# LESOTHO – Mafeteng and Quthing




# Vulnerability and Capacity Assessment in Mafeteng and Quthing

CRA Toolkit
CASE STUDY

This case study is part of a broader ProVention Consortium initiative aimed at collecting and analyzing community risk assessment cases. For more information on this project, see www.proventionconsortium.org.

**Bibliographical reference:** International Federation of Red Cross and Red Crescent Societies, *Vulnerability Capacity Assessment Communities: Matefeng and Quthing*, IFRC, Geneva, Switzerland (2006).

Click-on reference to the **ReliefWeb country file for Lesotho**:
http://www.reliefweb.int/rw/dbc.nsf/doc104?OpenForm&rc=1&cc=lso

**Note:**
A Guidance Note has been developed for this case study. It contains an abstract, analyzes the main findings of the study, provides contextual and strategic notes and highlights the main lessons learned from the case. The guidance note has been developed by Stephanie Bouris in close collaboration with the author(s) of the case study and the organization(s) involved.

Lesotho Red Cross Society

# Vulnerability & Capacity Assessment
## Mafeteng and Quthing Districts
## Lesotho

27 March – 7 April 2006

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## Acronyms

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ARCHI | African Red Cross and Red Crescent Health Initiative |
| ART | Anti-Retroviral Therapy |
| BRCS | British Red Cross Society |
| CDPPM | Community Development Peace and Promotion Movement |
| CHAL | Christian Health Association of Lesotho |
| CHBC | Community Home Based Care |
| DDMO | District Disaster Management Officer |
| DDMT | District Disaster Management Team |
| DMA | Disaster Management Authority |
| DP | Disaster Preparedness |
| FGD | Focus group discussions |
| HBC | Home Based Care |
| HIV | Human Immunodeficiency Virus |
| HSA | Health Service Area |
| ICHBC | Integrated Community Home Based Care |
| IEC | Information, Education and Communication |
| IFRC | International Federation of Red Cross and Red Crescent Societies |
| IGA | Income Generating Activities |
| LAPCA | Lesotho AIDS Programme Co-coordinating Authority |
| LENASO | Lesotho Network of AIDS Service Organizations |
| LRCS | Lesotho Red Cross Society |
| MOAFS | Ministry of Agriculture and Food Security |
| MOFLR | Ministry of Forestry and Land Reclamation |
| MOH | Ministry of Health and social welfare |
| MoHSW | Ministry of Health and Social Welfare |
| NAC | National AIDS Commission |
| NGO | Non Governmental organization |
| NGO's | Non governmental Organizations |
| OVC | Orphans and Vulnerable Children |
| PLWHA | People Living With HIV/AIDS |
| RSDA | Rural Self help Development Association |
| SANReMP | Sustainable Agriculture and Natural Resource Management Programme |
| SG | Secretary General |
| STI | Sexually Transmitted Infections |
| TB | Tuberculosis |
| UN | United Nations |
| UNDP | United Nations Development Programme |
| UNICEF | United Nations Children's Fund |
| VCA | Vulnerability and Capacity Assessment |
| VCT | Voluntary Counseling Test |
| VDMT | Village Disaster Management Team |
| VHW | Village Health Worker |
| WFP | World Food Program |
| WHO | World Health Organization |
| WV | World Vision |

## Executive Summary

The purpose of this assessment was to conduct Vulnerability and Capacity Assessment (VCA) in two disaster prone districts of Mafeteng and Quthing with a view to mapping out hazards, vulnerabilities and capacities within the target areas. This was to empower communities to identify their own needs and priorities. The study results will enable the Lesotho Red Cross Society (LRCS) to work with communities to design appropriate disaster risk reduction initiatives.

A representative sample was selected based on the geography of the districts and special circumstances such as the presence of the LRCS projects. To fulfil these criteria ten villages were selected from six administrative constituencies of Mafeteng and ten villages from the 5 administrative constituencies of Quthing district. The twenty villages were selected representing the geographical zones of mountains, foothills and lowlands as well as whether they were rural or 'peri-urban' villages (Growth points characterized by resettlement of people from different areas and with growing infrastructure) of the district.

Methodology for the study was within a triangulation framework. This included literature review of relevant documents; semi-structured interviews with key informants from local government departments, NGOs and other stakeholders were conducted. Community focus groups involving the contribution of 1,656 people representing rural areas and peri-urban areas were facilitated. Research tools such as timelines, seasonal calendars and community mapping enabled the communities to identify and rank their hazards capacities. Transect walks were also conducted for verification of information

The study results identified the main hazards confronting the people of the two districts of Mafeteng and Quthing to be; drought resulting in food insecurity, HIV/AIDS, which is having a devastating socio-economic effect on the community, poverty and an increased disease burden. This has increased the community's vulnerability and exhausted people's coping capacities resulting in the community relying on food aid.

The study also revealed that flash floods, pests and early frosts are issues of concern to communities. Another serious hazard in the communities is the poor sanitation coverage in the districts. Very few latrines could be observed in all the areas visited and communities openly admitted to using the bush and gullies ("dongas.) Hence, diarrhoeal diseases are among the top ten diseases of concern. Socio-economically, the two districts of Mafeteng and Quthing are reeling under the devastating impact of HIV/AIDS and women and grand- parents are bearing the brunt of this; looking after the sick and orphaned children with limited resources. In terms of HIV/AIDS, this has become the major challenge facing Lesotho, meaning that all efforts need to integrate the fight against the pandemic.

In relation to the hazards identified, communities were able to bring up the causes and measures that could be taken by the communities themselves to reduce the risks to the disasters although they gave an impression of helplessness. They saw disaster management as government responsibility. "We would like the government to develop a good road for us. We need a dam as well as a clinic here, since people have to walk for long distance to get help? We need toilets here! – These were some of the comments from the communities.

For the community to sustain efforts that can reduce their vulnerability they need to be able to change any of the limiting beliefs they have about their situation. Concerted efforts between institutions and the community are required to reduce water shortages. The Seque River is a major resource that can be fully exploited to change the fortunes of the district by increasing water availability to enabling sustainable food production thus reducing food insecurity.

Communities and key stakeholders made recommendations in terms of their needs and priorities which include:-

LRCS needs to work closely with other partners such as Ministry of Agriculture and Food security, Ministry of Forestry and Land Reclamation, UN Food and Agriculture Organization and UN World Food Programme and other relevant agencies to assist communities in sustainable livelihoods through food security interventions.

- Agricultural based livelihoods will need reliable water sources there is need to adress water shortage by fully utilizing the water resource potential from the mountains to be able to develop irrigation farming and livestock water points as well as, promote harvesting of rainwater for domestic use and home garden irrigation by user-friendly small-scale irrigation techniques, such as simple garden drip kits
- Support community empowerment through training on different agricultural techniques such as, conservation farming and use of organic manures. Provide targeted agricultural support with inputs such as, seed packs for home gardens and other field crops, as well as small garden tools
- HIV/AIDS is the most important challenge facing Lesotho today and needs to be addressed with a scaled up responses on all fronts – Prevention, care and support, treatment and care of OVCs
- Promotion of Health and Hygiene and encourage and facilitate the protection of water sources and construction of pit latrines.
- Increase sensitization for communities to take more responsibility for their health by creating a culture of public sanitation and proper waste management. E.g. competitions that foster a culture of cleanliness - tidiest village, keep your village clean!
- Awareness of environment issues is very low within the community, which makes it difficult to address on going environmental degradation. A sound environmental management education accompanied by rehabilitation activities like donga rehabilitation, planting of trees and reseeding of grass could prove beneficial.

The results of this study provide a unique opportunity for stakeholders to work in partnership on programmes that reduce people's vulnerability to disasters. The idea is that the programmes would be developed with a more integrated and participatory approach enabling actions in areas of prevention, mitigation, and community health and community development. Therefore the study results will be shared with all stakeholders with a view of developing a plan of action that will improve the situation of people of Mafeteng and Quthing district.

