):21

and recurring themes were again identified and these are discussed in depth in the results and discussion chapters. Respondents were given pseudonyms and their opinions were summarized and placed under the relevant themes in the research in line with the theories.

4.4.2 Data analysis

This was done using thematic analysis[231] by identifying key themes which emerge in the interviews which are raised by the interviewees in response to the kinds of questions asked.

4.5 Themes and questions in the semi-structured interview schedules and focus group discussion

I provide, below, a brief outline here of my interview questions (for more detailed versions of my interview schedules, and discussion (Appendices 1 and 2) but as I have indicated, many of the questions I asked were ones which emerged in the very process of conducting the interviews/discussions.

For the individual interviews with agricultural household members living with HIV/AIDS, I asked questions which sought information on other household members, regarding gender, age, and occupation etc. I proceeded to ask questions about their work and experiences of *living with HIV/AIDS* and how this had impacted at all on their relations with other members of the household and the roles they play and contributions they make in the household, and the support, if any, which they receive from other members of the household. I also asked them about support structures, if any, which were available for people with HIV/AIDS and which they were accessing outside the household and how useful they found these.

I wanted to pursue also whether, and if so how, HIV/AIDS had impacted on their, and their household's agricultural activities and livelihood pathways, and whether it had jeopardised

[231]Braun, V. and Clarke, V. (2006):79 This is one of the most common forms of analysis in qualitative research. "it emphasizes pin pointing, examining, and recording patterns (or themes) within data.

processes of knowledge and skills transfer from adults to children relating to agricultural production.

I also wanted to explore whether and if so how their sickness had impacted differently or similarly on males and females in the household, and more generally their views on the gendered impact of HIV/AIDS on households involved in agricultural production in their District. Finally I asked them about their reactions to being interviewed on these themes and topics (in a way which attempted to engage with them as active agents.)

In the semi-structured interviews with Policy makers and service provides, I wanted to find out from them what they thought were the key challenges faced by farm households with PLWHAs in the District; and the particular ways in which these impact on household members across gender, status and position, as well as how they respond to these.

I wanted to explore, with them the impact of HIV/AIDS on the livelihoods of PLWHAs and "affected households,"[232] especially in the following areas: inputs and technology adoption, "access to and control over"[233] productive resources, knowledge and information pathways. I wanted to assess too what mechanisms are in place (if any) to address issues of technology transfer and adoption specific to HIV positive farmers especially in the areas of labour saving devises and damage control.

4.6 Other complementary methods employed

As well as conducting semi-structured interviews, and focus group discussions with my participants, I also employed observation and diary keeping as research methods used to collect qualitative data[234] from the targeted population which was purposively selected for primary

[232]Muller, T R. (2005):18

[233]Muller, T R. (2005):18

[234]Bless, C. et al. (2006):116

data collection. Observation was used at the homes, crop and animal sites of PLWHAs, in order to ascertain what was said in the semi-structured individual interviews. From observation of activities undertaken throughout field study, a daily diary was kept that provided useful information and a better understanding of the respondents in the population that revealed information about their livelihood patterns, gender roles, nature of the interviewees.

4.7 Discussing the proposal and interview guides with authorities in Sierra Leone

In Sierra Leone, the research proposal and interview guides were discussed with authorities at the National HIV/AIDS Secretariat and Network of HIV/AIDS positives (NETHIPS) that provided useful inputs in finalizing the research approach and tool. A pilot study[235] was then conducted with few of the PLWHAs who were members of (NETHIPS) in Freetown because those in Koinadugu were unreachable for this phase of the research. These group of respondents in Freetown were however, not included in the final group of respondents for the work.

In considerations with the issues around stigma and ethics in research, there was concern about the nature and appropriateness of the questions. A thorough review of the research questionnaire / tool was conducted and pre-tested, and respondents gave their views on the type of questions asked to PLWHAs. As with such studies and the development of the research tool, it was realised that some of the questions were difficult to understand by the uneducated PLWHAs. Hence these were simplified. No translator was needed as all of the PLWHAs could speak 'Krio, the common medium of communication in Sierra Leone. The Krio language is a commonly used "lingua franca throughout Sierra Leone and is understood by 97% of the country's population, including millions of people who are not Creoles."[236]

[235]Bless, C. et al. (2006):184

[236]https://en.wikipedia.org/wiki/Krio_language (accessed April 2015)

The pilot testing of the research tool / questionnaire was characterised by the administration of the tool to a group similar to that of the research participants prior to a wider research.[237] This proved very helpful as the views of similar participants on the questions was got, and this guided the changes that needed to be done, for ease of use of tools and ordering of the questions. Pre-testing also helped in testing for comprehensiveness and in evaluating the overall study plan and time table.

4.8 Ethical considerations

Visits were made to the government hospital to ascertain the number of PLWHAs who are farmers in the selected study area to explore the possibility of talking with them prior to actual data collection. All participants were approached in a friendly and informal way that encouraged them to participate and the details of the informed consent forms (Appendix 3, 4 and 6) were explained to them and they were also encouraged to ask any question that they may want, after which, they gave their consent to participate, and therefore signed the acceptance to participate form (Appendix 5). Participants were then informed that during the interviews, there will be questions that will let them recall past incidences or by sharing current experience like the fear of the disease being incurable for now or the experience of stigma and discrimination which might cause them stress, and if they strongly feel, they do not want to respond they are free to discontinue with the interview. This was done to maintain the dignity of the participants.

In order to protect especially PLWHAs "from harm, the use of information-gathering method was kept to the strict minimum required to gain appropriate information on sensitive issues, in accordance with the basic ethical principle of beneficence."[238] It was ensured that no harm,

[237]Creswell; Kervin, Vielle, Herrington, Okely, as cited in Duke, J. (2012)

[238]Bless, C. et al. (2006):141

serious distress or injury was done, according to the principle of non-maleficence.[239] Therefore potential negative consequences were identified to "ensure that the interview did not lead to direct or indirect harm."[240] Also, members of the focus group discussion met at a central location away from their homes, while some others were interviewed in a secluded part of their homes.

Stress was minimized when discussing with PLWHAs by first having prior discussion with the participants through counsellors, then the PLWHAs were met with to discuss the importance of the research, I gave response to pertinent questions that were asked by PLWHAs. Participants were placed into two categories of respondents: those to be individually interviewed using a semi-structured interview guide and those to be part of the focus discussion group using a checklist. Informed consent forms for both individual interview and focus group discussion were given to all targeted PLWHAs who were willing to participate. Policy makers and service providers were also given their informed consent form, and interview guide (Appendices, 6 and 7); prior to interview, consent forms were signed before commencing interview.

PLWHAs who were literate were given the interview guides and consent forms in advance of scheduled interview and were allowed to ask questions on whatever they needed clarifications. In order to establish a trustworthy relationship between a researcher / the interviewer and respondents, generally, during the interviews each person's current situation and experiences (both participants and researcher) were willingly shared. This approach enhanced the readiness of participants to discuss the issues of interest and kick started the interview thereafter.

[239]Bless, C. et al. (2006):141

[240]Bless, C. et al. (2006):141

Next each participant was constantly reminded that they can opt out of the interview if they so wished and could "decline involvement at any time to answer any question that makes them feel uncomfortable,"[241] and that the participant will not face any penalty by dropping out. Selected participants (PLWHAs) first met with trained counsellors who conducted initial assessment. As mentioned before, no translators were required because all participants as well as the interviewers spoke Krio fluently.

No one in the group could read and write Krio, as this has only being taught in schools in the recent past in Sierra Leone. So with regards to the interview guides and informed consent forms, they were all written in English and translated by the interviewer in Krio to participants, with the exception of few Policy makers and service providers who preferred that they be interviewed in English. Their responses to the interviews were also tape recorded in Krio which was transcribed by the interviewer into English.

All pertinent letters of authorization to undertake this research in Sierra Leone were endorsed by the research supervisor at the University of KwaZulu-Natal (UKZN), then by relevant authorities in Sierra Leone confirming the student status of the interviewer / researcher at the university along with a brief background about the significance of the study. Having provided information on the nature of the research, permission was sought to work in the District as well. (Appendix 8) and permission was granted by relevant authorities (Appendices 9, 10, 11 and 12). On leaving for data collection in the field, the head of school/academic coordinator/supervisor at UKZN provided ethical clearance letter to enable data collection (Appendix13). An open letter to gatekeepers (Appendix 8) was granted for any other assistance I may need while on the field. Consent of PLWHAs, and Policy makers/service providers was sought and granted for various interviews and discussions.

[241]Bless, C. et al. (2006):141

During report writing, pseudonyms were used and data collection instruments were coded and well secured for any future reference after data analysis and the same for tape recordings that were transcribed and kept. The data collected will be held secured after coding and kept in a safe environment and both hard and soft copies disposed of between 3months and maximum five years after submission of dissertation.

With regards to the use of a tape recorder, it was very relevant for capturing details that the human memory may otherwise not recollect. The consent of all participants was asked to use a tape recorder as well to better enhance information collection. All participants willingly agreed. PLWHAs consent was also requested for photos of their livelihood activities, (Appendix 14) and this was granted.

