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Recommended Citation

Block, E. (2016). The AIDS House: Orphan care and the changing household in Lesotho. *Anthropological Quarterly*, 89(1), 151-180. <http://dx.doi.org/10.1353/anq.2016.0004>

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The AIDS House: Orphan Care and the Changing Household in Lesotho

Ellen Block, *College of Saint Benedict and Saint John's University*

ABSTRACT

HIV/AIDS has brought the connections between care and relatedness into sharp relief. In the midst of social change driven largely by the AIDS epidemic, the house has emerged as the most stable element connecting kin in Lesotho. Houses provide spaces that frame human actions, transform relationships, and reflect the social order. The house is a key crossroads for human movement. It is also the site where physical connections, emotional bonds, and feelings of love and affection are nurtured. Most significantly, it is the site where physical acts of caring take place. Based on extensive ethnographic research, I demonstrate that the house is one of the places where the pressures of AIDS-driven change are most felt because of its role in structuring care. AIDS has intensified the importance of the house as caregiving has become a primary means for shaping relatedness. [Keywords: HIV/AIDS, orphans, caregiving, aging, houses and house life, anthropology, grandmothers]

Introduction: The AIDS House¹

When I first approached the Masilo family's house, located in the rural highlands of Lesotho, I immediately noticed the *lehlaka*, a long reed placed over the entrance of the house to indicate that a baby was recently born. When I entered the single circular room that is typical of rural *rondavels*, I could barely make out the shape of the mother sitting on a thin mattress on the floor. An opaque stream of smoke emanating from the hearth of the dark room obscured my view. Once my eyes adjusted, I saw three tiny bundles wrapped in blankets: triplets. The babies were two weeks old—two girls and a boy, weighing six, five, and four pounds, respectively. They were born a month prematurely, which is common among multiple births and HIV-positive women (Goldenberg et al. 2008, Steer 2005). Because of her HIV-status, 'M'e2 Masilo gave birth at the hospital and followed the appropriate guidelines to prevent mother-to-child transmission (PMTCT).

The birth of the triplets brought the number of people living in the Masilo home to 11: the mother, father, and their now nine children. The outreach workers of a local NGO wanted to take the babies to a temporary safe home until they gained some weight, but the father refused, claiming they would be best cared for at home. During my visits, there were a number of other women in the Masilo home helping to prepare bottles (as 'M'e Masilo was not able to breastfeed), do laundry, cook, and bathe the infants. On one occasion, the three infants had colds and were being kept warm with numerous blankets. One was lying on her mother's legs, and the other two were swaddled on either side of her as she gently patted their backs when they coughed. Early on in my fieldwork, I encountered children and their caregivers primarily in clinics, hospitals, and the halls and offices of a local NGO. But, it was this scene that led me to an important realization: if all we knew about care was from observations outside the house, we would know almost nothing.

After that visit, I believed Ntate Masilo was right in wanting to keep the babies at home. However, the next time I saw them, they were in the hospital. The children had not been able to recover from their cold, and the biggest one—a girl—had died. The other two were tested for HIV, and the boy's test came back positive. I went to the hospital to convey my condolences to 'M'e Masilo. She lay in bed with her two children in the crowded sterility of the hospital room. There were no relatives to help, no pots cooking over a fire, no sounds of life coming from outside. I realized how difficult it would be to know anything about this mother—her relationship with her children or the daily acts of care she performed or neglected—outside of her home. Yet, I also knew that caring for newborn, HIV-exposed triplets in a remote rural village presents its own risks and challenges. When approached again by the outreach workers with the offer of temporarily housing the children, the father refused, effectively privileging the processes of bonding and kin-making which, in the context of AIDS in Lesotho, are increasingly centered on the house.

HIV/AIDS has brought the connections between care and relatedness into sharp relief (Ansell and van Blerk 2004, Klaits 2010, Ndaba-Mbata and Seloilwe 2000, Parker and Short 2009, Townsend and Dawes 2004). High levels of marital instability, strained relations between women and their affinal kin, and changing ideas about lineality have weakened the social networks that previously supported orphans and vulnerable children. This article suggests that in the midst of this shifting landscape, kinship is reproduced in the house in new and different ways because of its role in structuring care for those affected and infected by AIDS. One way of getting at these new configurations of kin is through close ethnographic investigation of the house.

The house is a key crossroads for human movement through fostering, marriage, and migration. As such, it is also the site where physical connections, emotional bonds, and feelings of love and affection are nurtured. Most significantly, it is the site where the labor of care takes place (Dahl 2009). Yet, the house is not merely a passive vessel in the process of caring. Rather, it is a necessary and strategic space where kinship networks are shaped and reformed through intentional acts of care and neglect (Klaitis 2010).³ While many ethnographic examples defy a co-residence explanation of household analysis (see, e.g., Yanagisako 1979), the demographic pressures of AIDS have increased the need for care, and the home is often the locus of this labor. This is particularly true because of the unprecedented prevalence of orphans in rural southern Africa (UNICEF 2006). The epidemic has encoded itself into the rural landscape in unexpected ways. One might expect the AIDS house to be an abandoned space of disease, death, and collapse, and, of course, it sometimes is. However, by observing everyday practices centered on many Basotho houses, one can detect a space that is bolstered by its ability to withstand the pressure of AIDS in order to facilitate care. This newly intensified role of the house in structuring care can be observed in two ways: by examining the physical and material space as well as objects in the house and by looking at the intensified caregiving relationships that are taking place within its walls. It is to these two ends that the ethnographic evidence in this article is devoted.