# Chapter 1.

## Vulnerability and Capacity Assessment in Mafeteng and Quthing Districts

### Background

Lesotho is a small mountainous country, completely surrounded by the Republic of South Africa, with a total land area of 30,355 square kilometres. The present population is estimated at about 2.35 million people with more than 80 percent of them living in the rural areas. The country is divided into four geo-ecological zones: the lowlands, foothills, mountains, and the Senqu River valley. The climate in Lesotho is harsh, with temperatures varying from –10°C in winter to 30°C in summer in the lowlands. Winters are severe in the highlands, with heavy snowfalls that cut off mountain settlements from basic essentials. (UNDP2004) [1]

Lesotho's economy is based on subsistence agriculture, including livestock, remittances from migrant workers employed mainly in South African mines and the informal sector. Although agriculture only contributes about 17% of GDP, it supports rural livelihoods of 85% of the population. The rest of the contribution to the GDP comes from industry - 43% and services - 40%.

Like most Southern African countries, the "triple threat" of food insecurity, HIV/AIDS and chronic poverty poses a great challenge for the country. The HIV/AIDS infection rates currently stands at 29% (LVAC, 2005, FAO/WFP CFSAM, 2005) and has negatively impacted on the livelihoods of many households, grossly reducing their coping strategies and affecting food/money availability at household level. Lesotho experiences natural disasters such as drought, heavy snowfalls, severe frosts, hailstorms and localized flash floods. These natural disasters have progressively affected vulnerable people crop and livestock production.

### Drought/Food security

Lesotho's agricultural production has been threatened by recurring drought since 2001. This has led to recurring humanitarian crisis compounded by chronic poverty and the impact of HIV/AIDS. Since 2002, Lesotho has been dependent on food aid to supplement local production and commercial imports. In Lesotho, more than 80% of the population lives in the rural where they depend on agriculture for their livelihood. However the topography of the country presents a challenge in the pursuit for food security. Three quarters of the country is made up highlands which rise to over 3,500 meters while one quarter of country is lowlands. Only 10% of the country mass is suitable arable land whilst 66% is considered grassland and pastures which means there is less arable land per rural family with severe implications for agricultural production.

The limited availability of land and other factors have hindered efforts to produce enough food. As a result Lesotho has become a net importer of food crops. The main factors that have constrained agricultural development include; poor distribution of water resources, the mountains receive adequate rains where the lowlands receive less rain during the growing seasons. The other factors include: soil fertility, soil erosion, poor marketing infrastructure, limited access to agricultural inputs and lack of access to capital. The food security situation is further exacerbated by the harsh winters which compromise crop production in the mountains especially if they do not grow frost resistant crops. The effects of HIV/AIDS on food security cannot be ignored because loss of labour, subsequent loss of capital and loss of technical agriculture knowledge.

Livestock has also declined mainly by overgrazing which resulted in rangeland degradation. Overstocking affects poor animal nutrition and leads to low milk production.

### Environment

[1] Sources of information from common country assessment of Lesotho UNDP December 2004

Lesotho continues to face chronic environmental problems, specifically land degradation and deforestation, exacerbated by erratic rainfall and recurring droughts. Soil loss continues to gnaw away at arable land and it is estimated that only 9% of total land area is now suitable for agriculture. Ploughing practices on steep slopes, next to rivers and very close to gullies, without appropriate supporting conservation techniques, especially in the mountain region promote soil erosion and continued gully formation. Deep eroded gullies called 'dongas' dominate the landscape. While some soil and water conservation and tree planting initiatives are being undertaken, these are few compared with the rate of degradation.

**Water and Sanitation**

Lesotho has abundant water most of the year and supplies water to the Republic of South Africa, through the Lesotho Highlands Water Project. However, while mountain areas have plenty of available water, distribution across the country is a problem. This is especially the case with lowland areas where the population is increasing due to urbanization,and the land is stricken by drought in the dry season. In terms of sanitation TO BECOMPLETED…

**Health**

In Lesotho, the health care delivery has four tiers, namely the central level, health service area (HSA) level, health centre level and the community level. The country has adopted the primary health care strategy aimed at ensuring access to basic health care for the majority of the population. The HSA is the most important unit for the health care delivery. It incorporates a defined geographical area with a hospital as its focus. A public health team made up of a doctor, public health nurse, health inspector supervise health centres and clinics within a catchment area of an HSA. At the community level, there are village health committees that support village / community health workers, and traditional birth attendants. There are a total of 18 HSA hospitals and 160 health centres 52% of which are owned by government and the remaining 48% are owned by Christian Health Association of Lesotho (CHAL) and other NGOs. LRCS owns four health centres supported by government.

**HIV/AIDS**

Lesotho faces a serious and worsening HIV/AIDS problem. Currently, at least one in three Basotho adults are infected with HIV. This translates into approximately 350,000 people living with HIV/AIDS. The WHO characterizes the epidemic in Lesotho as a mature type, with a high fatality ratio; 70 people die each day of AIDS related illnesses. The epidemic has contributed to the decline in life expectancy of Basotho from 60 years in 2003 down to 40 years in 2005. Despite government efforts to control the spread of the epidemic, infection rates continue to rise. In the year 2000, His Majesty King Letsie III declared HIV/AIDS as a national disaster and has since continued to use every opportunity to exhort all citizens and partners of good will to do everything in their power to help control and manage the epidemic.

The prevailing poverty, lack of job opportunities in the country when combined with the HIV/AIDS epidemic is slowly eroding the coping mechanisms of the Basotho people, especially in rural areas. HIV/AIDS epidemic poses one of the major developmental challenges in the country. According to the World Bank, HIV/AIDS will reduce gross domestic product by almost 30% by the year 2015. The government has taken significant steps in addressing the HIV/AIDS pandemic. It developed a National policy on HIV/AIDS as well as National AIDS strategic plan. About 2% budget allocation from every government Ministry has been set aside to address pressing HIV/AIDS priorities in the respective sectors. In 2004, the government scaled up its response against the pandemic by launching Voluntary Counselling and Testing programme (VCT) as well as introducing free anti retroviral treatment. Several international agencies like UNAIDS, UNICEF and UNDP as well as NGOs such as CHAL and Lesotho Network of AIDS Service Organizations (LENASO) are also involved in the fight against HIV/AIDS.

## Lesotho Red Cross Society (LRCS)

LRCS was formed by an act of parliament a year after Lesotho gained its independence in 1967. Through its 10 year strategic plan (2002-2012), the LRCS aims to address problems that stem from poverty, caused by the poor economic situation, environmental challenges such as the recurrent drought, vulnerability to other severe weather conditions and the impact of the HIV & Aids pandemic

There are 10 Divisional Red Cross Offices covering the whole country and there are branches within the divisions. In terms of human resources, the society has at approximately 8,600 volunteers and members; as well as 19 paid staff at HQ plus 10 divisional coordinators; LRCS also have four health clinics around the country, which are maintained by the Ministry of Works. Government pays clinic staff and Divisional Secretaries are paid from Divisional funds.

**Overview of projects / key areas of work:**

- *HIV / AIDS programming* – home-based care, support to orphans and vulnerable children (OVC), psychosocial support, food security, previously also includeda WatSan component
- *Relief programme* – food security involving food distribution at household level, and horticulture projects at community and household levels.
- *Disaster management programme* – capacity building of staff and volunteers (basic disaster management training, SPHERE), formation of DM Action Teams (15 people per team in 7 of 10 divisions)
- *First Aid* – community based first aid ensuring trained volunteers in villages, commercial first aid for industries, offices and government, including provision of manuals and kits.
- *Water and sanitation* (currently on hold due to lack of funding) – latrine construction at household level and access to safe water at community level.
- *Health Clinics* – 4 sites run with government assistance, providing primary health care services, referrals, VCT and increasing links with the HIV / AIDS programme.
- *Information dissemination* – publish information on the Red Cross,its Fundamental Principles, and the International Humanitarian Law (IHL). Communication with divisions. Coordination with the ICRC.
- *Organisational development* – strengthening of divisions through their involvement with national programmes and coordination between divisions.
- *Income generating activities* – rental of buildings. Limited fundraising activities currently.