4.9 Ethical issues which emerged when conducting interviews with PLWHAs

Most PLWHAs expected that by participating in the interviews and articulating concerns and anxieties they might receive assistance, and I had to remind them constantly that this was a student research project and that I was not in a position to offer any assistance, other than to make recommendations on the basis of my research which might influence Policy makers develop interventions aimed at providing help.

With regards to their mood while being interviewed, one of the PLWHAs was depressed even after pre-counselling and prior discussion with a counsellor and researcher. This resulted in a halt to the interview, and when she was asked whether she wanted to continue or not and she declined to continue. But the other interviewees seemed to be quite happy to reflect on their concerns during the interview and particularly keen to discuss suggestions for possible interventions.

Chapter Five

The Impact of HIV/AIDS on Farming Households and the Community: Main Concerns and Issues Raised by PLWHAs, and Policy makers/ Service Providers

5.1 Introduction

In this chapter, I identify and discuss key themes which emerged in the interviews with PLWHAs, Policy makers and service providers in relation to the broad objectives outlined in the first chapter on the gendered impact of HIV/AIDS on agricultural households in Koinadugu District.

5.2 Main concerns and issues raised by Policy makers/ service providers

I begin by reporting on issues raised by the Policy makers which, I hope, will help to provide a context for making sense of concerns and issues raised by people with HIV/AIDS in farming households whom I interviewed. The service providers and Policy makers were interviewed about 1) challenges faced by farming households in Koinadugu District with members with HIV/AIDS, and 2) their views about how to proceed with regard to HIV/AIDS and its impact on farming households in the District. I report on issues raised by the Policy makers which I hope will help to provide a context for making sense of concerns and issues raised by people with HIV/AIDS in farming households whom I interviewed.

5.2.1 The prevalence of petty trading among women and their social and economic vulnerability in the context of HIV/AIDS

One of themes which emerged in the discussions with the service providers/Policy makers concerned: the prevalence of petty trading among women and their social and economic vulnerability in the context of HIV/AIDS.

While the main livelihood option in the District used to be farming, the increased cost of agricultural activities, especially the cost of labour has led to serious reduction of farm sizes. So gradually people are moving away from farming in this District to petty trading as it is less labour intensive. Most people prefer to buy from the few farmers in villages that are still able to cultivate and sell during market days "lomors". And because of the gradual reduction in production, the cost of local foodstuff has increased.

Most of the women are involved in petty trading either as a first or second livelihood activity. If a woman falls ill in this community, the children will do the selling of their goods. At a very early age the children are introduced to petty trading. Some NGOs help the PLWHAs with income generating activities. The money is not given on credit; it is given to them free of cost. Some organizations do come with micro credit facilities but some authorities have kicked against that saying "*they are sick people who could die at any time*" Marian (service provider). When these monies are given out the PLWHAs are expected to repay with interest.

In the event that this person has been sick and is bedridden, the person will use the money to get food or to provide support for their household, if by the time they come to collect these monies and the PLWHAs are unable to pay back, they are molested. Also, all issues pertaining to HIV/AIDS in the District have to go through the relevant authorities and those NGOs involved in providing financial assistance to PLWHAs have always been told in no uncertain terms that if the money is for credit, they should take their monies back.

5.2.2 The economic vulnerability of PLWHAs involved in agricultural production

Another theme related to the above which was introduced by my interviews concerned the economic vulnerability of PLWHAs involved in agricultural production who found it difficult to attract investors because of presumptions of reduced mortality and also because of weakness arising from illness. The economic vulnerability of people involved in agricultural production who became infected with HIV/AIDS (and their families) was highlighted in discussions about

providing funding and training options to PLWHAs, and how "*some support groups are encouraging and enabling PLWHAs, especially farmers, to diversify their livelihood options."* (Johannes)

However some of my interviewees were critical of the lack of specific support for PLWHAs in agricultural production, and concerns were raised that if PLWHAs still have some strength they should not be diverted from agriculture into another livelihood option. Rather they should be provided with the needed support like labour saving devices. But it was mentioned that one of the assumptions, which militates against providing economic support for PLWHAs according research participants, is that *'they are already going to die, so why invest so much on them'.* But as the use of anti- retro virals becomes more prevalent in the community, and as it became apparent that people taking these could live many years, my interviewees were hopeful of more investment for PLWHAs to continue pursuing agricultural activities will be on the way.

5.2.3 The consequences for households when men or women become infected with HIV/AIDS

The gender of adults in the families who are infected, impacts differently on households and livelihood options given the different roles men and women play in households and the different activities in which they engage. In spite of the significance which tends to be accorded to men as heads of households, the consequences of women becoming HIV positive and dying were said by a number of participants to be particularly problematic for households. According to Marian:

> *"It is very difficult if not impossible for a man to care for his household without taking ARV drugs to boost him up. But it is even worse if it is the woman/mother who is HIV positive as up to 70% of breadwinners in this district are women and women are the majority of those infected. If it was the men that were mainly infected the homes would have still been well run."*

Mohamed noted that in families run by women, the death of the woman means the children will lack education and the absence of the mother will lead to a total breakdown.

> *"As their roles are very significant and even during market days it is the women you see carrying their produce on their heads for sale and they in turn buy other food and material stuffs needed in the household."*

5.2.4 The marginalization of women through lack of access to productive resources

The marginalization of women in relation to their access (or lack of access) to productive resources was a major concern which was raised by the respondents. Referring to the Fula tribe, Felicia noted:

> *"the women are still worried over their husbands not giving them access to their properties especially cows, which is their own strong asset. If the woman wants to sell her cow, the man or the husband will have to give the go ahead and he will be the one to sell it on behalf of the woman and give her whatever he thinks fit or else the woman will not sell the cow, even when the woman knows how to go about the trade."*

Felicia stated that women have "no right to property here", and that while they are involved in production and selling, the men control the money. This is explained and justified in terms of 'customs' which require women to be 'submissive to their husbands'. Reflecting and reinforcing the economic vulnerability of wives, especially in the context of HIV/AIDS, Felicia pointed out that:

> "In the situation wherein the husband dies his family grabs everything left behind, at times they even asked the wife and children to move out of the house."

Johannes expressed the need to engage and involve women in decision making and leadership positions:

"We need to involved women in decision making and to give them leadership positions, to have access to land. These should be done through sensitization and consultation with other NGOs and line ministries and even the local council."

5.2.5 Women internalising views about their inferiority

Marian indicated that the vulnerability of women in Koinadugu was linked with the tendency for them to internalize dominant views about their subordination in households, views which were justified and legitimated as a feature of their societies' "traditions" which needed to be preserved.

"*They even say to the men "anything you say or decide is fine with me'' they expect the men to make decisions on their behalf, even in the homes, if the man is absent the women cannot make any decision, they see it as being respectful to their husbands and it is their tradition, but again the tradition has made the women into fouls because they are not able to do anything without the men and that again subject them to all sorts of violence and as we are talking now, we have a very high rate of violence especially matrimonial violence against women in this community."*

These kinds of gender power relations, according to Marian, were manifested in social relations between teenage girls and older men, with girls becoming pregnant and infected with sexually transmitted diseases including HIV as young as 10-12 years old.

"During a research and monitoring activity we conducted, it was found out that some of the impregnated teenage girls hide under the guise of their peers after they get impregnated by elderly men who may not want to take responsibility. It will be great if institutions could intensify awareness at community level on the problems that surround gender issues especially on the inclusion of women in governance."

Sylvester raised concerns about early marriage of girls which was justified in the community in terms of ideas about 'tradition' and 'culture', even though this, he pointed out, has been challenged by various Acts passed by Government.

5.2.6 Stigma, gender and HIV/AIDS status disclosure

The importance of viewing the impact of HIV/AIDS on households in Koinadugu District through a gendered lens was underscored in challenges some of my interviewees raised about the vulnerability of women PLWHAs in households and difficulties they had disclosing their HIV status if infected.

This reflects a powerful double sexual standard, as discussed in Chapter 2, whereby women who become HIV positive are often judged as immoral whereas and liable to be stigmatized. While stigma and discrimination affects both men and women PLWHAs according to the service providers I interviewed, girls and women were particularly stigmatised.

As one of my interviewees, Marian, elaborated:

> *"it is very difficult for the wives to disclose their status to their husbands. It takes great persuasion for them to do so. On the other hand, the husbands easily disclose their status to their wives. This is because women in this part of the country fear their husbands. When the women test positive, they actually beg that their husbands should not be informed, because if he knows, she will be thrown out of the house as he will accuse her of bringing the disease in the home."*

Another interviewee, Johannes shared his experience with a PLWHA, '*whose family got suspicious about her positive status due to the continuous referrals that were done during the early stages of ill health. When she was finally confirmed positive and counselled she disclosed her status to her family and was accepted. But this, he stressed, was the exception rather than the norm.'*

Culture and religion are appropriated in ways which contribute to the stigmatization of people with HIV/AIDS as pointed out by Dennis: *"This is really one of the biggest challenges as an organization we are trying to make head way on. This community is a Muslim dominated one and they are still living in denial of the disease, this is because they are the ones with many wives and they are the same that send their children into early marriage."*

Significantly Dennis upon being told about the nature of my research when I was trying to obtain informed consent cautioned that I might have problems with PLWHAs refusing to let me talk to members of their households due to stigma and indeed this proved to be the case.