I show how the house in Lesotho has become a compressed space. Quite literally, houses are crowded with children, cluttered with the signs of caregiving, of funerals, of the materials that accompany household migration, and of AIDS. The house serves as a clinic, a hospice, a halfway house, and a foster home. Of course, it has always performed these functions, but AIDS has compressed the house's different caregiving roles in both frequency and intensity in a way that is unprecedented, and can only be understood as exceptional in the context of a widespread disturbance of such far-reaching proportions. While the house represents only one component of

caregiving, acting as a shelter and a space where many acts of care take place, it is densely important due to the compressed space of the AIDS house. I refer to a basic principle of natural science to better understand this change in the function and form of the house: when pressure increases on the outside of a solid substance, the melting point of that substance rises. As the substance heats, the particles gain energy and vibrate against each other. The substance responds to the increase in pressure by withstanding more heat. The same appears to be happening for the houses described here, at least in terms of caregiving. AIDS has increased the pressure on Basotho households, thereby increasing the heat inside the house and the frequency and intensity of the interactions of its inhabitants. Basotho houses must shelter and feed more (and increasingly different) members, and take on more responsibility in upholding kinship networks. Yet, as in chemistry, the boiling point of the house has also increased in the sense that houses, and the kinship networks they shelter, are able to withstand more heat without collapsing. This work is not intended to minimize the suffering of those impacted by AIDS in Lesotho or to disregard the ways that increased pressure on the house has detrimental impacts on families, particularly regarding the distribution of limited resources, changing marital practices, and the restructuring of households (Block 2014). Its purpose is to draw attention to the strength of the house to withstand this pressure despite these limitations.

The house's transformation under the pressure of HIV/AIDS has been rapid and intense. The HIV-prevalence rate in Lesotho rose from nearly zero to 23 percent in less than a decade (UNAIDS 2010). This is much faster than other external household pressures in Lesotho, most notably migrant labor, which has fluctuated over more than a century (Kimble 1982, Murray 1981). Of course, not all of the increased pressure stemming from AIDS is felt in the house. AIDS's impact reverberates through lineages and other social institutions such as villages, clinics, schools, orphanages, and churches. But AIDS is invariably enmeshed in the physical space of the house in ways that are not seen outside of its insulated walls. The ability for the house to withstand this extra pressure in order to respond to the caregiving needs of kin shows its resilience as a social institution and the importance of the house in helping to maintain networks of kin by keeping family members together. The reorganization of families around household units also reveals how, under duress, care becomes a primary organizing principle of social life. In taking on this extra pressure, the house is not only caring for kin, but also for kinship itself.

Orphans and vulnerable children such as the Masilo triplets provide a useful starting point to examine the house's role in shaping care precisely because the care of children is highly visible and observable. The stigma surrounding HIV is compounded by the stigma of adult dependency, making the care of adults an extremely sensitive and private affair. Most of the Basotho caregivers I worked with care for children in a way that is more affectionate, more revealing and more permanent than how they care for adults, who typically either recover or die of AIDS. While HIV can linger in an untreated patient for years, many of the caregivers I worked with had family members return from work or their married homes once AIDS was full-blown and they could no longer care for themselves. They often died within a matter of weeks or months if left untreated or if the treatment was ineffective. In contrast, orphan care rearranges families and households, pushing the boundaries of patrilocal residence and other idealized markers of relatedness because of the scale and movement of orphaned children in the AIDS era, who largely remain cared for by kin (Adato et al. 2005, Ansell and van Blerk 2004, Cooper 2012, Nyambedha et al. 2003, Prazak 2012, Zaghene 2011). Parents and caregivers must reimagine the places of children within the family structure as their needs are constant and long-term.

In providing for children, caregivers create strong social bonds that are shaped and constrained by the spaces where care takes place. The “inhabited space”—namely the house—is where children learn the embodiment of practice (Bourdieu 1977:89). Here, I draw on Bourdieu, who emphasizes time and experience in order to explain how practical kinship is “continuously practiced, kept up, and cultivated” (1977:37). This approach emphasizes the dialectic relationship that exists between the person and the house. Furthermore, I employ a “dwelling” perspective of the house (Heidegger 1971), as opposed to merely a “building” perspective,⁴ whereby “the forms people build...only arise within the current of their life activities” (Ingold 2000:154). Outside of the house, care for children is far more homogeneous. While it may be possible to infer signs of neglect outside of the house based on a child’s appearance, these signs are often obfuscated by poverty.⁵ It is inside the home where care—as well as neglect, fracturing, and anomie—is most readily experienced and observed. The house has become an increasingly important space in which to both observe and understand caregiving and to reveal the changing processes of relatedness that are shaping families across Lesotho in the context of AIDS. In this article, I largely exclude observations from wealthy households both because rural Lesotho has generalized poverty⁶ and because I hope that these observations might provide a basis for supporting poor households impacted by HIV/AIDS.

Anthropology of the House Revisited

Early investigations of the house in anthropology recognized the connection between houses and social life—particularly regarding food sharing, hospitality, nurturing, and caring (Morgan 2006), and the containment and re-shaping of ambiguous social relations (Lévi-Strauss 1969). More recent work on kinship and relatedness has broadened this framework to include the complex interactions between social and biological factors and the multitude of forms and processes that constitute contemporary family life (Carsten 2000, Franklin and McKinnon 2001, Schneider 1984). Scholarly investigations of the house viewed through this new lens recognize that political processes (Healy-Clancy and Hickel 2014, Bloch 1995, Dalakoglou 2010, Drucker-Brown 2001, Ramphela 1993, Kuper 1993) and gendered divisions and inequalities (Mueggler 2001, Oboler 1994, Waldman 2003), as well as materiality and the (social) mobility of houses (Carsten and Hugh-Jones 1995, Ingold 2000), are inextricably joined to processes of relatedness. It is this approach to relatedness that allows for a “dwelling” perspective, which reinforces the “dynamic” nature of the house (Carsten and Hugh-Jones 1995:1). The focus on the house in contemporary Lesotho is driven by this dynamic understanding of the dialectic relationship between houses and their inhabitants, and is strengthened by the house’s role in structuring care. I observed firsthand the importance of the house for Basotho as a space where feeding, raising, sheltering, nurturing, clothing, caring, procreating, birthing, and dying occurs. These caregiving processes are intensified in the context of HIV/AIDS in Lesotho where ailing adult children and grandchildren, complicated drug regimens, opportunistic infections, and increased uncertainty from migration make the work of caregivers even more arduous. Care is shaped by the physical structure of the home because of the ways in which space both allows and constrains activities that take place within it (Birdwell-Pheasant and Lawrence-Zúñiga 1999). The small size and intimacy of one room rondavels, which dominate the rural landscape in the Lesotho highlands, exemplify this influence. Intensive caregiving relationships among Basotho families strengthen the bonds between caregiver and children. These have become more important than other