**Key achievements of the organisation:**

Government, NGOs and the public, in part because of its Fundamental Principles, regard LRCS as a credible organisation. Its operational role in First Aid, Disaster Management, HIV & AIDS, and OVC programming is also known and respected. LRCS has a good working relationship with other stakeholders.

**Collaboration & coordination with other stakeholders:**

LRCS collaborates and coordinate with other stakeholders, government, national and international organisations:

- The NS has bilateral arrangements with other Red Cross Societies such as the German Red Cross, the British Red Cross
- LRCS partners with WFP to distribute food rations
- Disaster Management Authority - this is a Government unit that coordinates all the organizations involved in food relief and disaster management.
- International Federation of the Red Cross and Red Crescent Societies provides financial and technical support from staff.
- International Committee of the Red Cross and Red Crescent - on dissemination, IHL, legal issues
- Ministry of Health Departments: Environment & sanitation, public health, social welfare, HIV/AIDS programme
- UNICEF Workshops, publications, advice

- UNAIDS – advize on OVC programme
- WFP- Food assistance for the most vulnerable

**Disaster Management programme**

The LRCS is in the process of strengthening its disaster management capacities to reduce the risks of the most vulnerableIn the past, the approach to disaster management has been reactive to disaster situations and more often than not, interventions were ineffective as they focused on providing relief without reducing risks.

Disasters common to Lesotho include droughts, flooding, snowstorms, hailstorms, hurricane storms, veldt fires and HIV/AIDS. Due to the country's disaster scenarios and vulnerabilities, there is need to empower communities to reduce risks through community-based initiatives. The LRCS received funding from DFID through the IFRC to support risk reduction programmes in two districts Mafeteng and Quthing. Vulnerability Capacity Assessment (VCA) was conducted in these two disaster prone districts. This was conducted to assist in mapping out hazards, vulnerabilities and capacities within the target areas in order to enable the design of appropriated disaster risk reduction programmes.

## Chapter 2. Mafeteng and Quthing District

### Background

Mafeteng district is 80km south of Maseru, with a total population of 250,000 people. Geographical features of the district include the foothills and the lowlands. There are approximately 38,208 households located in the lowlands and 3,188 are located in the foothills. Mafeteng is classified as one of the most vulnerable districts to drought and poverty with 57% of the population classified as living below the poverty line and 7% are living in a state of chronic illness. Drought and erratic rainfall are the major concerns in this district.

Quthing is one of the southernmost districts of Lesotho located about 200km south of the capital Maseru. It has an estimated population of 140,000 of people. There are three ethnic groups in this district namely the Bathepu / Xhoza, the Baphuthi and the Basotho. The district is geographically divided into four ecological zones, the Senqu River Valley, the lowlands, foothills and the highlands comprising of range of mountains. Winters are severe in the highlands, with heavy snowfalls that cut off mountain settlements from basic essentials. Early frosts can be experience from as early as mid-April.

### Livelihood sources

Livelihood sources are generally unreliable and unsustainable within the two districts. Limited income is obtained from sale of casual labour (stone collection for building of kraals, working in the fields, etc.), pensions, domestic work and petty trade such as selling of firewood and cigarettes. Although there have been retrenchments from South African mines, migrant labour remittances are still the largest source of income (accounting for up to 30% of GDP).

**Table 1. Income sources**

| Sources of income | Mafeteng | Quthing |
|---|---|---|
| Remittances | 14% | 10% |
| Livestock | 2% | 2% |
| Small business | 4% | 4% |
| Crop production | 4% | 2% |
| Salary/pensions | 18% | 18% |
| Casual labour | 35% | 26% |
| Beer Brewing | 16% | 20% |
| Other | 7% | 18% |
| | 100% | 100% |

***Source: DMA/WFP targeting exercise March 2006***

### Education Please validate

Since 200, primary education is free in Lesotho. The enrollement ratios in primary and post primary education, indicates that both rates for men and women have increased in the past eight years.Literacy rates are rising in the country. Among children aged 6-14, statistics indicate that after the introduction of free primary education, the percentage of drop outs decreased because even children from the poorest families had access to education.However, girls seem to be more likely to drop out than boys especially at the end of standard 6 and 7, on average, only slightly more girls than boys dropped out (5.7% as compared to 6%). Generally 7% of boys drop out of school at the end of standard 6 compared to 11% of girls, 23 % of girls leave the education system at the end of standard 7 compared to 18% of boys. When comparing the repetition rate between the genders, on average 12% of boys repeated as compared to 9.5% of girls. Repetition and drop out rates during 2004 enrolment (percentage)

| District | Repeat | Drop out |
|---|---|---|
| Mafeteng | 6.8-25.7 | 0.3-32.4 |
| Quthing | 2.0-19.5 | 0.0-10.5 |

Source; Demographic& Health Survey 2004

Number of schools/ students**? (to be Completed)**

**Communication**

Only 3.5% of the total population has access to radio and only communities in the lowlands have access to cellular networks and telephone. This therefore limits the general service delivery coupled with a poor transportation infrastructure. (1996 Census report)

**Health**

In line with the health care systems in Lesotho, health care in the districts is delivered through health services area level. Mafeteng has 1 district hospital and 14 clinics which are owned by both government and Christian Health Association of Lesotho (CHAL). In Quthing, there is one government hospital in the main town of Moyeni. In addition, CHAL has three health clinics and five government health clinics, which provide extended medical services throughout the district. However, due to the sparsely located villages some patients have to travel long distances to get health services. The village health workers (VHW) have become a community resource. They help to disseminate information and raise awareness on many of the common diseases. They give health education and advice on good hygiene practices. Table 2 indicate the priority diseases in the districts.

Table 2.
Priority disease in the districts

| Mafeteng | Quthing |
|---|---|
| T.B | T.B |
| HIV/AIDS | HIV/AIDS |
| Hypertension | Hypertension |
| STI's | Mellitus |
| Otitis (ear infection) | STI's |
| Tonsillitis | Otitis (ear infection) |
| Diseases of the skin | Tonsillitis |
| Diseases of muscles& connective tissue | Diseases of the skin |
| | Diseases of muscles& connective tissue |

Sources: interviews with Public health nurses for MAFETENG & QUTHING Government Hospitals.

.**HIV/AIDS**

Quthing is one of the districts hit hardest by the HIV/AIDS pandemic. Quthing is amongst four districts categorized as poor due to the limited arable land exacerbated by severe soil erosion. Studies showed that the district has one of the highest unemployment rates and HIV/AIDS affects people mostly of reproductive age groups. The HIV/AIDS infection rates among women and men aged between15-24 in Quthing and Mafeteng are as follows as provided by demographic and health survey 2004.

| District | % HIV Positive women | %HIV Positive Men | Total % |
|---|---|---|---|
| Quthing | 13.8% | 10.5% | 12.6% |
| Mafeteng | 14.8% | 2.6% | 8.9% |

**Water and Sanitation**

The sources of water for households in ? (Lesotho, Mafeteng or Quithing?) stand as follows:

- 11.6% of piped water is in the residences.
- 54.6% of piped water is in the communities.

- 12% of water is from the public wells, in the mountain area.
- 8.2% of the water is found from the covered spring.
- 12.8% of water comes from the river, which poses a threat in terms of water-borne diseases.
- 66% of all households have access to safe water.