5.2.7 Gender power relations in polygamous families and the problems this poses in relation to HIV/AIDS

All respondents mentioned the "polygamous status"[242] of the community and that in most homes the men have three or more wives. If one of the women is HIV positive, she cannot disclose her status to the husband and ultimately it is likely they will all become positive.

Cases were mentioned where one wife was sick of AIDS and hospitalized, with the husband refusing to do the test to know his status and yet marrying a new wife, and this only came to public attention when the new wife was pregnant and had to do a compulsory HIV test.

Saffa said very few husbands accept their positive wives if they [the husbands] are negative, and at times the husbands will ask the positive wife to leave and not spread the disease to him and the other wife/ves even without him and the other wife/ves knowing their statuses:

> "*The positive wives normally just move out quietly to her family house or even out of the community as they do not want any further scandal, none of them to my knowledge has ever taken legal action, and this action cuts across both literate and illiterate men."*

[242] Interviews with PLWHAs and Policy makers/service providers

Saffa indicated that his institution is trying to educate people in the district to address the issue of stigmatization and to protect positive women/wives against abuse by either their husbands and or other household members, but he cautioned that this depends on the woman making her status known to her husband and/or other household members, which, in the context of the stigmatization of HIV positive women, may not easily do.

Mohammed explained that their institution received two cases of husbands sending their wives away because they are "HIV positive". These cases were referred to the counsellors in the hospitals, but the intervention of the counsellors did not make any difference.

5.2.8 Gender power relations as manifested in marriages between young girls and much older men

Concerns were expressed about early marriage of girls, and how this was justified in the community in terms of 'tradition' and 'culture'. Even though this, as pointed out, was challenged by various Acts passed by the government, still *'Most people in this District believe that it is an abomination for a girl with "full breast" which is a sign of maturity to stay at the family house, rather she should be married and in her husband's house.'* At the time of interview, three girls who were taken out of school and sent into marriage, have been removed from the marriages and sent back to school.

5.2.9 Children offering support for their HIV positive mothers and fathers

According to the Policy makers/service deliverers I interviewed, men "tend to abandon their wives" if she becomes HIV positive in the sense that they give them "very little support". This happens even without the husbands knowing their own status. Generally if the husband becomes HIV positive it is the wife and the boys who will offer support and care, whereas if the wife becomes ill with HIV care for her and the family is forthcoming mainly from the girls. Sometimes older girls in the family turn to prostitution to meet the needs of the home when the

mother is sick. Though some of my respondents also mentioned that there were variations between families in their responses to when husbands and/or wives become HIV infected, and that some husbands did offer care and support.

5.2.10 Problems of inadequate support and care services in HIV/AIDS affected farming households

All respondents highlighted as a major challenge service delivery "especially in the area of care and support"[243] for all the OVCs. Saffa stated that some funding had been provided by government and Non-Governmental Organizations in this regard, but it is expected that those institutions operating in the District most show some financial commitments towards this intervention.

But there is only one such organization supporting the PLWHAs and OVCs. He suggested that this must be discussed and made mandatory that all NGOs operating in the District should provide support especially for the OVCs as they are on the increase. Service providers interviewed were concerned that if this is not done as a mitigating factor, the children will also be exposed to the virus; especially the girls through exchange of sex for cash, food and or material needs and this will lead to more infection rate in the District.

All PLWHAs acknowledged receiving free medical attention including free ARVs and some mentioned receiving food rations from the Daindenbeh Federation and World Food Programme (WFP). They indicated, however, that the food rations were not enough. All respondents indicated that the community did not provide them with any support. On the contrary they experienced stigmatization from people in the community. Few of them reported on receiving some form of support from their family members as well.

[243]Government of Sierra Leone (2002b)

5.3 Main concerns and issues raised by PLWHAs

5.3.1 The debilitating effects of HIV/AIDS in relation to farming

Most PLWHAs I interviewed whose main source of livelihood was farming, indicated that it was very difficult to make their living since they started falling ill; they are all involved in farming as a main source of livelihood. Hawanatu explained '*how she used to cultivate large plots of rice, cassava and potatoes, but since becoming HIV positive, this has changed:' "I therefore just concentrate on vegetable cultivation and the plot is not that large also. After sales I buy non-agricultural goods that I also sell in the community."*

It is mainly the poorer households, as in the case of the participants in my study, who are normally late in their farming activities, while the better off hire labourers for their agricultural operation during peak labour seasonal demands.[244] This was expressed by Joseph '*who mentioned that he was involved in cash crop cultivation, money from which he used to finance his crop farm.'* But for many affected households, some members of the households resorted to working within the community for wages, especially provision of hired labour as a livelihood option to meet household livelihood needs. "With fewer prime- age adults in the household, non-farm income is likely to fall, as they are mostly gender specific."[245]

5.3.2 Agricultural knowledge transfer and adoption

PLWHAs accepted that their grown up children already know so much about agriculture. But most of them are in their own separate households, it is the younger ones that are still staying with them, and need to learn those agricultural skills. At the same time all of them mentioned that agriculture is no longer earning much income, and the children will only stay in agriculture

[244]Chiwona-Kaltun et al, as cited in Arrehag; L et al (2006):60

[245]Arrehag, L. et al. (2006):74

if there is value addition that will lead to increased earnings from agricultural activities otherwise their children will be as poor like them if they stayed in agriculture. Some of them recognized that with the provision of compulsory primary schooling, which they welcomed as providing opportunities for their children to better themselves, there may be a conflict between adult expectations that their children should take over their family farms and the interests of their children.

These were expressed by Hawanatu and Margaret in the respective extracts below:

"*At an early age parents introduce their children to farming, though it is not the case as it was in the past, due to a lot of awareness as some parents do not even want their children to go into farming because it is associated with poverty. They want them to go to school in the bigger towns and come back as role models in the community, as agriculture is not attractive at all. Especially those of us involve in crop farming. Those involved in cattle rearing are the richer ones here and they do not even bother to send their children to school as they have to take care of the animals* (Hawanatu PLWHA).

"So gradually crop farming is becoming less and less, thus the high cost in agricultural goods in this District. I doubt whether any of the children, would want to take up crop farming after their parents or caregivers. As it is, people prefer to buy from the few available farmers, and sell during market days, rather than planting." I will not want my children to be poor like me that is why I am encouraging them to go to school or at least learn other trades. With agriculture we suffer so much, we use our bare hands, no machine, and the one that is available, I cannot afford to hire, but there is nothing more I can do. I am just worried about the children" (Margaret).

5.3.3 Some technologies identified as easily accepted by HIV positive farmers

Labour saving and or drudgery reduction technologies for AIDS affected farm households will be a right step in the right direction. This will not be limited to just farm activities but others

such as fetching water, and food processing. Women are in most communities responsible for fetching water, fire wood, caring for the sick and therefore need extra supply of water for washing. HIV/AIDS exacerbates the gender and age division of labour in an "affected farm household,"[246] as some tasks are gender and age specific. The need to learn new technologies on especially labour saving devices, improved seeds cultivation, crop preservation, and postharvest loss reduction was expressed by PLWHAs.

5.3.4 Providing help to farming households affected by HIV/AIDS to adopt alternative livelihood pathways

One of the PLWHAs in my study, Sylvester, alerted me to the gendered impact of HIV/AIDS on households when he pointed out that the *'the death of the head of the family, especially if it is a man who is experienced in agricultural production, usually leads to forms of household disintegration, unless alternative livelihood pathways are found usually involving petty trading.'* All the respondents acknowledged the fact that interventions need to first and foremost identify whether there are any members of the "afflicted" farm household that is/are ready to continue with agriculture, then thereafter, support them either in agricultural skills training and inputs or otherwise. Sylvester, Mohamed and Saffa believed that '*the best intervention will be training, in entrepreneurship skills and work with them to see which business venture they could successfully undertake and provide the relevant support needed in that direction especially if the household member who invariably is sick, is the head, and if the deceased was the head, then they should consider the person who assumes the role of the head of that household.* Mohammed added that '*the government is putting up the Agricultural Business Units that will provide facilities like stores, seeds, machines and fertilizers for farmers, in order to make agriculture attractive so that more people will be encouraged to go into farming.*' And if someone was a successful farmer before being diagnosed with HIV, they

[246]Muller, T R. (2005):18

will still continue farming as they will still be in a better position to pay for hired labour which is the greatest challenge for PLWHAs.

David suggested that *"for PLWHAs to continue cultivating, they should organize themselves into an agricultural group through which they could attract funding to undertake their faming activities, but if they all start quitting, then there will be a huge crisis in food availability and affordability as production will drop and cost will increase. As it is already, he continued, cost of agricultural produce here has increased greatly compared to previous years. Some agencies providing funds for PLWHAs who were farmers had to give up owing to ill health."* However these funds were not aimed at helping them continue farming, but to give them the necessary skills and resources to engage in other income generating initiatives such as petty trading or soap making or gara tie dyeing etc. These funding agencies, the respondents suggested, should instead encourage PLWHAs who are farmers to form themselves into small farming units and fund their agricultural activities instead of diverting their livelihood option.