markers of kinship as dictated by idealized notions of patrilineality (Block 2014). These emerging caregiving responsibilities, which are primarily undertaken by women in Lesotho (Robson et al. 2006), reinforce the house as a highly gendered space (Beidelman 1972, Waldman 2003).

Throughout this article, I refer to both houses and households. The house—both the physical dwelling place and the space that surrounds it—is conceived here as a place which holds “dense webs of signification” that we use to “structure, think, and experience the world” (Carsten and Hugh-Jones 1995:3). While the definition of the household and its boundaries has been historically contested in anthropology (c.f. Bender 1967, Gillespie 2000, Harris 1982, Wilk 1989), I employ the characterization by Wilk and Netting (1984), which broadly conceives of the household as an economic and social unit that can vary widely in both structure and significance. In this article, “the house” refers to the physical space that is significant in both its functionality and its symbolic and affective importance, while “the household” refers broadly to some part or whole of the social and economic unit of the house and its members (cohabiting or not). While these two concepts are connected, they are not synonymous. The attention given to both in this article underscores the role of the house in shaping and structuring care, which in turn alters processes of relatedness that impact household and population-level change.

Changes in the Basotho Household: Migration and AIDS

The characterization of households above emphasizes their flexibility in responding to social, political, and economic conditions. Paradoxically, it is precisely this ability to change and adapt, generated by the persistent need for sheltering, nurturing, and caring, that leads households to be rather stable features of social life. The stability of households—and, as part of that, houses—does not stem from inertia or rigidity, but rather from their endurance as key social institutions that withstand, absorb, and reflect broader social changes. Household change in Lesotho is not new to the AIDS era. Rather, the Basotho household has been responding to social disruptions as well as political and economic pressures since Lesotho’s emergence as a polity in the 19th century. Lesotho has had over a century-long dependence on migrant labor to South Africa, predominantly from gold mining, but also from other diverse sources of employment such as agriculture and domestic work (Eldredge 1993, Murray 1981, Romero-Daza and Himmelgreen 1998) as well as a fluctuating textile industry in the region’s lowlands (Crush 2010). While widespread labor migration was economically beneficial to rural households, families also experienced hardships as a result of migrants’ absence, creating tensions and divisions that harmed social relationships and weakened marriages (Murray 1981, Spiegel 1981). Since the 1990s, economic contributions to households from migrant workers and non-cohabiting relatives have been in decline because of large-scale retrenchment of mine workers (Crush et al. 2007, Lesotho Bureau of Statistics 2007). These fluctuations in the global economy have had lasting impacts on Basotho households.

Migrant labor and its unfortunate coincidence with the restrictive immigration policies of apartheid created ideal conditions for the astonishingly rapid proliferation of HIV in the rural Basotho countryside (Romero-Daza and Himmelgreen 1998). The high rates of HIV infection and the speed with which it spread have had a dramatic impact on Basotho households. With nearly one-quarter of the population infected, no family has gone untouched by the ravages of the disease. As a result, life expectancy, which had slowly risen from the 1970s on, dropped precipitously in the 2000s (Lesotho Ministry of Health and Social Welfare 2010).⁷ The region’s

under-five mortality rate has dropped steadily since 1990 (WHO 2015).⁸ AIDS is not only the major cause of death for the adult population; it is also the main cause of vulnerability for the children left behind.⁹ The demographic impact of HIV/AIDS on households is staggering, and creates significant challenges for kin-based caregiving networks.

The contemporary phenomenon of AIDS-related child fostering needs to be read against a long history of child circulation in Lesotho due in part to the labor migration of parents (Ansell and van Blerk 2004, Madhavan 2004). Child-fostering practices, which have deep roots across sub-Saharan and West Africa, have historically allowed families to cope with external social and economic pressures that benefited both the children and caregivers (Bledsoe 1989, Goody 1984, Page 1989). Labor migration remains a significant factor in the movement of children, especially given the gendered shift in the labor market. More Basotho women are employed doing domestic and factory work while work for male migrants has simultaneously decreased (Crush 2010, Turkon 2009). During the peak of Lesotho's remittance economy from 1970 to the mid-1990s, men migrated without their wives, who were unable to cross the South African border without a permit during the apartheid era (Murray 1981). Households were certainly disrupted during that period (Murray 1981, Coplan 1991),¹⁰ and child circulation was one coping mechanism for redistributing resources and care. However, during extended periods of male labor migration, children largely remained with their mothers. A child is far more likely to be fostered or to change households in the absence of a mother than a father (Page 1989). Contemporary child-fostering practices in response to HIV/AIDS are closely connected with high rates of maternal mortality. Thus, there is a more direct relationship between the enduring role and meaning of houses and the AIDS epidemic's impact on increasing the circulation of children than there was during the protracted period of male labor migration.

The Sesotho House

The new kin relations that are centered on the house are best viewed through an ethnographic lens. Care is structured by the house not only because it takes place within its walls, but because the house is a central landmark among Basotho families which brings together young and old, living and dead. As Kuper (1993:472) notes of Zulu homesteads, the physical geography of the house maps out both contemporary and historical kinship relations. In line with a dwelling perspective of the house, this section describes the Sesotho house in detail. Feeley-Harnik (1980:561) calls the house "a microcosm of the social order." This is certainly true in Lesotho, where various aspects of the house—such as the floor, walls, roofs, and objects within—reflect the inhabitants of the house over time through the layering and accumulation of material things. The house plays a central role not only in day-to-day activities such as eating, sleeping, sex, and food production, but also in major life events such as birth, death, and marriage. Basotho live in the same houses for generations, and these become places where history and sociality unfold. Fostering is closely linked with houses because relationships are solidified by the relocation of a child from one home to another where they share space and food, and participate in both mundane and ritual household activities.