**Table 3. Percentage of people with access to safe water**

| Location | Number | Type of access to Safe water | | |
|---|---|---|---|---|
| | | Access 1 | Access 2 | Access3 |
| Mafeteng | 8,512 | 56.6 | 83 | 84.5 |
| Quthing | 5,409 | 60.3 | 60.3 | 70.6 |

Access 1: Access to piped water in one's dwelling or from a public pipe
Access 2: Access to piped water and from a borehole
Access 3: Access to piped water, borehole and water from covered spring

**Table 4. Percentage Distribution of households according to toilet facility**

| Location | Number | No toilet Bush/ donga | Flush pour | Pit latrine | VIP latrine | Bucket system | Public toilet | Others | Total |
|---|---|---|---|---|---|---|---|---|---|
| Mafeteng | 1,740 | 45.7 | 0.7 | 31.8 | 20.2 | 0.1 | 0.0 | 1.5 | 100 |
| Quthing | 1,023 | 73.9 | .08 | 10.9 | 14.1 | 0.2 | 0.1 | 0.0 | 100 |

(***adapted from Lesotho Demographic Survey 2001)***

## Chapter 3.

# METHODOLOGY

### Purpose of the Study

The LRCS received funding from DFID through the International Federation of the Red Cross and Red Crescent Societies (IFRC) to support risk reduction programmes in two districts. Hence, the purpose of this assessment was to conduct a Vulnerability Capacity Assessment (VCA) in the two disaster prone districts of Mafeteng and Quthing with a view to mapping out hazards, vulnerabilities and capacities within the target areas to be able to empower communities to identify their needs and priorities. The study results would enable the national society to work with communities to design appropriate disaster risk reduction programmes.

### Objective:

The main objective of the study was to work with the communities to identify the vulnerabilities, hazards and capacities with a view of designing appropriate programmes that focus on risk reduction.

### Preparations for the VCA

In preparation to undertake the VCA, the LRCS held consultation and sensitisation meetings with stakeholders at national level and in the study districts of Mafeteng and Quthing. People consulted include local authority officials, community leaders (chiefs), local Red Cross Divisional Executive Committee (DEC) and other NGOs working in the districts. Discussions were conducted to ensure commitment from all stakeholders.

To assist in the process the LRCS requested for technical support from the Federation Regional Delegation and the Regional Disaster Technical Manager was sent to assist in the process including training of data collectors. The Federation Relief Delegate also supported the VCA process in terms of guidance and administrative issues.

### Training of data collectors:

Twenty-two staff and volunteers from the national society and other stakeholders were selected from the two districts and trained to facilitate the VCA process in a culturally and linguistically sound manner. The training provided insight into key aspects of VCA process and suggestions on how best to prepare for fieldwork and data collection. List of participants attached as annex 3.

### Action Plan

Following the VCA training an action plan was developed detailing all action to be undertaken until completion of the assessments. Two days were devoted to orientation of the VCA Teams in both Mafeteng and Quthing. Time was spent covering all administrative and logistics matters including confirming appointments with key informants and notification of selected communities of dates and times of community interviews as well as collecting secondary data. This involved allocation of tasks, responsibilities and familiarization with tools for the assessment for both teams and ensuring that everyone was comfortable with the whole process. Data collection took 5 days to cover the 10 selected villages (areas) in each of the two districts. This was followed by data analysis/interpretation and 3 days drafting the report.

### Vulnerable and Capacity Assessment Teams

To facilitate the VCA process in data gathering two teams of 10 members each were selected from trained LRCS personnel and local stakeholders. The Regional Federation Disaster Management Technical Manager and the Federation Relief Delegate gave technical support to both teams.

The team from Mafeteng Division comprised of: -

- 1 LRCS Disaster Management Coordinator
- 1 LRCS Mafeteng Division – Divisional Coordinator
- 1 LRCS Mafeteng Division - Disaster Risk Reduction Officer

- 1 LRCS Mafeteng Division - Integrated Community HBC Project Officer
- 2 LRCS Mafeteng Division –Volunteers
- 1 NAC Peace Corps - Volunteer
- 2 World Vision Food Aid Monitors
- 1 MOFLR District Conservation Officer
- 1 CDPPM Executive Director

The team from Quthing district comprised of: -

- 1 LRCS Quthing division – Divisional Coordinator
- 1 LRCS Quthing division - Integrated Community HBC Project Officer
- 3 LRCS Quthing division – Volunteers
- 1 DMA - District Disaster Management Officer
- 1 MoH - District Health and Sanitation Officer
- 1 MOFLR - RMO
- 1 MoA - DFR
- 1 Wildlife DT - Volunteer

**Sample:**

The two districts selected for the implementation of the risk reduction programmes had been identified through the government and other stakeholder surveys on disaster prone areas. The districts are within the two livelihood zones of Southern lowlands for Mafeteng and Quthing in the Senqu River valley areas. To select a representative sample the criteria used included geography of the community and special circumstances. To fulfil these criteria it was essential to choose a sample from ten villages from six administrative constituencies out of nine constituencies of Mafeteng district. In Quthing district 10 villages were selected from the 5 administrative constituencies. Villages were also selected from the geographical zones of mountain areas, foothills, and lowlands as well as whether they were rural or 'peri-urban' villages (Growth points characterized by resettlement of people from different areas and with growing infrastructure) of the district. A sample number of people were selected from the desired geographical areas. However, selections of individual participants within the groups were based on those who had attended the meetings. The choice of key informants from service providers were selected based on the services that they provided in the community. Table 5 shows how the sample sites were selected: -

**Table 5 Assessment Sample sites**

| Mafeteng | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Constituency** | **Village** | **Highlands** | **Foothills** | **Lowlands** | **Peri-urban** | **Rural** | **LRCS** |
| Maliepetsane | Tajane | x | | | | x | |
| | Ha Nthonyana | x | | | | x | |
| Mafeteng | Ha Seitlheko Matlapaneng | | x | x | x | x | x |
| Thabana Morena | Ha Turupu Ha Sechaba | x | x | | | x | x x |
| Kolo | Mapotu | | | | | | |
| Likhoele | Tsaeeng Matsepe | | x | x | X | x | |
| Qalabane | Ha Khojane | | | x | | x | |

| Quthing | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Constituency** | **Village** | **Highlands** | **Foothills** | **Lowlands** | **Peri-urban** | **Rural** | **LRCS** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Tele | A'skop | | | x | x | | X |
| Sebapala | Tsatsang<br>Tosing<br>Mosenek o | | x<br>x<br>x | | | x<br>x<br>x | x<br>x<br>x |
| Mt Mooposi | Mt Mooposi | | | x | x | | X |
| Qhoaki | Mphaki<br>Seforong | X<br>x | | | x | <br>x | X<br>X |
| Moyeni | Ha Setoko | | | x | | x | X |
| | | | | | | | |
| ***(Red Cross operates in all the constituencies through health centres and schools, which are food distribution points for the food donated by the WFP.)*** | | | | | | | |

**Research Methods**

The research framework used mainly qualitative approaches, using a variety of participatory techniques. Research tools comprising of community maps, seasonal calendars and timelines were also used with community members. Transit walks were also conducted enabling direct observations. This enabled triangulation of information and to give validity to the findings.

**Sources of Information**

Secondary data was obtained from literature review of relevant reports, publications and books. This provided background information as well as support data to primary sources. However, obtaining secondary data from stakeholders became a major challenge for the teams, as stakeholders were rather reluctant to share reports.

Qualitative information was obtained from interviews with key informants from service providers in the Districts. Qualitative information was also obtained from focus group discussions with a cross section of community members, school children from a local primary and secondary schools.