5.3.5 The double standards which operate in households when women and men become infected with HIV/AIDS

The majority of PLWHAs I interviewed mentioned that in most situations where the wife is HIV positive and the husband is not, the husband "goes mad", and most times the wives are sent out of the house. Mansaray said *'only very few husbands "who have the fear of God" will continue to encourage the woman. In the majority of cases the men are very aggressive and are the ones that even try to expose the wife to other people. In the event of any problems, it is he who will remind her of her HIV positive condition.'* A female respondent '*also mentioned that she was in her sick bed when her husband married another woman, not knowing that he too was already positive.'* In the focus group one female respondent mentioned *'the issue of being abandoned by her husband when her situation worsened and she is presently with her biological family for over 5 years (from date of interview) and the husband never bothered to check on her'.* She specified that there were no Chiefdom bylaws with regards HIV/AIDS, and

the HIV/AIDS policy is only implemented against other members of the community, but not husbands, as the wives do no report cases of abuse.

Indeed this seems to be the most conservative District concerning gendered practices. There is no woman chief in Koinadugu District, and this is precluded on the grounds of "tradition". However this is happening in other Districts, following a campaign being conducted in the radio aimed at sensitizing people on gender inequalities in relation to power and land resources. Hawanatu stated that *"men justify the exclusion of women with regards chieftaincy in Koinadugu District on the grounds that when women are in power, they will not be able to rule. Even if a woman is from a ruling house, she cannot be a chief."*

5.3.6 The consequences for boys and girls in households when men or women become infected with HIV/AIDS

It was evident in my research with PLWHAs that roles played by people in their households in response to being infected or affected by HIV/AIDS were often clearly delineated on gender lines and reflected and contributed to patriarchal structures, and this was illustrated in the differential impact on men and women affected or infected in households by HIV/AIDS.

According to my participants the gendered division of labour among children was not much affected by one of the adults becoming HIV positive. Other household members have to step in to compensate for the sick member in terms of his/her contribution in the house be it through work or financially and these roles are socially and culturally prescribed gender roles. The provision of care and support, however heavily depends on the sex of the sick person: if it is a woman, the girls and other female household members will help, if a man it is the boys, wife and if there is any adult male in the household, but the heaviest part will be borne by the wife or wives as the case maybe.

Some children, according to the interviewees are supportive, whilst others are not. For instance, in some situations when it is the mother who is positive and asks the children to perform any domestic chores, some children will be the ones to expose their parents and will start shouting and grumbling that they are tired and that they are not responsible for their mothers predicament. Interestingly despite the unpaid care work performed by of adult women in households, all the PLWHAs I interviewed acknowledged that the boys are more supportive than the girls towards adult family members who are infected with HIV/AIDS. Boys were said to provide care and support: fetch water, fire wood, help in holding hands to move about during weakness and in every other area except for bathing them if it is the opposite sex.

However if boys were more "supportive" than girls in households affected by HIV/AIDS , the social impact of parents becoming infected seemed to be greater on girls than boys, with girls being much more likely than boys, according to the PLWHAs I interviewed, to be withdrawn from school in order to raise income through petty trading, or help with providing care for younger siblings. Sometimes, I was told, girls were even sent into early marriage, if their parents became infected, in order to recruit additional labour from the spouses of their daughters and their families. There was one case in which an orphan, who had lost a father, was sent into early marriage unknowingly to an HIV positive man (Mansaray) who was one of my interviewees.

When parents become infected with HIV/AIDS, youths or children are used either to provide care, or as household labour and some are even used as breadwinners. For example, Musu mentioned that *"her sister in law arrived at her house to take one of her daughters to the city with the deception of letting her learn a trade. Musu said that upon her visit to the city for medical attention, she realised that, that was not the case so she brought her daughter back, who unfortunately had been impregnated and had dropped out of school."*

Also, the increased dependency ratio becomes evident as adults in their prime get seriously ill and die, leaving the old and orphaned children. Adult healthy household members will undertake additional work to earn extra income. Additional work includes provision of hired labour for a fee within the community, and sometimes they may even migrate to other communities or towns and get involved in petty trading to mention a few.

5.4 The gendering of HIV/AIDS and its impact on farming households in Koinadugu District

I conclude this chapter by reflecting on the themes which emerged from interviews and discussions with Policy makers and service providers and PLWHAs about the impact of HIV/AIDS on farming households.

My research focuses on the impact of HIV/AIDS on farming households and livelihoods. But one of my key findings concerns how tied up livelihoods are with gender expectations and cultural assumptions about the roles of men and women, and how gendered the effects of HIV/AIDS are on families in agricultural communities infected and affected by HIV/AIDS.

A key finding from your research concerns the vulnerability of women in rural households given the construction of male adults as the leaders and breadwinners and females as people responsible for care, domestic work, and other tasks and activities which often are not regarded as work or do not carry the same cultural importance and significance as work associated with men in rural communities. The importance of caring and domestic work in rural homesteads and the vulnerability of women as well as families which depend so much on the unpaid caring roles women play (along with other roles) in the household is demonstrated in the impact in which HIV/AIDS makes on households and livelihoods, as your thesis so powerfully demonstrates.

Theoretically one of the key arguments which emerges from my research is that while it is important to recognise the economic status and position of small rural households dependent on subsistence farming (in my research site) and their precarious situation in the context of social and economic changes and problems, it is equally as important recognise how gender intersects with economics as an important source of power and inequality, and how it is necessary, as I do, to explore not just agricultural households in rural areas as the unit of analysis, but the gendered ways in which these are divided and experienced by the people living in these.

In exploring the impact of HIV/AIDS on livelihoods and households in rural areas I found that this was highly gendered. For example while the impact of HIV/AIDS had devastating impacts on the economies of farming households these were experienced very differently by adult men and women who were infected or affected and by girls and boys in these households. Women were much more vulnerable with their position in the household depending upon the authority of the adult male. This made it difficult for them to disclose their status if they were HIV positive for fear of being excluded from the household by her husband. Her vulnerability was reinforced by cultural double sexual standards which blamed women for spreading the disease, and also which tended to deny or discount the importance of caring and domestic work in rural homesteads.

Similarly the impact of HIV/AIDS is gendered in farming households not just in relation to adults but also children and youth, with the lives of young girls, more likely to change dramatically through being pushed from the household, removed from school or being encouraged into early marriage with an older man in another household.

The power of men and the vulnerability of women in the household economy is buttressed institutionally by men's positions as owners of land and property, and ideologically by popular conceptions of men as leaders and women as subordinates. In such an economy the caring work

and domestic activities undertaken predominantly by women is not recognised or counted as real work and is unpaid. These women are overloaded with other chores, thereby reducing their time to engage in income earning activities,[247] tasks for which they are also not paid for. This consequently undermines the sustainability of their livelihoods and that of other household members which may include children. This is the level to which women are made more vulnerable, at the expense of their survival and those of their children.

These are precisely concerns which socialist feminists raise, which I discussed in Chapter 3, who draw attention to the ways the exploitation of women in households and families, through their precarious and exploitative position as providers of unpaid care and domestic work, resonates with and buttresses and supports wider forms of exploitation in capitalist society.

The vulnerability of women in such households is made particularly apparent and acute, as I found in my study, in the context of HIV/AIDS. My argument then is that a purely economic understanding of agricultural livelihoods is not sufficient in addressing the needs of HIV/AIDS infected and affected households, a 'livelihoods approach' needs a gender lens which will consider the issues of wellbeing and response strategies in households having members living with HIV/AIDS. As Hanrahan[248] specifically emphasises in her research on the impact of HIV/AIDS in agricultural communities in Ghana, livelihoods are shaped by and reinforce gender power relations.

My research findings have highlighted the (gendered) impact of HIV/AIDS on farming households and livelihoods, and how such households function through the subordination of women and girls in the context of HIV/AIDS. While functionalist views of the family have often downplayed issues, raised by feminists, about unequal roles which men and women, boys and girls play in families, I found evidence that roles that people played in the households in

[247]Arrehag, L. et al., (2006):74

[248]Hanrahan, K. (2015)

my study were often clearly delineated on gender lines and contributed to patriarchal structures. This was illustrated in the differential impact on women and men affected or infected in households by HIV/AIDS.

5.5 Participants' (Policy makers/service providers and PLWHAs) reflections about being interviewed

Some Policy makers/service providers found the format of the interview particularly conducive to open an exploratory discussion which caused them to reflect on their own concerns and practices in relation to the themes about the effects of HIV/AIDS on members of farming households and how these relate to the gender power dynamics of the households. Some of the participants also mentioned that the interview has helped them to reflect on what they knew about Koinadugu District. As Johannes said:

"It has reminded me of issues that maybe for the past one year, a month or a week (from date of interview), I have not being thinking of critically. So asking me about them I just said to myself so these things are still important to some people and the interview reminds me again of updating myself about information in all the Districts we are operating so that I am well prepared whenever I am faced with this similar situation of being interviewed on my agency, I will have the authority to provide these pieces of information, and it helps me to remind myself about what I know about Koinadugu District, so the interview is really useful to me as well."

Some found the interview 'educative' and welcomed the opportunities to highlight issues which their institutions have raised but have been unable to implement owing to lack of funding. Mohamed said the interview was 'educative' because *"the people the research was targeting were those that their institution is interested in providing services for"*, together with their families.