In rural villages, where there is no electricity or plumbing, houses are primarily small round structures, called rondavels (see Figure 1). Rural households typically consist of two or more houses, a garden, and nearby fields and are situated in villages ranging from as few as ten households to more than 100. While households within villages may be quite close together, they are delineated by demarcations outside the house that create a sort of yard-like space. These

spaces are marked by structural additions such as poles and laundry lines, planted bushes, low rock walls, empty coke-bottle barriers, keyhole gardens, and razed strips of earth. These



Figure 1: Rondavels in rural Lesotho, with terraced fields in countryside; 2008.¹¹

exterior structures increase the space controlled by the family and provide an outdoor space for socializing and household tasks such as laundry, crop preparation, and sometimes cooking. These elements of the landscape are considered part of a household's inheritance. For example, a friend of mine invited me to a celebration in honor of her deceased father's life at her natal home where she gathered with her four siblings. In order to expand the road, the government had to remove a few trees from the family's compound. The family was compensated for the trees their deceased father had planted. They used some of the money to purchase a goat for the feast, and divided the remainder between them.

The outer walls of rondavels are made of large stones that are abundant in the surrounding landscape. The inside walls are made from a combination of mud and dung, and the roof is made of beams covered with carefully laid thick grass or wheat stalks (see Figure 2). Houses are typically built by men, though women participate in collecting materials. While household members often build their own houses with the help of their kin and neighbors, new houses increasingly are built by hired local experts skilled in the difficult task of securing walls and thatching roofs to keep out rain, wind, and snow. Rondavels are praised for their ability to retain heat in the winter and remain cool in the summer, which aids in maintaining health and providing care. The materials needed to build and repair them can be collected and are, therefore,

preferred by rural Basotho. Houses in the town of Mokhotlong and other urban and peri-urban areas are predominantly square houses made of cement and corrugated tin roofing or tiles (see Figure 3). While village houses are typically owned by the family living in them, urban and peri-



FIGURE 2 A man enters his rural Basotho home. The bundle of stalks on the side of the house will be used to repair the roof.

urban houses are often rented. Houses in town are more likely to employ such amenities as small propane heating units, electricity, and gas burners or ovens, due both to increased income through employment and the ease of transporting materials, and the difficulty of collecting wood from in town. The majority of Basotho living in town also have rural houses and fields that belong to them or their families. Houses in town may have small vegetable gardens, but field space on the outskirts of town is limited. Care in town homes is, in many ways, similar to care in rural villages, yet it differs in a few key aspects. First, proximity to the district hospital and the road makes intensive care for a sick family member easier. Also, caregivers living in town are more likely to be employed due to increased opportunities or relocation for employment purposes. Children are more likely to be cared for by a neighbor during the day, or to attend one of the many home daycares or preschools in town. It is also common for adults of child-bearing age to live and work in town while some or all of their children to remain in their rural village with relatives. Yet, there are many children living with grandparents in town, and their daily care is attended to in many of the same ways as in rural villages, particularly for young children whose needs are prolonged and numerous. While a desire for more space and aspirations of “modernity” (Ferguson 2006) have led to an increasing number of multi-chambered dwellings made of cinder blocks across Lesotho’s highlands, rondavels still dominate the rural landscape.¹² Furthermore, the population of Lesotho, and of the highlands in particular, remains largely rural.

The house—whether rural or urban—is a moralized space of respect and honor that is replete with social courtesies (Beidelman 1972, Feeley-Harnik 1980) that are best viewed from inside the house. The interior configurations of *rondavels* in rural communities are relatively standard. They usually consist of a small hearth for cooking that is dug approximately six inches into the floor. A collection of pots, storage containers, plates, and cups are usually neatly stacked along one wall, and this area is often decorated with plastic tablecloths, cutouts from newspapers, colorful flyers and posters, or calendars given away at clinics and shops (see Figure 4).



FIGURE 3 Aerial view of Mokhotlong.



FIGURE 4 Interior of *rondavel*, Mokhotlong, Lesotho.

People's homes are almost always kept immaculately clean—a necessity in such crowded living spaces. Because my visits were often unexpected, I was frequently asked to wait outside so that my host could sweep or put away dishes from the previous meal. Almost without exception, hosts collected chairs or benches from neighbors if they did not have their own—a courtesy given to all visitors from outside the village. I was occasionally offered prepared food, or given freshly picked beans, spinach, and even a live chicken to return home with as a sign of hospitality. One maternal grandfather, Ntate Kapo, with whom I met frequently, was proud of his home and its meager furnishings, but lamented the condition of one of his tables. He told me:

The legs [of my table] are looking like the legs of an elephant. And they get broken. I want to have a carpet and chairs and a table so that the visitors like you can sit on them, and you are now just sitting on a bench. The important people like you.

Ntate Kapo's concerns attest to the importance of the house as a social space of hospitality. His description of an abandoned home emphasizes the sheltering and caring quality of houses:

I have seen that if you go and live somewhere else, your home will be turned to shambles, and the rats will live in it...That's why I have been living here...And when it has fallen down I will have nowhere to live.

For Ntate Kapo and others, the home is a place where one is rooted and where one must dwell in order to maintain those roots. Although inter-household movement is common, the maintenance of the house by resident members helps to orient both the inhabitants and the migrants who call it home.