In preparation for the process of conducting focus groups preliminary meetings were held with community leaders to explain the purpose of the study. They were also requested to mobilize community members, from a cross section of the community that included men, women, disabled individuals, church members and community leaders. Focus groups members were selected from the mobilized community members that attended meetings. Focus groups made up of 12 members either females or male or mix groups of all ages were facilitated. In addition to the focus group discussions, community members were also divided into groups that used different tools such as seasonal calendars, timelines, community maps and transit walks to gain more information within a triangulation methodology.

To facilitate the focus groups discussions, guidelines and topics to be covered were developed and the VCA teams were oriented on how to facilitate and manage the focus groups. Focus group discussions began with the community defining and agreeing on common VCA concepts to ensure that all participants and team members had the same understanding. The concepts defined by the community were, disaster, vulnerability, hazard and capacity. Figure 1-2 shows distribution of focus groups by location and gender.

Community members enthusiastically participated, enabling for informed discussions. The participants appreciated being given an opportunity to contribute to their own empowerment. However, the communities visited expressed their disappointment about people who conduct research and never give them feedback on the outcomes and hoped LRCS would not do the same. The national society has put a plan of action to ensure that all communities and other stakeholders receive feedback.

**Figure 1**

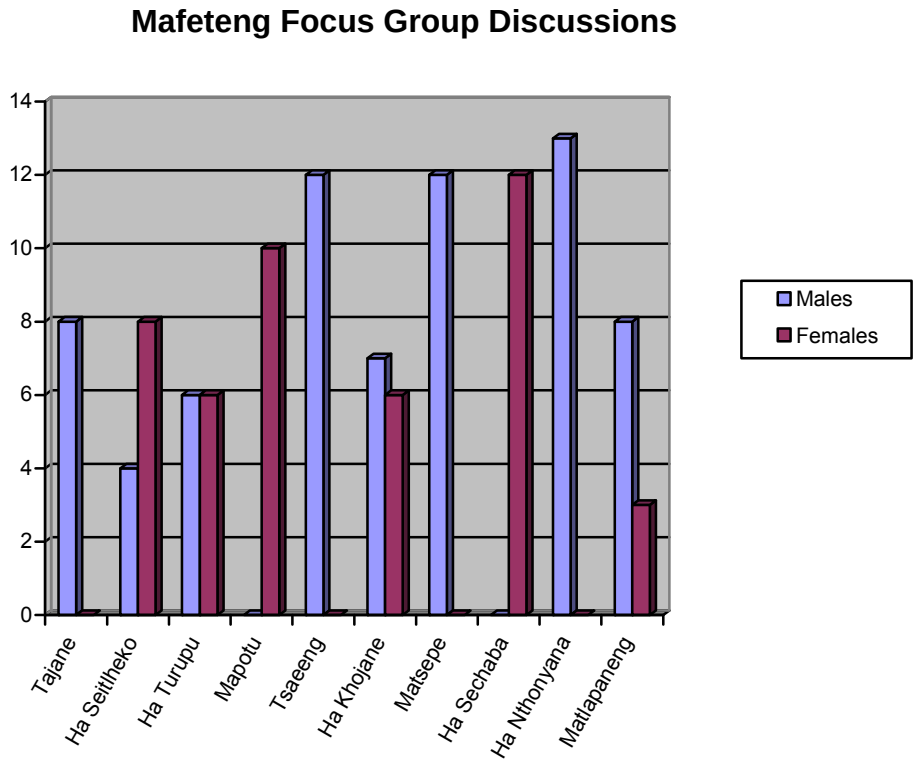
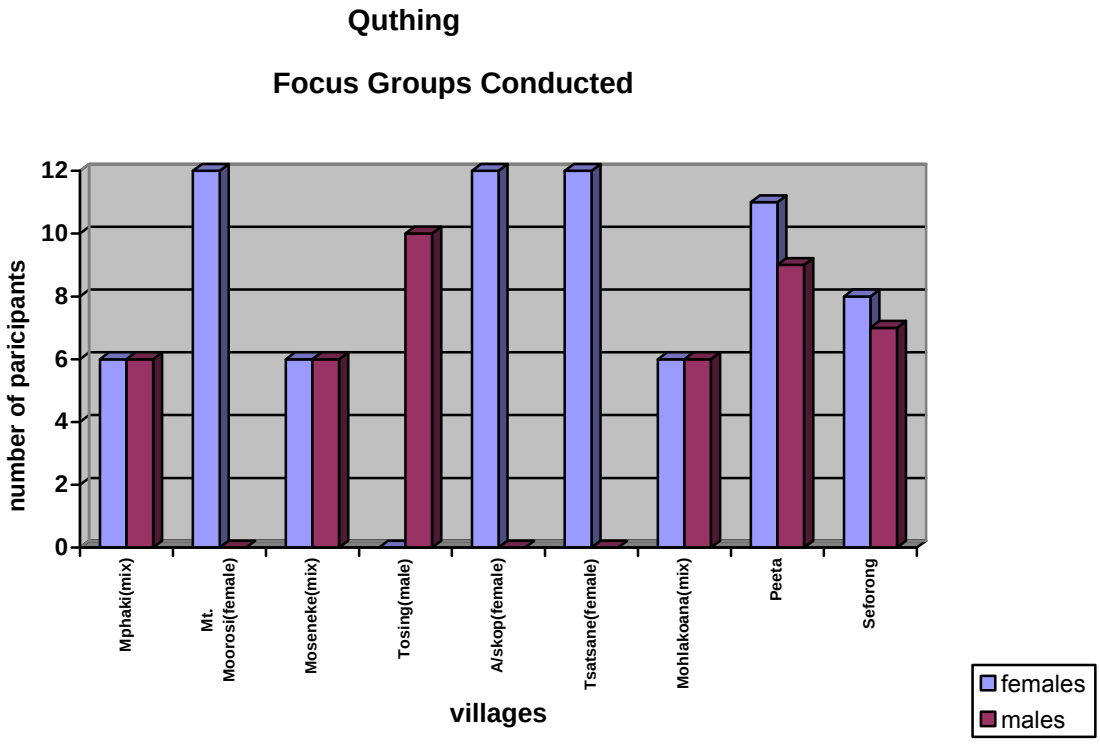



**Figure 2**




**Key Informants/Service Providers:**
The teams selected key informants from the districts based on the services that they provided in the community: These included government and council officials, NGOs, chiefs and Red Cross chair person operating in the districts. The purpose of interviewing these representatives was to ascertain their roles and capacities in disaster management. The list of people interviewed appears in annex 2

**Validity**

- All stages of the research process were developed in a participatory and transparent manner involving key stakeholders
- Sampling was determined by the purpose of the study and took into consideration the issues of geography, community types and special circumstances
- Views of children and youths were also taken into consideration
- Various research tools were used to enable triangulation
- Daily feedback sessions with the VCA data collection teams were facilitated to highlight challenges, progress and to monitor the process
- Senior Officers from the Disaster Management Authority and other senior government officers were presented with the preliminary findings and they assisted in giving feedback to the teams in terms of content and emphasis of the report

**Data Analysis and Interpretation**

It was agreed during preparation of the assessment that daily reports would be produced to ensure that information would be recorded whilst still fresh in people's minds. Reports highlighted the main issues emerging from the information gathered according to guideline headings. When all the data had been collected, the teams started the process of analysis and interpretation of the data collected in all the ten villages in each district. However, the major challenge of the whole process was the time allocated (three days) for the data analysis and drafting the report was a great challenge.

The findings of this study from the two districts show similarities with minor differences in the hazards presented. Mafeteng although it experiences cold winters, communities did not mention snowfalls as an issue for them.

## Chapter 4. Major Findings:

Findings of this study are based on the information obtained from discussions with community members and key informants representing service providers within the visited communities. The findings represent the perceptions of communities emerging from the study.