Most participants commented positively on the 'holistic' nature of the discussion and the questions posed which covered a wide range of issues in relation to the effects of HIV/AIDS

on farming households. One consideration which was raised which had implications for my research with members of farming 'households affected by HIV/AIDS"[249] concerned children and their experiences in such households.

On the part of PLWHAs, all interviewed appreciated participating in the interviews and focus group discussions and were grateful to be given this opportunity to air their views. They expressed hope that the issues they raised about the social and economic effects of being infected with HIV/AIDS on their households would be taken up by Policy makers and other organization with an interest in helping them.

Chapter Six

Conclusion and Recommendations

[249]Muller, T R. (2005):18

6.1 Introduction

The study examined the livelihood options of PLWHAs and how HIV/AIDS has affected them and the various response strategies employed by PLWHAs and institutions working on HIV/AIDS, with regards to nutrition and ARV treatment. Based on data collected from the two groups of respondents in my study: (PLWHAs and Policy makers/service providers), this chapter provides a summary of key findings which relate to the challenges posed by the impact of HIV/AIDS on farming households in Koinadugu District in Sierra Leone and recommendations for addressing these.

Concerns about social stigma were raised by respondents which they indicated exacerbated the social and economic impact of HIV/AIDS on farming households. How to address this and encourage community support were mentioned as key challenges. The reluctance of PLWHAs in farming households to disclose their status to others in their households, let alone to the wider community, in the context of a culture of stigma and discrimination compounded the difficulties and problems such households experienced and provided further challenges.

My research sought to engage with and understand PLWHAs in farming households in Sierra Leone not simply as people with medical illnesses, with particular problematic symptoms which mitigate against productivity, but also as people who experience particular social problems and forms of discrimination which tell us as much about certain (problematic) cultural norms and values as they do about the illness itself.

The impact of HIV/AIDS at household levels is determined by several variables and specifically, as evidenced in this study, by the socio-economic status of the infected person and that of other household members, the age and household composition, the PLWHA's position and role in the household and also the culture, tradition and religious beliefs with regards marriage and the issues of inheritance.

Other concerns were raised in this study about issues of gender role differentiation in farming households before and after HIV/AIDS, status disclosure, discordant couples in farming households affected and infected by HIV/AIDS, and gender laws in the area of rights of inheritance. The expression of these was motivated by concerns with protecting the rights of ownership of other household members on the death of household heads, especially if the head was a male, given the tendency for his relatives to take his possessions and leave his wife and children with few resources.

The common social expectation that women, not men, are carers makes them particularly vulnerable and open to exploitation in farming households "infected and affected"[250] by HIV/AIDS. My respondents (both women PLWHAs and some of the Policy makers/service providers) also indicated that women were particularly susceptible to being stigmatised for being HIV positive and blamed for engaging in 'frivolous' or immoral sex. This meant that wives who were HIV positive were particularly vulnerable and subject to forms of exclusion from their households.

Men's abusive relationships with women connect with investments in particular stereotypes of masculinity.[251] One of the most deep rooted beliefs in most part of sub- Saharan Africa, is that 'being a man' means being dominant and in control, especially in sexual relationship.[252] And in provincial Sierra Leone to be specific, wives most times have no say in the number of wives a husband want to have and when they want to remarry another.

Gender issues therefore should be of grave concern in prevention and mitigation efforts to address the impact of HIV/AIDS. That all mitigation efforts will only be meaningful if among others cultural beliefs and gender stereotypes as in most cultures in Sierra Leone even among

[250]Muller, T R. (2005):18

[251]Arrehag et al., (2006):44

[252]Arrehag et al., (2006):44

the educated be minimized to a great extent, as these continue to promote female subordination and male superiority at all levels of decision making processes.

Mitigating the impact of HIV/AIDS on farming household's needs to take cognizance of cultural factors as this will influence other components directly or indirectly. For instance, the right of inheritance of women to their deceased husband's property will make it less likely for them to engage in risky social activity in order to make ends meet when their husband dies.

As elaborated in Chapter 3, the livelihood perspective states that livelihoods are only "sustainable when they can cope with and recover from stresses and shocks and maintains or enhances its capabilities and assets both now and in the future, while not undermining the natural resource base"[253]. And at the same time the issues of social wellbeing and gender considerations must be key for livelihoods to be sustainable.[254]In my study we saw how sustaining livelihoods in HIV/AIDS infected households proves very difficult, if not impossible. While some families attempted to move from production to petty trading or from rice farming to vegetable growing partly in order to alleviate the strains exacerbated by their illness, some households disintegrated, with wives and children ending up as breadwinners or going into early marriage or prostitution to survive.

We learnt in my study how women as care givers for the sick were being overburdened with sustaining the livelihoods of both husbands and children in the households, some of which were polygamous. Drawing on the feminist socialist perspective discussed in Chapter 3 which argues that, "women's oppression results from their dual roles as paid and unpaid workers in a capitalist economy",[255] I argue for interventions which are concerned with empowering women, especially in farming households in Sierra Leone in the era of HIV/AIDS. In most

[253]Scoones, I, (1998):5

[254]Hanrahan, K. (2015)

[255]Ferrante, J. (2008):290

cultures of rural Sierra Leone including study District, women are seen as part of their husband's property that should be inherited by a male family member upon his death.

There is therefore the need to reduce if not to eradicate gender related constraints impacting on women if HIV/AIDS is to be successfully mitigated. On the other hand, this determines the livelihood strategies of both men and women, in mitigating the stress posed by HIV/AIDS infection, and efforts must be gender sensitive in such a way that it must focus as a priority issue on improving women's status in society and changing gender relations bearing in mind the interest of both categories, if we should talk about sustaining livelihoods. But this must be done with a strong involvement of men, as rural Sierra Leone is mainly governed by traditional laws, and men are the custodian of these laws.

6.2 Recommendations

Government as a policy action must consider providing support for farmers especially with regards to farm inputs and labour, especially labour saving techniques more especially for farmers who are PLWHAs, so that they do not shift to alternative sources of livelihoods, but rather continue with their agricultural activities.

The need for agricultural education and skills development cannot be overemphasized given the consequent agricultural knowledge gap that is created by the morbidity and death of older farm household members, with rich experience and knowledge relating to agricultural productivity. Organizations and support groups can help PLWHAs with food for work especially in areas of technology adoption, particularly those requiring an initial input of labour.

There is a need for PLWHAs to belong to farmer field schools as they expressed challenges which could be solved by their being members of farmer field schools. But how this could be done without facing stigma and discrimination needs expert opinion. Through these farmer

field schools agricultural extension officers can organize key times in the agricultural calendar to demonstrate the impact of labour saving technologies especially those that has to do with crop protection, storage and processing which are some of the major challenges expressed by PLWHAs in this research.

HIV positive farmers in this District can also, as an alternative source of livelihood option, be trained in honey bee harvesting and processing. Therefore if they could be trained and funded to embark on this, it will be a step in the right direction as well, as this District is re-known for having honey bee.

In a bid to create a positive impact in addressing some of the stresses posed by HIV/AIDS on "affected farm households,"[256] addressing women's issues must be key. Timely distribution of improved seeds, fertilizers and provision of marketing possibilities to affected households with key consideration for homestead vegetable gardening as a source of livelihood recovery measure may all things being equal help increase productivity. The need also exist for the provision of labour saving technologies especially for women. Technologies such as small-scale, simple land preparation and food storage and processing equipment operated at either community or if possible household levels will help greatly in ameliorating the socio-economic and psychological stresses experienced in such farming households. This intervention will go a very long way in ameliorating some of the problems faced by HIV/AIDS "infected and affected farming households,"[257] and this will lead to a sustainable livelihood.

Policy interventions must embark on addressing gender imbalances, and innovations that will cut down on the extra stress that women and children go through: like long distance trips to fetch water and fire wood, to go to market days, and to visit health centers to mention but a

[256]Muller, T R. (2005):18

[257]Muller, T R. (2005):18

few. Parts of the gender laws which lay premium on traditional laws need to be revisited and amended.

There should be a stop to wife inheritance on the one hand, or if it has to be done it should not be coercive. On the other hand though, since it is done because of land and other property rights, other measures should therefore be put in place by Policy makers at all levels to ensure that parts if not all, of the deceased husband's/father's property acquired during the years of marriage are actually given to the widow /children as a short term measure. In other words this means the effective implementation of the gender Act.

Implementing the inheritance laws may be one good step in combating the impact of HIV/AIDS. For land, widows and orphans may not have the labour or finance to farm, but they should be given the right to rent it if they want to as this could act as another source of income. Because sale of agricultural land in most parts of rural Sierra Leone is not possible due to the land tenure system in the country as it is mostly communally or family owned.

Sensitization packages to effect behaviour change must be on going and should include encouraging people to go for HIV testing to know their status whether they believe that it exists or not and thereafter, they can take the medication in time, rather than wait until the situation has worsen and traditional medicine has failed before resorting to hospital when it is too late. Also that traditional medication is yet to cure HIV/AIDS; therefore people should not waste their resources when there is free ARV treatment.

There is need to embrace a sustainable livelihood programming approach while emphasising a holistic approach. Therefore partnership strengthening with other organisations in the areas of HIV, gender issues, agriculture/livelihood to offer additional capacity building is of necessity.