Houses and households have long been central features of the social and familial lives of Basotho. Almost all Basotho live in multiple houses throughout their lives. People are associated with their various homes, and their current and past houses help to orient them socially and materially. Child circulation can be voluntary or precipitated by a negative life event such as parental death. Men and women migrate because of marriage, divorce, education, health, labor, and family responsibilities. The memory of building one's house, and the historical and contemporary movement of people in and out of one's house is an important way of creating and binding kin, including ancestral kin, and of tracing movement over space and time. Building is an essential part of maintaining and expanding households in Lesotho. Existing houses are regularly repaired with new outer rock walls, mud floors, inside walls, and thatch roofs. After a few years of marriage, couples often build a new house to add to the husband's parents' household, or expand their existing household as their family grows. Repairing old structures and building new ones deepens a household's history and strengthens the social webs that it encompasses. As Heidegger so eloquently puts it, "We attain to dwelling, so it seems, only by means of building" (1971:347).

Basotho's orientation toward their households is especially significant, since the potential for social dissolution through migration is great (Murray 1981; Coplan 1987, 1991). While many Basotho migrate for work or marriage, they are rooted in one or two villages, and those places are central to their identities and social embeddedness. Even young migrants, who often express a preference for urban life, maintain strong identities and ties to their villages. One such young migrant, 'M'e Mabolokang, died of AIDS while working in South Africa, orphaning her 18-month-old daughter, Rethabile. A paternal uncle brought Rethabile back to her mother's married home in Lesotho. Though her mother had conceived her while separated from her husband,

Rethabile was welcomed by her mother's husband (her *pater*), aunts, and siblings because of the strong bonds between kin that tightly connect identity and household. Rethabile was very ill when she returned, and her uncle concluded that her natal home was the best place for her to receive care or to die. Since her father had paid bridewealth at the time of his marriage to her mother, she belonged to them. She is now a thriving eight-year-old whose father continues to be her primary supporter and caregiver, taking her every month to the clinic for her antiretroviral medication. In this case, the ties binding Rethabile to her social father's household in Lesotho were more powerful than the potential dissolution of kin ties resulting from migrant labor and marital infidelity and were motivated by powerful ideologies of care.

Married women also maintain strong ties to their natal homes, as reflected in the language they use to describe their various localities. Women usually refer to their marital homes as "my house" (*ha ka*), whereas they refer to their natal homes as "my home" (*haeso*) or "my household" (*lapeng*). These terms indicate, particularly for newly married women, a sense of deeper connectedness to their natal homes. These feelings are further cemented as women return to their natal homes to give birth to their first child, and sometimes subsequent children, and remain for the first few months of the child's infancy. Women's temporary migration to their natal homes for birth and the post-natal period helps to strengthen a child's relationship to their maternal relatives. While they do not share their name or clan, they inhabit the space of their homes in an important and formative time of their lives. Such connections have proven invaluable as many maternal relatives now care for AIDS orphans (Block 2014).

Houses hold particular significance for the health and well-being of their inhabitants. This is evident both in the regular maintenance and care of houses as well as the concern over their collapse. 'M'e Mamolupe was caring for her brother-in-law's three children who relocated from their father's house after he died. She pointed across the road, down the hill toward the houses where the children were born, indicating the new outhouse that she had just installed there. She told me that she had one of her young, unmarried cousins living in those houses so they would not fall apart while the children were too young to live there by themselves. 'M'e Mamolupe explained:

I didn't want their family to be deserted. I don't like that family to be dead. This 'M'e who is sitting there is the one, I put her there to live, to protect those houses. Which means, I am looking out for these children who are growing up.

In this case, 'M'e Mamolupe equates the houses with family and cares for them so that the orphans will inherit property, reinforcing the inseparability of financial and familial value. Like its inhabitants, the house is both a giver and receiver of care and is an increasingly important space in the context of AIDS.

Caregiving and the Sesotho House

Memory and Materiality

One of the most tangible ways of tracing household change is through memory and material possessions, as the house is "a fascinating repository of culture and meaning" (Bahloul 1996:2). In Lesotho, houses stand as historical (social) witnesses to the marked contrast between former (perceived) financial and physical well-being and health, and current conditions of impoverishment and ill-health. The legacy of migrant labor is revealed by a closer look at the

symbolically significant artifacts of a more affluent time—items that powerfully evoke memories (Miller 2001, Olsen 2010). As Morton (2007) suggests, it is insufficient to think of the house as merely a vessel for memory; it is rather an active partner in the process of remembering through building and rebuilding. In Mokhotlong, most of the elderly caregivers’ husbands worked in the gold mines, and the remnants of this prosperous time are reflected within their houses. Extra items such as bookshelves, cupboards, broken clocks, drawers, wooden trunks, teacups and saucers, and tables are manifestations of a period of greater cash influx into the local economy.

In many cases, elderly widows, whose homes were filled with such treasures, have very little income beyond their meager old-age pension. In the cash economy, they often struggle to meet their needs for things such as soap, oil, candles, school fees, shoes, and money for transportation to the clinic or hospital. Many of the elderly caregivers I spoke with remembered migrant labor as a time of relative prosperity when they had easy access to cash, often forgetting the struggle of separation that characterized that time (Edkins et al. 1990, Epprecht 1993, Gordon 1994, Murray 1981). While treasured, their now defunct and even cumbersome possessions— as they take up precious space in small living quarters—are reminders of that time. Measurement tools used to assess household wealth in developing countries routinely use such durable goods as indicators of wealth (Grosh and Glewwe 1995). Such an assessment would be misleading as to a family’s current wealth and access to cash and thus their ability to perform caregiving tasks. ‘M’e Masello’s house exemplifies the tension between material possessions and presumed wealth, while highlighting the importance of material things in evoking and shaping memory. At the time I met her in 2007, this 77-year-old grandmother lived with six maternal grandchildren and one paternal grandchild ranging in age from two to 16, all orphaned by AIDS. ‘M’e Masello was ill herself with chronic asthma and arthritis, for which she had been hospitalized several times, and from which she died in 2010. ‘M’e Masello had had two houses; however, one of them collapsed a year before I met her, and it had yet to be rebuilt. The rocks and caved-in thatched roof lay in a heap next to the one remaining rondavel, which was also in need of repair (see Figure 5).