### Main Findings

- Communities in the areas visited identified drought or lack of rainfall in last 4 years as the major hazard, followed by HIV/AIDS, diseases, soil erosion and pests particularly worms that affects crops in the fields. Unemployment, bad roads, lack of clinics at village level, alcoholism, political clashes and trans-boundary fights between Basotho and Maqhotsa over stock theft were also identified as issues of concern for the community
- Communities identified children particularly orphans, elderly people, disabled people chronically ill and HIV/AIDS affected people, destitute (asset poor people) and women as the most vulnerable groups.
- HIV/AIDS is having a devastating socio-economic effect on the community,
- Chronic food insecurity due to poor rainfall and other factors was cause for concern as the vulnerable community relied on food aid for their survival.
- Insufficient clean water supply
- Lack of sanitary toilets

### Suggested measures to address identified hazards

- Cost effective ways of ensuring sustainable water availability should be designed such as introduction of sustainable irrigation schemes, water harvesting, local gravity flow irrigation projects with the collaboration of the Ministry of Agriculture.
- Greater promotion of agricultural diversity and growing of drought resistant crops and increase crop management by involving the other.
- Provision training on food utilization and preservation in order to secure continuous food supply all year round
- Promotion of educational campaign to educate the communities on the link between various illnesses and drinking of unsafe water and how this could be overcome.
- Encourage and support construction and use of VIP ? latrines.
- A sound environmental management education accompanied by rehabilitation activities like donga rehabilitation, planting of trees and reseeding of grass could prove beneficial

### Hazards

The findings showed that the people of both Mafeteng and Quthing districts are experiencing the same “triple effect” of food-insecurity; poverty and the devastating impact of HIV/AIDS as the rest Lesotho and Southern Africa. Throughout the villages surveyed communities identified: food insecurity due to prolonged droughts, the constant deaths within the villages, which were, attributed to increased disease burden and unemployment levels as hazards.

Mafeteng is one of the driest districts in the country and drought is considered the most priority hazard for the community. The main livelihood of the rural communities is rain-fed agriculture hence having endured drought in the past four years has spelled food insecurity for the communities. The erratic rainfall patterns, environmental degradation and poor agricultural practices have heightened the food security situation for the poor. In addition, to food insecurity drought conditions have also had negative effects on water availability for household use and livestock survival.

On asking communities about the diseases affecting them they talked of diarrhoea, TB and general ill health. The definition of and exposure to hazards did not vary much from community to community. There was a general understanding that hazards cause harm and there was

agreement within the community on the most common hazards between different gender and age groups.

Unemployment was seen as affecting the community because some people have turned to stealing other people's food and properties in the villages in order to get something to eat. This has resulted in a high rate of crime and thefts. People who are unemployed migrate to other countries (RSA) and even to other districts within the country in search of employment. Women are forced to engage in commercial sex because they are financially poor and in most cases depend on men to generate income.

On the issue of HIV/AIDS community members in Mafeteng, understood that this disease was killing a lot of people and was of great concern. In one village called Tsaeeng, the team was informed that there were four deaths that morning of the meeting. Community members pointed out that at least 10 deaths per month in all the villages around. Many of these deaths were related to chronic illnesses, diarrhea, herpes, and TB, or a combination of these. However, the level of awareness on HIV/AIDS was rather limited with women being more knowledgeable than the men who were rather dismissive.

The other concerns for the communities included mosquito outbreaks and pests that affected their crops and livestock. As the survey was done during the current heavy rains in the country, participants were mostly concerned about things that were affecting them at the time. Due to the recent heavy rains and high temperatures, this fuelled breeding of the mosquitoes. They caused people to have large sores, as the mosquitoes are not the type that cause malaria but are pest to the communities. Like mosquitoes, crop pests are caused by weather conditions respectively, e,g cutworm is being exacerbated by dry conditions whilst bollworm is aggravated by heavy rainfall. The people also place very high value on livestock- cattle, sheep and goats. They would like to keep them health and would wish to have veterinary services near their communities.

Some communities lamented about the level of alcoholism, which seems to have taken root in the communities. People who are not employed tend to entertain themselves in the "sheebins" (these are households that brew local beer for sell within the villages.) Those who brew the beer saw this as a household capacity but this has negative effects because men spend any money they get in these sheebins leading to negative behaviour. Unprotected sex, unwanted pregnancies and rape cases were attributed to the influence of alcohol hence, increasing the spread of communicable diseases, such as STIs.

Political clashes have been experienced during election times and this affects the stability of the community destroying the unity of the communities and derailing any development efforts. The information in table 6 indicates hazards, their locations and the vulnerable groups as identified by the communities.

**Table 6 Hazards, their location, and the vulnerable groups**

| Hazards | Locations | Vulnerable Groups |
|---|---|---|
| Drought – Food security | Through out the district | • The elderly people (above 65yrs) said to be too old to help themselves<br>• The physically handicapped/ disabled<br>• The orphans as they are discriminated against by their guardians<br>• The chronically/ terminally ill as they spend most of their time in bed<br>• Pregnant and lactating mothers who need extra nutrients |
| 2. Diseases - Diarrhoeal Tuberculosis (TB ) | Generally whole district but vary in severity between locations | • Community in general but children are more vulnerable<br>• The children (under 5yrs), the elderly and the terminally ill, as their immunity status is weak and will catch most opportunistic diseases<br>• Those living in overcrowded conditions |
| 3. HIV/AIDS | The whole district | • Age group between the 15 – 49yrs as they are the most sexually active<br>• Children between 0-5yrs as they are infected through mother to child transmission<br>• Married women, as they are powerless to negotiate on the use of the condoms/safer sex.<br>• Specific groups such as long distance truckers, migrant South African miners are more susceptible due to their separation from spouses. |
| 4. Environmental degradation | Field and pastures on the sloppy locations, Foothills | • Community at large<br>• Farmers |
| 5. Pests | Through out the district | • Farmers |
| 6. Early frost | The highlands communities | • People/children herding cattle<br>• Farmers |
| 7. Flash floods | Areas along streams and rivers Low lying fields and houses | • People living near the river banks<br>• Adults or school children that have to walk across these rivers regularly. |

The order of importance of occurrences and hazards outlined above reflects the perception of hazards as they affect communities. These are hazards that communities have come to experience and live with although they have a devastating impact on their livelihoods. Drought and its impact on communities was a priority concern in all areas visited because they have endured at least four years of poor rainfalls and the consequential food insecurity. Although, food is usually available in shops and markets but the price increases of basic commodities make food purchases go beyond the reach of many.

**Vulnerable Groups**

Some social groups are more vulnerable to certain hazards than others. This has to do with their level of exposure to hazards, level of resilience and ability to cope. Equally, the same people can be more or less vulnerable at different times of the year. Therefore, vulnerability is dynamic and varies amongst different people and over time.

For the purpose of the study it was essential that all parties had the same understanding of vulnerability. At the beginning of all discussions, participants were requested to define vulnerability

and to identify the vulnerable groups in relation to hazards and disasters. During the interviews, communities identified children particularly orphans, elderly people, disabled people, chronically ill and HIV/AIDS affected people, destitute people (asset poor people) and women as the most vulnerable groups and provided reasons for justification of their opinions. When asked on how they could identify the most vulnerable, participants came up with the following definition: - People who have no capacity to help themselves when any disaster occurs and depend on others to help them: - e.g. children or terminally ill people or those

**Orphans and other vulnerable children (OVC):**
This group of community members do not make decisions for themselves which makes them dependent upon the adults for their livelihood and welfare. Due to their age, they are exposed to various hazards against which they need protection. This group lacks the basic needs for survival with dignity (food, clothing and sometimes shelter).The orphan children suffer the most, first they suffer the emotional trauma of loosing their parents then they face discrimination by their guardians and often suffer emotional, physical and sexual abuse. This has severe psychological effects in their development. In times of disasters some adults exploit children for their own gratification and do not get adequate care and support form immediate family or friends. Some of these children are born infected with HIV and AIDS and lack care they have no one to care for them. Grandparents who are also very vulnerable are now looking after many orphans. In food insecure households children are the first to develop malnutrition, as they don't get enough nutrients. They are not engaged in agricultural activities because they do not own productive assets. Sometimes greedy relatives and neighbours take their assets away.