Also all agencies wanting to or are intervening in HIV/AIDS issues should at the very initial stage fully involve the PLWHAs in the planning and development through HIV counsellors to

be well abreast of the needs and anxieties of the benefactors of the project, and a baseline survey must be conducted to act as a blueprint in developing these proposals.

The effectiveness of ARVs came up vividly in this piece of work and therefore the researcher thought it fit to review literature in this regard to enable her come up with recommendations that will suit the scenario in her study population. In this light therefore these are recommendations with regards the use of ARVs in Sierra Leone; a collaborated approach of blending both clinical and traditional prevention and care for HIV/AIDS due to the health seeking behaviour of the afflicted, to address the problems associated with late diagnosis and consequently early death, as it is only when traditional healing fails, they resort to the hospital, by which time it is too late.

With these recommendations based on the findings of this research, it will go a long way in ameliorating gender and agricultural/livelihood constraints of HIV/AIDS affected households if taken into consideration by Policy makers/service providers and PLWHAs themselves.

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Appendices

Appendix 1

Individual semi-structured interview questions for PLWHAs

Time…….

Start……..

End …….

Date:……..

Information on household members

1. Can you tell me a little bit about members of your household (composition, number, age, sex and relationship
2. How many boys go to school?……
3. How many girls go to school?……
4. Is any household member of school going age not going to school. If not, why not? .....
5. If any member(s) is/are employed, how many, and in what sector(s)
6. If not working why not?

General information on participant

1. Age ……
2. 2. Sex……
3. What, if anything, do you do for a living?…If you have more than one source of livelihood please name them, and specify which is your main source and why?
4. Do you do work, such as domestic or other duties which is unpaid? If so please indicate what you do
5. Has your illness affected the type and amount of work you are able to do? If so please elaborate.
6. Marital status? If married, is your wife/wives/husband living in the same household?

Main Questions

Living with HIV/AIDS

1. For how long have you known you were HIV positive?
2. Why did you get tested?/ How did you get to know your status

3. When did you communicate your status to members of your household? How did they respond? Were they supportive or not?
4. As a result of your illness are you accessing any kind of support outside the home? If so what does this entail? Please elaborate (Food rations, counselling, ARVs etc.)
5. Are you accessing any treatment? If yes, what does this entail (Free treatment for opportunistic infections, ARV)? What effect, if any, has this treatment had on your illness and what you are able to do in terms of work and responsibilities inside and outside the home?
6. How has this support changed the life style of other people in your household?

Impact of HIV/AIDS on household

7. What would you say are the main constraints and challenges which have arisen, if any, because of your illness for a) you and b) members of your household? Please elaborate, giving examples?
8. Have your living conditions changed as a result of your relative becoming sick? If so, how? (for example, eating patterns, types of food eaten, assets owned, money in the house etc.).
9. Have the livelihood options available to you as a household changed because of your ill health, if so how?
10. What are the impacts of HIV/AIDS on your household's livelihood/agricultural activities,
11. What are the impacts of HIV/AIDS on your household's agricultural knowledge
12. What are the impacts of HIV/AIDS on agriculture./livelihood information pathways among members of your households
13. How has HIV/AIDS status of your relative affected you and other members of your household in accessing markets?
14. What has been the response to the various challenges faced by your household since this your relative got ill?

15. What value do you think can be added to the functioning of institutions that are intervening in agriculture/livelihood if any, to address some of the challenges faced by PLWHAs and their households?
16. What value do you think can be added to the functioning of institutions that are intervening in gender issues if any, to address some of the challenges faced by PLWHAs and their households?
17. What value do you think can be added to the functioning of institutions that are intervening in the availability of markets if any, to address some of the challenges faced by PLWHAs and their households?
18. What value do you think can be added to the functioning of institutions that are intervening in technology adoption and transfer if any, to address some of the challenges faced by PLWHAs and their households?
19. What alternative pathways can be used when the traditional knowledge pathways become ineffective in addressing the livelihood needs of members of the households affected by HIV/AIDS in the transfer of agricultural knowledge and skills?
20. How is your household performing in the marketing system in order to be able to meet their food and income needs?
21. Are there any differences in coping strategies employed between your household and other households affected by HIV/AIDS? If yes why do you think so, if not why?
22. Has your relationship with other members of the household changed since you got sick? If so with which members of the household, and how has this changed?
23. What kind of support, if any, have particular members of the household provided for you? (for example, emotional, material support, cleaning, providing food, washing etc) Please give examples of this and the household members who provide this.
24. Would you say you personally have changed in terms of your views or outlook or behaviour as a result of your illness If so, how?

25. Do you think your illness has affected men and women differently in the household in terms of what they do and how they interact with you and others? If so please elaborate.
26. Do you think that your illness has affected boys and girls differently in the household in terms of what they do and how they interact with you and others? If so please elaborate
27. Do you have any comments/ issues you want to raise which have not been covered in this interview?
28. How did you find the interview?

Interviewer's *immediate* impressions of the interview and the main concerns, issues and views raised by the interviewee, and brief comparisons with other interviewees in the same household……

.....

Note: This is an interview guide and does comprise all the questions the interviewer will ask. While the interviewer will certainly ask these kinds of general questions, most of the questions which will be asked will be more specific arising from the issues which the participants raise in the course of the interviews.

Appendix 2

Checklist for focus group discussion with PLWHAs who were not individually interviewed

Time……

Start…… End…….

Date……...

General information on participant

1. Average age of group:……
2. 2. Sex composition of group:……..
3. What, if anything, do you do for a living?…If you have more than one source of livelihood please name them and which is your main source?.
4. Do you do work, such as domestic or other duties which is unpaid? If so please indicate what you do
5. Has your illness affected the type and amount of work you are able to do? If so please elaborate.
6. Marital status? If married, is your wife/wives/husband living in the same household?
7. Can you tell me a little bit about members of your household (composition, number, age, sex and relationship (average number of household members of participants)
8. Is any household member of any of you here of school going age that is not going to school. If yes, why not? .....
9. Is there any member(s) of your household not working?
10. If not working why not?

Main questions

Living with AIDS

For how long have you known you were HIV positive and how has it changed your life? (Examples very important)

1. Why did you get tested? / How did you get to know your status?
2. When did you communicate your status to members of your household? How did they respond? Were they supportive or not? (stigma a/busy, if stigma why do you think so ensure more discussions, if psychological effect, how does that make you feel, if family abandonment how does that make you feel?)
3. Are you accessing any treatment? If yes, what does this entail (Free treatment for opportunistic infections, ARV)? What effect, if any, has this treatment had on your illness and what you are able to do in terms of work and responsibilities inside and outside the home?
4. As a result of your illness are you accessing any kind of support outside the home? If so what does this entail? Please elaborate (Food rations, counseling etc).
5. How has it changed the life style of other people in the household?

Impact of HIV/AIDS on household

1. What are the general supports you get from members of your household? / community/ others (then ask questions on specific things you are looking for)
2. How do you perceive this/these support/s?(family, community and others)
3. Do you get enough support
4. Will you like to get more support, what form and from whom?
5. What would you say are the main constraints and challenges which have arisen, if any, because of your illness for a) you and b) members of your household? (Please elaborate, giving examples)

6. Have your living conditions changed as a result of your relative becoming sick? If so, how? (For example, eating patterns, types of food eaten, assets owned, money in the house etc.).
7. What are the impacts of HIV/AIDS on your household's livelihood/agricultural activities,
8. What are the impacts of HIV/AIDS on your household's agricultural knowledge
9. What are the impacts of HIV/AIDS on agriculture/livelihood information pathways among members of your households
10. How has HIV/AIDS status of your relative affected you and other members of your household in accessing markets?
11. What has been the response to the various challenges faced by your household since this your relative got ill?
12. What value do you think can be added to the functioning of institutions that are intervening in agriculture/livelihood if any. to address some of the challenges faced by PLWHAs and their households?
13. What value do you think can be added to the functioning of institutions that are intervening in gender issues if any, to address some of the challenges faced by PLWHAs and their households?
14. What value do you think can be added to the functioning of institutions that are intervening in the availability of markets, if any to address some of the challenges faced by PLWHAs and their households?
15. What value do you think can be added to the functioning of institutions that are intervening in technology adoption and transfer if any to address some of the challenges faced by PLWHAs and their households?
16. What alternative pathways can be used when the traditional knowledge pathways become ineffective in addressing the livelihood needs of members of the households affected by HIV/AIDS in the transfer of agricultural knowledge and skills?

17. How is your household performing in the marketing system in order to be able to meet their food and income needs?
18. Are there any differences in coping strategies employed between your household and other households affected by HIV/AIDS? If yes why do you think so, if not why?
19. Have the livelihood options available to you as a household changed because of the ill health of your relative, if so how?
20. Has your relationship with other members of the household changed since you got sick? If so with which members of the household, and how has this changed?
21. What kind of support, if any, have particular members of the household provided for you? (for example, emotional, material support, cleaning, providing food, washing etc) Please give examples of this and the household members who provide this.
22. Would you say you personally have changed in terms of your views or outlook or behaviour as a result of your illness? If so, how?
23. Do you think your illness has affected men and women differently in the household in terms of what they do and how they interact with you and others? If so please elaborate.
24. Do you think that your illness has affected boys and girls differently in the household in terms of what they do and how they interact with you and others? If so please elaborate
25. Do you have any comments/ issues you want to raise which have not been covered in this interview?
26. How did you find the interview?
27. Interviewer's *immediate* impressions of the interview and the main concerns, issues and views raised by the during the discussion

Note: This is an interview guide and does comprise all the questions the interviewer will ask. While the interviewer will certainly ask these kinds of general questions, most of the questions which will be asked will be more specific arising from the issues which the participants raise in the course of the interviews.