FIGURE 5: ‘M’e Masello’s grandson boiling water in front of collapsed house (right).

After the first house collapsed, ‘M’e Masello moved all of her possessions into her one remaining home, creating extremely close quarters for the eight people living there. Inside her house she had one metal bed frame and mattress, where she slept with the youngest child. Next to that sat a bookshelf with an incomplete tea set and a broken clock on it, an old chest, and a small wooden table, as well as many other blankets, mats, dishes and containers for food and clothing. She said her deceased husband used to give her money, but now she struggled to buy basic necessities. Even with the sleeping mats leaning against the wall and the blankets folded, the space inside the house was impossibly cramped. The family desperately needed the space occupied by the decrepit possessions. The clock had no batteries in it, and the tea cups lay dusty, chipped, and unused. However, ‘M’e Masello would not part with these items, as they were a source of pride for her and an important connection to her late husband’s memory and labor. Objects help to maintain the presence of ancestral people, and in many cases, like ‘M’e Masello’s, are sheltered in the houses the ancestors built. In my most recent visit to Lesotho in 2015, I walked past ‘M’e Masello’s old house. Since its occupants have left, it stands empty and deteriorated—an artifact of the social lives and objects it once contained (see Figure 6).



Figure 6: ‘M’e Masello’s house, which has been unoccupied since 2010; 2015.

In the shadow of the decaying remnants of the prosperity of migrant labor lay the signs of AIDS-related household change. Among household members’ belongings were the material signs of an increasing number of interdependent children and adults. Bed rolls were tucked into corners, plastic buckets were filled with children’s clothes to be washed, black school notebooks

with red trim sat in neat stacks, and a pile of school uniforms awaited mending. These subtle signs of care were integrated with more obvious indicators of the impact of AIDS on the house. Small, dirty boxes filled with pill bottles and liquids sat undisturbed until 7:00 a.m., when it was time for antiretroviral medicines to be handed out. Calendars depicted a red AIDS ribbon emblazoned over a picture of a mother and child or, sometimes, a cartoon picture of an anthropomorphic condom. Religious items such as Bibles, crosses, and rosaries were tucked into corners. A nearly empty sack of maize meal with the blue World Food Program symbol sat on the ground. Many of these items symbolized poverty and illness, but at the same time, they denoted the intensive labor of care.

Caring and Thriving

Caregiving within the intimate space of the house is not new. Rather, it is the increased need for care influenced by the demographic pressures of AIDS that has augmented the house's role in shaping relatedness across households. The vital care that takes place between co-residing members of the family is most evident among young and HIV-positive children. While four-year-old Khotso's father lived only a 30-minute walk from his son's house, he rarely came to visit Khotso at his grandmother's house, except to take him for his monthly clinic appointments. I asked Khotso's grandmother why her son did not provide more assistance, as she had severe arthritis in her knees. She said it was because his father "was still living up there," indicating that even such a short distance was prohibitive to regular assistance and care. Another maternal grandmother, 'M'e Matello, also stressed the connection between the house and care when explaining why she would not let the paternal grandparents take her grandchildren. Her grandchildren came to live with her when their mother, her daughter, was sick with an AIDS-related illness and was not being properly cared for by her in-laws. When they sent a letter asking for the children she refused because they had previously neglected their caregiving responsibilities. She said, "They were just without a home." In another case, 'M'e Mathato was left with her deceased son's children after their mother migrated for work. She told me:

Their mother was going to Natal, and left the children. She left them outside her house on the ground at her place. I took the children of my son to me so they will live with me until I raise them up.

It is notable that she emphasized that the children were placed outside of the safe space of the house where care occurs. Of course, if the children were, in fact, left inside the house they would be less likely to be noticed. However, 'M'e Mathato emphasized this detail to draw attention to the moral quality of the house and to emphasize their mother's neglect by leaving them outside of that safe and caring space. She juxtaposed their mother's house with her house as a space where she would "live" and "raise" the children, reinforcing the importance of the physical acts of care in the space of a loving home.

The home is generally a caring space, but it can also be a place where care is neglected, and this is often signaled through its appearance. While details of household cleanliness may seem trivial, cleanliness of both person and space are moral imperatives (Klaits 2010, Livingston 2008) and Basotho go to great lengths to keep their homes clean and tidy, even as they are often cluttered. In one grandmother's home there were hundreds of flies all over the walls and dirty dishes, while clothes and garbage were strewn about the floor. After entering many Basotho homes, this one stood out in its state of disrepair. This grandmother was responsible for a three-year-old, HIV-positive orphan named Sabina. Given these rare outward signs of neglect, and

considering that even the most loving and capable caregivers have trouble adhering to the complex antiretroviral treatment schedule, it is doubtful that Sabina was receiving her medications correctly—an assumption supported by untreated open sores covering her lips and tongue. In this case, a local NGO recommended that another family member care for the child, but there was no one else available or willing. Likewise, three-year-old Lefu was living with his maternal grandfather, Ntate Tsela, despite the obvious reluctance of his young second wife who had four children of her own, including a nursing infant. In addition to Lefu, there were three other orphans living in the home, all children of Ntate Tsela’s two deceased and unmarried daughters from his first marriage. When I first visited Lefu, I asked his grandfather’s wife where he was, but she was unsure. His grandfather searched for him only to discover that he had been napping outside wearing only a small blanket, despite the cold and windy winter weather. Lefu seemed very unhappy, and as my research assistant noted, “He seems like he is not in his place or his family. He seems like he has visited them, not his real family.” The image of young Lefu sleeping outside powerfully reflects and symbolizes the ways that the house can reveal neglect as well as care.