**Elderly people:**
The elderly people were considered to be vulnerable as they were said to be too weak to help themselves. They are dependent on younger family members to provide for them. Elderly people without family members to support them are severely affected due to their frailty. The elderly depend on other people's assistance and are not able to care for themselves. They are likely to be more susceptible to infections due to a weak immune system and due to low economic power have low resistance to many hazards.

**Disabled people**:
This is one of the pocket groups identified vulnerable due to the fact that they have limited access to services to their condition, they are dependent on other people's assistance. The situation is worse if they are household heads, their decision making is compromised due to their disability to do things for themselves.

**Chronically ill and people living with HIV/AIDS:**
These are feeble and frail people who depend on other peoples' care and support. Their care and support is not always available to all of them depends on the goodness of the carers. This group is mostly poor due to ill health and costs of health care.

**Destitute (asset poor people**):
This group of people normally has no means of survival. These people do not own any productive assets are vulnerable to many hazards. The destitute may include people who are drug abusers, alcoholics, mentally ill, some widows and bankrupt people.

**Women:**
Most of the vulnerable people are women - caring for the ill, caring for OVCs, etc. Women, occupy a very low status in society often decreed to be minors in the eyes of the law and requiring a male guardian to enter into any financial transaction. They have to do almost all the household work even if they have outside work. With men migrating to urban areas and mines in SA, women are left even more vulnerable. Pregnant and lactating mothers in the rural areas find it hard to travel long distances to the hospital and because of the bad roads there is no transport to carry them to their destination. On top of that, women are still made vulnerable due to social systems that segregate them from the right to ownership of land and other assets. The DMA-WFP Targeting

Report of October 2005 indicates that most female- headed households are vulnerable due to lack of productive assets.

**Factors Fuelling Disasters and How They Could be Eliminated**

Community members were aware of certain behaviours within the communities that contributed to disasters. In terms of drought, people were aware that this could be a natural phenomenon due to drastic climatic changes. They also attributed drought to environmental degradation and the behaviour of people who cause bush fires, overgrazing of fields. It was also alleged that people were not respecting cultural beliefs hence; rains were no longer following the seasonal patterns. However, they were awareness that there are certain actions that could be taken to reduce the impact.

In cases of droughts and resultant food insecurity, it was explained that some actions such as water harvesting could be employed to conserve water as well as building of dams. To ward off hunger, people employed a variety of coping mechanism such as: gathering wild foods and preserving peaches for future consumption, selling local beer, other assets to buy food, reducing number and quantities of meals, doing some piecework for money/food or seek assistance from the Government and other humanitarian agencies. Sharing of food with the most vulnerable appears to be the most common coping mechanism along with keeping male children away from school to be herd boys. Seeds for following year crops are increasingly used as a food source. Household members have also been moving to towns in search of work and no one to support the elderly and women in the fields.

Asked on what factors were fuelling the spread of HIV/AIDS. Communities were of different opinions and understanding; from those who were clear on how HIV/AIDS is spread, to those who felt that they did not know much about the disease to those who thought the disease was brought on by the use of condoms. Some people felt that they needed more information to have an understanding about this disease. For those who were aware, they felt that many things could be done which could include, sensitising people about the disease, prevention and promotion of the "ABC'- abstinence, being faithful to one sexual partner, proper use of condoms and people knowing their status through voluntary counselling and testing (VCT) and changing their behaviour.

The reason behind the continuing high prevalence in HIV/AIDS was attributed to the promiscuity of people in sheebins, youths' bad behaviour of early sexual affairs, poverty which, forced people to engage in risky acts, not following "culture" and ignorance. It was also cited that the acceptance of erroneous traditional beliefs on causes and cures of HIV/AIDS and the slow onset of the disease continued to fuel the spread, which is not immediately apparent. However, during discussions women seemed to be more aware about HIV/AIDS whilst most men were rather reserved on this subject. Another reason is that discussion on sexual matters between parents and their children is not taking place and youths felt that adults did not give them appropriate sexual information.

In terms of diseases, the community was aware of the causes and measures that could be taken by the communities themselves to reduce the risks. In case of diarrhoeal diseases, community attributed this to poor personal hygiene, poor sanitation such as lack of pit latrines, unprotected water sources, improper food care, food poisoning, sharing of water sources with animals, upstream communities using streams and rivers as toilets, poor ventilation in crowded leaving places and poor household cleanliness and indiscriminate garbage disposal. The participants felt that with proper health and hygiene education, assistance with construction of pit latrines, protecting of water sources and communities empowered with community-based first aid by village health workers the factors fuelling the diseases could be eliminated.

Poverty was seen as the vice fuelling disasters because people have lost all morals in their quest for money to get them out of poverty. High unemployment is affecting the community because some people have turned to steal other people's food and properties in the village in order to get something to eat. This has resulted in a high rate of crime and theft. Women are forced to engage

in commercial sex because they are financially poor and in most cases depend on men to generate income. Poverty is also responsible for the migration of people who are unemployed to other countries (RSA) and even to other districts within the country in search of employment. Young girls are going out with older men for economic reasons which puts then at the risk of contracting HIV.

In terms environmental degradation, it felt that this is being fuel by the cutting down of trees, overgrazing and overstocking of animals as well as setting of wild fires that cause soil erosion.

The communities identified mosquito bites after particularly heavy rains experienced of late as a serious hazard that needs to be addressed. Fortunately, the mosquitoes do not cause malaria and authorities see mosquito bites as a nuisance but not much action is taken to control their breeding. Mosquitoes can be reduced by elimination of breeding grounds, slashing grass, and the utilization of traditional repellents.

Although the community mentioned all the measures that they could take to reduce risks, there was a general attitude of dependency on external assistance especially from government and other donors. However, in one village participants made comments that they are tired of food aid and would like to be able to grow their own food with assistance in learning the agricultural techniques. Table 7 highlights what the communities saw as factors contributing to disasters and the action that could be taken by the communities with support from other stakeholders to reduce the impact disasters.

**Table 7 Factors Fuelling Disasters and How They Could be Eliminated**

| Hazard | Factors fuelling the disasters | How they could be eliminated |
|---|---|---|
| Drought | ▪ Climatic conditions<br>▪ Low rainfall pattern<br>▪ Lack of conservation measures in place<br>▪ Environmental degradation<br>▪ Deforestation due to the need for firewood<br>▪ Inadequate irrigation schemes<br>▪ Poor agricultural practices<br>▪ Poor soils leading to low crop yield and poor animal pastures | ▪ Intensive sensitization on environmental conservation measures in schools and community<br>▪ Water harvesting schemes<br>▪ Reforestation initiatives through schools and community.<br>▪ Re-vegetation using grass & indigenous trees<br>▪ Rotational grazing<br>▪ Irrigation schemes development<br>▪ Promote sustainable agricultural practices. |
| 2. Diseases - Diarrhoea<br><br>TB | ▪ Poor personal hygiene<br>▪ Poor sanitation - lack of pit latrines<br>▪ Unprotected water sources<br>▪ Food poisoning<br>▪ Upstream communities using streams and rivers as toilets.<br>▪ Poor ventilation<br>▪ Crowded leaving places<br>▪ Lack of household cleanliness<br>▪ Indiscriminate disposal of rubbish | ▪ Personal hygiene<br>▪ Environment clean<br>▪ Proper handling of the food<br>▪ Water resources protection (covering)<br>▪ Construction of pit latrines<br>▪ Community based first aid with village health workers (VHW) |
| 3. HIV and AIDS | ▪ High poverty levels.<br>▪ Low status of women in society<br>▪ Strong traditional beliefs about the use of condoms<br>▪ Misinformation and peer pressure of youths<br>▪ Early marriages<br>▪ Prostitution<br>▪ Low use of condoms | ▪ Scaling up of HIV/AIDS programmes<br>▪ More awareness/sensitization<br>▪ Targeted appropriate messages for behavioural change and safe sex<br>▪ Anti-AIDS clubs for youths<br>▪ Help reduce poverty/dependency through promoting income- generating activities (IGA) for self-reliance.<br>▪ Promote sustainable agriculture to improve |