Appendix 3

Informed consent for PLWHAs who were individually interviewed

I am a Research Masters student in the University of KwaZulu -Natal in South Africa. I am conducting a research on Gendered Impact of HIV/AIDS on Livelihoods among Affected Farm Households in your Community. This District was selected based on a national sero – prevalence HIV/AIDS survey in 2005, which identified Koinadugu District as the highest HIV/AIDS infected District. I will be interviewing some members of this community and their households to get their views on gender roles, the livelihood options and the coping mechanisms employed by affected farm households. I will be grateful if you could please allow me to individually interview you and few members of your household who may include children.

The interview will take about 90 minutes for you, 60 and 30 minutes for adult and child household members respectively. All the information obtained will remain strictly confidential and your answers will never be identified with you and you have the right to withdraw or not answer any question if you think you do not want to. I am also aware that some of the questions are difficult or may cause you some discomfort during the interview, as some will let you recall past incidences or by sharing current experiences. If at any point (either before or during the interview), you think you need a counsellor please do not hesitate to say so, as provision has been made for that.

The benefit of this research is that it will give participants opportunities to convey problems and anxieties they may have which will be communicated to key stakeholders with the responsibilities for providing services to the District/community and households with PLWHAs. By doing this, you would have contributed to the formulation of policy or action plan on the issues under investigation in the future. When data collected is entered and analysed, all hard copies will be disposed of within 3 months and 5 years respectively after

submission of dissertation. But be rest assured that no information will be identified with anybody. Please find below my contact details and that of my supervisor and officers of my place of work, in case you need any further clarification/s:

Professor Robert Pattman

Academic Coordinator/Supervisor

School of Sociology and Social Studies

Faculty of Humanities Development and Social Studies

Howard Campus

University of KwaZulu -Natal

Email: pattman@ukza.zn

Tel: 0312601248

Cell: 0731251875

Dr. Idriss Baggie

Research Coordinator

Rokupr Agricultural Research Centre

Sierra Leone Agricultural Research Institute

Tower Hill

Freetown

Cell Number: 076-731-527

E-mail: ibaggiei@yahoo.co.uk

Dr. Dennis R. Taylor

Training Coordinator

Rokupr Agricultural Research Centre

Sierra Leone Agricultural Research Institute

Tower Hill

Freetown

Cell Number: 076-630-010

E-mail: denrtay@hotmail.com

Finda Bandor Jenkins

Student

School of Sociology and Social Studies

Faculty of Humanities Development and Social Studies

Howard Campus

University o KwaZulu- Natal

Email:209520694@ukza.zn/findajoseph2002@yahoo.com

Cell: 0027787839191 in South Africa/ 023276614000/0023277420800

in Sierra Leone.

Note:

Potential participants will be given time to read, understand and question the information given before giving consent. This will include timeout of the presence of investigator and time to consult friends and /family.

May I start now? Yes ☐ No ☐ Please tick relevant portion. If yes, participants will fill and sign acceptance to participate.

Appendix 4

Informed consent for PLWHAs who were in the focus group discussion

I am a Research Masters student in the University of KwaZulu- Natal in South Africa. I am conducting a research on Gendered impact of HIV/AIDS on livelihoods mong affected Farm Households in your community. This District was selected based on a national sero – prevalence HIV/AIDS survey in 2005, which identified Koinadugu District as the highest HIV/AIDS infected District. I will be interviewing some members of this community and their households to get their views on gender roles, the livelihood options and the coping mechanisms employed by affected farm households. I will be grateful if you could please give your consent to participate in a focus group discussion on the issues under investigations.

The discussion will take about between 60-90 minutes. Answers to all the information obtained will never be identified with you and you have the right to withdraw or not answer any question if you think you do not want to. But I will not assure you of confidentiality as any other member in this group will share your views with other people who are not part of this group. But I encourage all not to do so as we all need to respect the dignity of each other.

I am also aware that some of the questions are difficult or may cause you some discomfort during the interview, as some will let you recall past incidences or by sharing current experiences. If at any point (either before or during the interview), you think you need a counsellor please do not hesitate to say so, as provision has been made for that, The benefit of this research is that it will give participants opportunities to convey problems and anxieties they may have which will be communicated to key stakeholders with the responsibilities for providing services to the District/community and households with PLWHAs. By doing this, you would have contributed to the formulation of policy or action plan on the issues under investigation in the future.

When data collected is entered and analysed, all hard copies will be disposed of within 3 months and 5 years respectively after submission of dissertation. But be rest assured that no information will be identified with anybody. Please find below my contact details and that of my supervisor and officers of my place of work in case you need any further clarification/s:

Professor Robert Pattman

Academic Coordinator/Supervisor

School of Sociology and Social Studies

Faculty of Humanities Development and Social Studies

Howard Campus

University of KwaZulu- Natal

Email: pattman@ukza.zn

Tel: 0312601248

Cell: 0731251875

Dr. Idriss Baggie

Research Coordinator

Rokupr Research Centre

Sierra Leone Agricultural Research Institute

Tower Hill

Freetown

Cell Number: 076-731-527

E-mail: ibaggiei@yahoo.co.uk

Dr. Dennis R. Taylor

Training Coordinator

Rokupr Agricultural Research Centre

Sierra Leone Agricultural Research Institute

Tower Hill

Freetown

Cell Number: 076-630-010

E-mail: denrtay@hotmail.com

Finda Bandor Jenkins

Student

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Howard Campus

University of KwaZulu- Natal

Email:209520694@ukza.zn/findajoseph2002@yahoo.com

Cell: 0027787839191 in South Africa/ 023276614000/0023277420800 in Sierra Leone.

Note:

Potential participants will be given time to read, understand and question the information given before giving consent. This will include timeout of the presence of investigator and time to consult friends and / family.

May I start now? Yes ☐ No ☐ lease tick relevant portion. If yes, participants will fill and sign acceptance to participate.

Appendix 5

Acceptance to participate

I …….. (Full name of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and consent to participating in the project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

Signature/thumb print of participant …… Date……....

If a child respondent, signature /thumbprint of parent/caregiver to endorse acceptance of child/ward to participate. ……..... Date…….....

Potential participants should be given time to read, understand and question the information given before giving consent. This should include timeout of the presence of investigator and time to consult friends and /or family.

May I start now? Yes ☐ No ☐ Please tick relevant portion.

Appendix 6

Informed consent for Policy makers/service providers who were individually interviewed

I am a Research Masters student in the University of KwaZulu-Natal in South Africa. I am conducting a research on Gendered impact of HIV/AIDS on livelihoods among affected Farm households in your community. This District was selected based on a national sero – prevalence HIV/AIDS survey in 2005, which identified Koinadugu District as the highest HIV/AIDS infected District. I will be interviewing some members of this community and their households to get their views on gender roles, the livelihood options and the coping mechanisms employed by affected farm households. I will be grateful if you could please allow me to individually interview you as either a policy maker/ service provider in this community on the issues under investigation.

The interview will take about 30-60 minutes. All the information obtained will remain strictly confidential and your answers will never be identified with you or your office and you have the right to withdraw or not answer any question if you think you do not want to. The benefit of this research is that it will give participants opportunities to convey their views around the issues under investigation. By doing this, you would have contributed to the formulation of policy or action plan on the issues under investigation in the future. When data collected is entered and analysed, all hard copies will be disposed of within 3 months and 5 years respectively. But be rest assured that no information will be identified with anybody.

Please find below my contact details and that of my supervisor and place of work in case you need any further clarification/s:

Professor Robert Pattman

Academic Coordinator/Supervisor

School of Sociology and Social Studies

Faculty of Humanities Development and Social Studies

Howard Campus

University of KwaZulu-Natal

Email: pattman@ukza.zn

Tel: 0312601248

Cell: 0731251875

Dr. Idriss Baggie

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Rokupr Research Centre

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Dr. Dennis R. Taylor

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E-mail: denrtay@hotmail.com

Finda Bandor Jenkins

Student

School of Sociology and Social Studies

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Howard Campus

University of KwaZulu-Natal

Email:209520694@ukza.zn/findajoseph2002@yahoo.com

Cell: 0027787839191 in South Africa/ 023276614000/0023277420800 in Sierra Leone.

Note: Potential participants will be given time to read, understand and question the information given before giving consent. This will include timeout of the presence of investigator and time to consult friends and / family.

May I start now? Yes ☐ No ☐ Please tick relevant portion. If yes, participants will fill and sign acceptance to participate.

Appendix7

Individual semi-structured interview guide for Policy makers/ service providers

Time…….

Start…… End…….

Date……..