FIGURE 7 A grandmother prepares *papa* (maize meal) for her grandchildren in a rondavel used only for cooking.

The house’s role in food preparation and food sharing has both real and symbolic significance. When ‘M’e Masello died, one of her maternal grandsons, Tlatso, was to inherit her houses because both of her sons had died without any children. Another relative enviously

remarked to Tlatso, “How lucky you are. You will eat the inheritance of the Masello family, but you are a Mareka,” emphasizing the importance of future shared substance implied by this transaction. Food was repeatedly noted as an essential element of good care, and the lack of food was a primary concern for many caregivers (see Figure 7). As ‘M’e Marefiloe said, “For a child to develop normally, they need to eat well, yes... And the child will be looking good, if I’m feeding her well, and taking good care of her.” The connection between food and care, while not surprising, takes on greater importance for those on antiretroviral treatment, as good nutrition is emphasized as a necessary accompaniment to treatment. The consequences of poverty for those living with HIV-positive children are dire and are intimately linked with their ability to provide care.

Food sharing is also strongly connected to the house as a space where social courtesies are enacted. It is essential to share food at ritual and community events, such as funerals, where even an extremely poor family is expected to produce a feast for funeral guests. Food at a funeral is thought necessary to help “accompany the person to the grave.” When I asked ‘M’e Masello after the death of a grandson if even a very poor family had to cook for a funeral, she responded, “*Ach*, what about those people working hard digging the grave? How will they feel? We should still cook.” Beer is also typically brewed for funerals, and the house of the deceased will host friends and family for several days after the funeral until all the beer has been drunk. While food sharing has the power to draw friends and relatives closer, the absence of food sharing or the refusal to share food can be highly destructive to social relationships. ‘M’e Matshepo, a young woman who was having problems with her husband, described a major conflict where he refused to eat food that she had served him:

There was a funeral for the child of my...sister-in-law, and when I was going to give [my husband] food...he refused to take it. And I went back crying because I was very angry...my mother-in-law was very angry. And I told them that he has not eaten it... And his mother said she doesn’t know what to do because he’s old and she can’t beat him. And I’m always telling her that the life I’m living is so difficult.

‘M’e Matshepo’s husband’s rejection was seen, even by his own mother, as rude and disrespectful.

Beyond food sharing, a funeral is a time of intense ritual care that is centered on the house. After a person dies, the house is emptied of all its contents and the body is laid on a blanket on the floor, or in an open coffin. Family members take turns keeping watch over the corpse at all times until the burial in a final act of care for the physical body. After the funeral is over, the floors and walls of the house must be freshly recovered in a cement-like mud-dung mixture before everyday activities such as sleeping and eating can take place. The floors are recovered because they have encountered death and are considered unclean, but also as a way of communicating familial care and respect to the ancestors (Morton 2007). As one young widow told me, “When [the ancestors] come, they find us having done everything.” Another grandmother said, “The ancestors are used to coming to see what has happened to their place. If they find that there is no smoke, they say, at their house there is no one to make a fire.” The fire indicates familial care—through warmth and cooking—for both the house and the people within it. Even in death, the house is a moralized space where processes of relatedness continue and where caregiving takes place in both mundane and ritual ways.

AIDS has intensified the importance of the house as a space where care takes place. Routine daily care is punctuated by the complexities and challenges of caring for a child with acute HIV or associated opportunistic illnesses such as tuberculosis, oral thrush, malnutrition,

diarrhea, or severe rash. Such care is physically and emotionally draining, and limits caregivers' ability to maintain employment, complete housework, work in the fields, and care for other children. 'M'e Mapoloko described what it was like caring for one-year-old Joki before he was receiving treatment and assistance:

It's difficult to take care of the babies. It's difficult, and he was very sick, Joki...Yes, 'M'e. He wasn't [healthy] like this. He had a rash. And he had a swollen face like he still has now. He was coughing. He was crying during the day and night. He was scratching himself. And he had diarrhea...Ah, it was difficult, because I was not sleeping during the day and night.

This elderly grandmother's burden of 24-hour care is compounded by the remote, rural context of her house.

Several children I encountered came to live with their maternal grandmothers because their mothers returned to their natal homes in order to be cared for in the final stages of AIDS. In one such case, two-year-old Thapo and his mother came to live with his grandmother, 'M'e Masekha, when they were both very ill. 'M'e Masekha, giving rare insight into adult care, described this difficult experience as if she were caring for two babies:

It was difficult. She had vomiting and diarrhea, vomiting, diarrhea, vomiting, diarrhea...Because she had diarrhea and I was supposed to wash her like a small child. I was just washing her again and again and again. Changing the clothes time and time again...Because they came both sick, I didn't know what to do. I was still taking them to Sesotho doctors. She passed away because there was no one helping me to take her to the doctors. She was very sick...She didn't have time...It was difficult, because they were both wearing the nappies, and I was changing them both. I was changing the mother, then changing the baby, then changing the baby, then changing the mother, even at night. Even at night.

This level of care is made profoundly difficult by the challenges of village life where there is no electricity, no running water in the homes, limited transportation, and variable weather. Everyday acts of care that take place in the house both transform and are transformed by the physical and the material locality. HIV/AIDS adds an extra dimension intensifying these dynamics, and creates increased need for care that significantly shapes relatedness.

Conclusion: Structuring Care

Households are durable social institutions that are nonetheless capable of responding to social pressures and needs. In Carsten and Hugh-Jones's own words, houses are "places in which the to and fro of life unfolds, built, modified, moved or abandoned in accord with the changing circumstances of their inhabitants" (1995:1). Houses remain central to understanding kinship because they reflect social changes and the social order by their contents and by the movements of people in and between them. Furthermore, the house is a space where many acts of kin-making take place. AIDS has compressed the space of the house, intensifying its role in structuring care and absorbing the pressure of AIDS-related mortality and migration. The co-residential household unit is increasingly the locus of daily acts of care, which strengthen and shape relatedness. As the pressures and burdens of HIV forge deeper into communities and economic opportunities continue to diminish, especially for migrant workers, these sites of kin-making become increasingly

important to the broad landscape of kinship networks in southern Africa, where HIV rates are alarmingly high.

Close investigation of everyday practice within the boundaries of the house illuminates household changes brought about by AIDS and the caregiving practices that are impacting kinship networks. The intimate lives of Basotho families are unfolding in a context that places increasing demands on its caregivers. The many acts of care required of grandmothers, grandfathers, aunts, uncles, siblings and others within the space of the house are creating lasting bonds with children, solidifying their social identities, and helping to compensate for the loss of one or both parents to AIDS. Houses have always been important physical and social spaces for Basotho families. Unlike many aspects of the pandemic that have created rifts among families, AIDS has intensified the importance of the house as caregiving has become a primary motivation for cohabiting kin. This ethnographic study reveals the heterogeneity of care within the space of the house, which can be both unitive and divisive. The physical structures as well as the people within them bear signs of the quality and nature of care in a way that observation outside of the home does not permit.

The house transformed by AIDS continues to be a space where local ideas about gender, age, politics, kinship, and marriage are shaped and reflected (Bloch 1995, Drucker-Brown 2001, Feeley-Harnik 1980, Ramphele 1993, Waldman 2003). In many ways, this study raises as many questions as it answers. What types of household are most likely to dissolve? What coping mechanisms are successful households employing? What types of households do Basotho consider to be successful? And what types of social support enable household success? However, what is clear is that houses and households have adapted to the demographic pressures of HIV/AIDS by making space for those in need of care. This work does not merely draw attention to the increased number of southern Africans in need of care as a result of HIV/AIDS. Nor does it simply reaffirm that those in need of care receive that care in the house. Instead, I argue that all Basotho, whether sick or not, are part of a larger network of changes precipitated by the rapid onset and proliferation of AIDS. These changes have positioned the house as central for structuring care and, thus, for shaping relatedness in contemporary Lesotho.

A c k n o w l e d g m e n t s :

The W. K. Kellogg Family Fellowship in Children and Families and the Population Studies and Training Center (PSTC) at Brown University funded this research. The PSTC receives core support from Eunice Kennedy Shriver National Institute of Child Health and Human Development (5R24HD041020). Additionally, I would like to thank the Mokhotlong Children's Services staff and caregivers for all of their help and support, and Mandy Terc, Adia Benton, Melissa Hackman, and Jennifer Stampe for reading earlier versions of this article. I would especially like to thank Jessaca Leinaweaver for her constant feedback and support and Gillian Feeley-Harnik for her close reading and heartfelt encouragement.

E n d n o t e s :

1My analysis is based on 24 months of ethnographic fieldwork in the rural highland community of Mokhotlong, Lesotho, between 2007 and 2015. I conducted a series of in-depth interviews with caregivers of AIDS orphans and HIV-positive mothers in their homes; I observed the service delivery of outreach and residential care services by a local NGO serving orphaned and vulnerable

children in rural villages; I observed the activities of clinic and hospital staff; I interviewed key community personnel including healthcare and social workers, NGO employees, religious leaders, traditional healers, and village chiefs; and I participated in numerous community functions including religious services, weddings, funerals, and HIV-awareness events. Qualitative data was analyzed using atlas.ti.

2'M'e (lit. "mother") and Ntate (lit. "father") are the Sesotho honorifics for adult women and men, respectively.

3As Klaitz (2010) shows, members of a church in Botswana use the location of care as a way of shaping relatedness among otherwise unrelated parishioners.

4In "Building, Dwelling, Thinking" Heidegger explores the relationship of building to dwelling, writing "only if we are capable of dwelling, only then can we build" (1971:362). He emphasizes the role of dwelling to our situated place in the world and to our very "being." While earlier studies of houses expanded social science's understanding of a "building" perspective, these insights are not rendered insignificant by a "dwelling" perspective. Rather, the two approaches are synergistic.

5In theory, social workers and healthcare professionals rely on these outward signs to make decisions about severe neglect that could result in the removal of a child from a household. However, these recommendations usually come from neighbors or chiefs who more closely observe abuse or neglect, both because of proximity and a shortage of social services and personnel.

6Turkon (2009) discusses the emergence of class differences in rural Lesotho. While these are still relevant, these differences have diminished since remittances have decreased significantly with the retrenchment of mine workers in the late 1990s.

7Life expectancy in Lesotho rose from 51 for both sexes in 1976 to 59 in 1996, but had dropped, despite better access to biomedical treatment, to 41.2 by 2006 as a result of HIV, malnutrition, and poverty (Lesotho Ministry of Health and Social Welfare 2010).

8In 1990, the under-five mortality rate (per 1,000 live births) was 86. By 2013, it had risen to 98 deaths per 1,000 live births.

9UNICEF estimates that there are between 110,000 and 120,000 AIDS orphans in Lesotho; of these children, 12,000 are HIV-positive. An AIDS orphan is defined as a child who has lost one or both parents to AIDS (Lesotho Ministry of Health and Social Welfare and National AIDS Commission 2009, UNICEF 2010).

10The shifts in household membership, marriage practices, and lineality have been tremendous in Lesotho. While this article focuses primarily on changing household arrangements to care for children impacted by AIDS, several authors have examined changes in households and families based on over a century-long dependence on migrant labor, apartheid, and a shifting political economy. For examples, see Coplan (1991), Turkon (2009), Murray (1981), and Block (2014).

11Ferguson (2006) notes that during his fieldwork in the 1980s, wealthy Basotho aspired to build square multi-room houses instead of rondavels because of the comfort afforded by larger multi-room houses compared to single-room houses, and because of aspirations for modernity. While this is still true in urban and peri-urban areas where materials are more readily available, rondavels continue to dominate the rural landscape, especially in villages far from the main road.

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