General information on participant

1. Age of Respondent:……..
2. Sex:……
3. Occupational Status…… Member……..

Main questions

1. How long has your organization been working in this community?.....
2. What is/are the functions of your Institution?
3. Is HIV/AIDS/Gender/Agriculture/Livelihood Interventions part of your activities? If so, how?, if not why
4. What do you think are the livelihood options available for PLWHAs and their households
5. Do you think there is /are change/changes in the livelihood patterns and styles of PLWHAs and their household that is /are specifically due to HIV infection? If so why/ if not how?
6. What is the relationship between PLWHAs and other members of the community? Has it changed or not? If yes how has this changed? If not why?
7. What are the impacts of HIV/AIDS on the livelihood/agricultural activities of households affected by HIV/AIDS in this community?
8. What are the impacts of HIV/AIDS on the agricultural knowledge based systems of households affected by HIV/AIDS in this community?
9. What are the impacts of HIV/AIDS on agriculture/livelihood information pathways among members of households affected by HIV/AIDS?

10. How do you think HIV/AIDS has affected access to markets in households that are affected by HIV/AIDS?
11. What do you think has been the response/s to these various challenges if any, faced by households?
12. What value do you think can be added to the functioning of institutions that are intervening in agriculture/livelihood activities if any, to address some of the challenges faced by PLWHAs and their households?
13. What value do you think can be added to the functioning of institutions that are intervening gender issues if any, to address some of the challenges faced by PLWHAs and their households?
14. What value do you think can be added to the functioning of institutions that are intervening in access to market if any, to address some of the challenges faced by PLWHAs and their households?
15. What value do you think can be added to the functioning of institutions that are intervening in technology adoption and transfer if any to address some of the challenges faced by PLWHAs and their households?
16. What alternative pathways can be used when the traditional knowledge pathways become ineffective in addressing the livelihood needs of members of the households affected by HIV/AIDS in the transfer of agricultural knowledge and skills?
17. What kind/s of support, if any, have your organisation provided/is providing for PLWHAs in this community? (for example, emotional, material support, providing food, medication etc.)
18. What kind/s of support, if any, do various other members of the community provide for PLWHAs? (For example, emotional, material support, providing food, medication etc.)
19. What are the major challenges faced by PLWHAs and their households in this community?

20. What impact if any, do these have on the lives of PLWHAs and members of their household?
21. How do you think relevant institutions and members of the community should respond to these?
22. Do you think that the HIV/AIDS pandemic has affected men and women differently in households affected by HIV/AIDS in terms of what they do and their interactions with others? If so please elaborate.
23. Do you think that the HIV/AIDS pandemic has affected boys and girls differently in HIV/AIDS affected households in terms of what they do and their interactions with others? If so please elaborate
24. Do you have any comments/ issues you want to raise which have not been covered in this interview?
25. How did you find the interview?

Interviewer's *immediate* impressions of the interview and the main concerns, issues and views raised by the interviewee and brief comparisons with other interviewees in the same household……

……

……

……

Note: This is an interview guide and does comprise all the questions the interviewer will ask. While the interviewer will certainly ask these kinds of general questions, most of the questions which will be asked will be more specific arising from the issues which the participants raise in the course of the interviews.

Appendix 8

Open letter to gate keepers

Faculty of Humanities, Development and
Social Studies School of Sociology
Howard Campus, Durban
4041, South Africa
Tel: 0312601248/0312602302
Cell: 0027787839191/0027731251875
Email: findajoseph2002@yahoo.com
209520694@ukzn.ac.za
pattman@ukzn.ac.za

Date:

…….

…….

…….

Sierra Leone.

Dear Sir,

HIV/AIDS research in Koinadugu District

I am Finda Bandor Jenkins(Mrs.), a Sierra Leonean studying for a research Master's degree at the above mentioned university in South Africa and a Research Officer of the Sierra Leone Agricultural Research Institute(SLARI); specifically the Rokupr Agriculture Research Centre. The title of my research project is 'Gendered impact of HIV/AIDS on livelihoods among affected households in a community in Koinadugu District, Sierra Leone'.

This District was selected by me for this project because results of the 2005 sero prevalence survey in Sierra Leone revealed it has the highest HIV/AIDS prevalent rate. It is against this backdrop, I therefore want to undertake this research to investigate the gendered impact of the

disease on the livelihoods of the people living with the virus and how it has affected/is affecting them and their families. I will be interviewing not just the people living with the Virus, but also few members of their families, which will include children.

In this light, I therefore will be grateful if you could please use your office to help me conduct a pilot interview with some of your members (whose family is in the known of their status) and few of their family members including children in order to help me effectively carry out this research. Please be informed that letters have been sent to authorities in the District for their permission to work in their District on this project.

Please find enclosed a copy of my ethical clearance form from the University's Research Ethics Committee for the project. Grateful Sir/Madam, if my request meets your kindest consideration and approval.

Yours sincerely,

Finda Bandor Jenkins (Mrs.)
Student.

Endorsed

Rob Pattman (Prof.)
Supervisor.

Appendix 9

The District Medical Officer

Koinadugu District

Government Hospital

Kabala.

26th March, 2010.

University of KwaZulu Natal

Sociology Department

Howard College Campus

Memorial Tower Building

South Africa.

Dear Finda,

RE: PERMISSION TO UNDERTAKE RESEARCH IN KOINADUGU DISTRICT.

It is with greatest pleasure to first of all thank you for your interest in conducting this project in my district, and especially to conduct a research of this nature in Sierra Leone as much has not been done on the issues raised in your project. I write to inform you and your Supervisor that you are most welcome and to assure you of my personal support and that of my staff, especially those attached to the HIV/AIDS wing.

I wish you a pleasant stay in the district and a successful paper, my staff and I will be grateful to get feedback on your findings.

Yours Truly,

.....

Dr. Mohamed Vandi

DISTRICT MEDICAL OFFICER

KOINADUGU.

Appendix 10

KOINADUGU DISTRICT COUNCIL

The Chairman

Koinadugu District Council

Kabala.

30th March, 2010.

University of KwaZulu Natal

Sociology Department

Howard College Campus

Memorial Tower Building

South Africa.

Dear Ms. Finda Jenkins,

RE: PERMISSION TO UNDERTAKE RESEARCH IN KOINADUGU DISTRICT.

With reference to the above subject matter, I write to inform you that you are most welcome to undertake your research in this district and on behalf of my staff and on my personal behalf we appreciate your interest in working in this part of the Country.

My office will be very grateful if you could please liaise findings of your studies to us to guide us as to which issues are most relevant that needs policy or service intervention which could be used for the purpose of advocacy.

I therefore wish you an enjoyable stay in the district and a successful research paper.

Yours Sincerely,

.....

Mr. Peter Bayuku Konteh

Chairman KOC

KOINADUGU.

KOINADUGU DISTRICT COUNCIL
SIGN
DATE
CHAIR-MAN

Appendix 11

The Paramount Chief

Wara Wara Yagala Chiefdom

Koinadugu District.

29th March, 2010.

University of KwaZulu Natal

Sociology Department

Howard College Campus

Memorial Tower Building

South Africa.

Dear Finda,

RE: PERMISSION TO UNDERTAKE RESEARCH IN KOINADUGU DISTRICT.

I write to acknowledge receipt of your letter for permission to work in the Koinadugu District, and specifically in my chiefdom. My people and I are very happy to know that you express an interest in this district. We therefore welcome you and wish you a pleasant stay as you go about your work, and hope you will have very good pieces of information to come out with very good findings that will attract various authorities and institutions to the issues that are affecting my people.

Once more we wish you well and a safe trip back to your destination.

Yours Sincerely,

.....

PC Gbawuru 111.

P.C. GBAWURU MANSARAY III
DATE 30/03/10
SIGN
WARA WARA YAGALA CHIEFDOM

Appendix 12

The Paramount Chief

Sengbeh Chiefdom

Koinadugu District.

26th March, 2010.

University of KwaZulu Natal

Sociology Department

Howard College Campus

Memorial Tower Building

South Africa.

Dear Finda,

RE: PERMISSION TO UNDERTAKE RESEARCH IN KOINADUGU DISTRICT.

On behalf of my people, I wish to thank you for your interest in developing an interest working in my chiefdom. You are more than welcome to work here and you are assured of a hospitable stay. We want to thank you from the bottom of our hearts for this as we know a lot of people are going to know about this District and the issues affecting us by reading your work.

For this we are grateful and we wish you well in your studies and a successful career thereafter.

Yours Sincerely,

Hon. P.C. Ali-Balansama Marah 111.

Appendix 13

RESEARCH OFFICE (GOVAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031 – 2603587
EMAIL : ximbap@ukzn.ac.za

UNIVERSITY OF KWAZULU-NATAL

22 SEPTEMBER 2009

Mrs. Finda Bandor Jenkins (209520694)
Sociology and Social Studies
HDSS
Howard College

Dear Mrs. Jenkins

ETHICAL CLEARANCE APPROVAL NUMBER: HSS/0585/09M

I wish to inform you that your application for ethical clearance has received full approval for the following project:

"Gendered impact of HIV/AIDS on livelihoods among affected households in a selected community in Koinadugu District, Sierra Leone".

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....

PROFESSOR STEVEN COLLINGS (CHAIR)
HUMANITIES & SOCIAL SCIENCES ETHICS COMMITTEE

cc. Supervisor (Rob Pattman))
cc. Suzette van der Westhuizen

Appendix 14: Livelihood option of PLWHAs