| | | |
|---|---|---|
| | ▪ Poverty<br>▪ Ignorance due to high levels of illiteracy | household food security.<br>▪ Incorporate HIV/AIDS awareness into school curriculum.<br>▪ Life testimonies by PLWHAS<br>▪ Community income generating activities to reduce the negative impact<br>▪ Involvement of men, church and traditional leaders |
| 4. Environmental degradation | ▪ Soil erosion- ploughing down the slope or near river banks<br>▪ Deforestation<br>▪ Overgrazing<br>▪ Overstocking animals<br>▪ Wild fires | ▪ Plant (kikuyu) grass in the dongas and trees to hold the soil firmly and make silt traps<br>▪ Planting of more trees<br>▪ Rotational grazing<br>▪ Growing supplementary fodder<br>▪ Environmental management education. |
| 5.Early frost | ▪ Change in climatic conditions | ▪ Ploughing of frost resistant crops |
| 6. Flash floods | ▪ Poor drainage system due to the hilly topography.<br>▪ Siltation due to river bank cultivation<br>▪ Poor bridges and maintenance of road<br>▪ Poor drainage system due<br>▪ Poor building materials | ▪ Use of cement instead of mud for building houses.<br>▪ Road maintenance<br>▪ Harness the water into construction of dams<br>▪ Reforestation |

**Impact of disasters on the Communities**

The identified effects of the disasters experienced in these communities fall into the 'triple threat' framework - poverty, food insecurity and the HIV/AIDS pandemic. This can be placed in the three main categories of health, socio-economic and infrastructure damage. The effects summarised include, increased health costs, low productivity, reduced income, increased dependency and no capacity to manage households headed by orphans and elderly.

In terms of drought and its negative effect, the most notable economic impact highlighted by the communities interviewed is for people adapting to negative coping mechanisms of selling of assets like small animals and reliance on brewing beer. Those without assets such as animals are compelled to rely on unconventional subsistence systems like cut trees for sell, migrating to mines in SA, providing labour to those who own fields and household chores. Unfortunately, financial gain through such economic activities is spent buying beer. Many of the villages open beer drinking establishments, mostly run by women. The team observed people drinking early in the morning. This activity is now worrying communities who highlighted that alcoholism is increasing with people spending money they get in the local bars. There was a plea that there should be bylaws to regulate the opening times of these shebeen bars.

The diseases identified by the communities are among the common diseases contributing to high mortality rates in the districts. Most villages identified diarrhoea and TB. The impact of diseases on the communities are the high morbidity, loss of manpower due to illness and costs of health care.

In terms of HIV/AIDS, this disease has had a dramatic effect on the communities in all aspects of health, economic and social spheres. There are the high costs of medical care, loss of productivity at household and community levels, breakdown of family bonds, increase in the number of orphans and other vulnerable children (OVC).
On the issue of environmental degradation, the environmental impact is soil erosion leaving unproductive fields and poor pastures resulting in unproductive land. Table 8 highlights impact of disasters as experienced and articulated by the communities

**Table 8**

## Effects and Impact of Disasters on the community

| Hazards | Impact of Disasters in the community | | |
|---|---|---|---|
| | **General Health** | **Socio-economical** | **Infrastructure** |
| 1. Drought | ▪ Insufficient water for both people and livestock<br>▪ Unsafe drinking water from the lake or streams shared with animals.<br>▪ Forced to walk long distances to water points<br>▪ Food insecurity<br>▪ Feeding habits change e.g. number of meals are reduced<br>▪ Reliance on certain fruits as major meals leading to malnutrition and other related diseases<br>▪ loss of weight and sometimes death<br>▪ Skin diseases become common as people will rarely take baths<br>▪<br>▪ Poor hygiene practices due to lack of water | ▪ Pastures for livestock affected<br>▪ Affects food production<br>▪ People are forced to drink unsafe water from the lake or streams.<br>▪ Forced to walk long distances to water points<br>▪ Poor crop and animal yields due to drought<br>▪ Feeding habits change e.g. number of meals are reduced, Reliance on certain fruits as major meals often leading to malnutrition and other related diseases<br>▪ Due to the need for adequate food, loss of weight and sometimes death<br>▪ Women involved promiscuity lead to spread of HIV/AIDS | ▪ Dams and some bore-holes dry-up<br>▪ Water sources shared with animals<br>▪ Positive development of new infrastructure i.e. bore holes and dams |
| 2. Diseases - Diarrhoeas TB | ▪ Lose of manpower due to diseases<br>▪ Chain of infections leading to deaths especially diseases related to poor sanitation are of great concern | ▪ Inability to work due to ill heath<br>▪ Lack of basic necessities<br>▪ Health care costs escalate | ▪ Poor sanitation facilities<br>▪ Positive impact<br>▪ Water sanitation programmes implemented |

| | | | |
|---|---|---|---|
| . HIV/AIDS | ▪ Many people are dying especially the migrant mine workers.<br>▪ Increases cases of AIDS Related Conditions ( ARCs) in the communities e.g. T.B. cases<br>▪ General morbidity<br>▪ Premature deaths<br>▪ Psychological impact<br>▪ Over stretching of available medical services and facilities | ▪ Resources channelled to meet medical expenses for the sick e.g. time, money for drugs and food etc<br>▪ Erosion of family economy<br>▪ Children may have to stop school if it's the head of the household who is sick<br>▪ Families are forced to sell-off assets to meet basic needs<br>▪ Loss of productivity at household and community levels<br>▪ Breakdown of family bonds<br>▪ Increase in the number of OVCs<br>▪ Stigmatization of affected patients | ▪ Over stretching of available medical services and facilities due to greater numbers of people seeking medical attention |
| 4. Environmental degradation | ▪ Animals and people fall in the gullies | ▪ Soil erosion – soils are easily washed away by winds and rains leaving unproductive fields and poor pastures.<br>▪ The resultant fact is poor farming | ▪ Unproductive land<br>▪ Gully formations reducing arable land |
| 5. Pests | ▪ Destroyed crops reducing crop yield and leading to hunger | ▪ Poor harvest<br>▪ Food insecurity | ▪ Impact on field<br>▪ Grazing land |
| 6. Early frost | ▪ Frost bites to people especially<br>▪ Herd boys<br>▪ Animals affected | ▪ Destruction of crops before they mature thus leading to poor harvest which lead to food shortages | ▪ |
| 7. Flash floods | ▪ Contamination of clean waterbodies by run-offs, increasing diarrhoeal diseases<br>▪ Injuries to people and sometimes death<br>▪ Increased mosquito breeding grounds | ▪ Loss of crops growing along the river banks<br>▪ Relocation of affected people, leading to loss of capital assets<br>▪ Food insecurity may result if community fields have been affected<br>▪ Increased soil erosion in areas thus making soils less productive<br>▪ Losses of crops, houses and children | ▪ Landslides that destroy fields and block roads<br>▪ Distraction of houses, bridges<br>▪ Streams become flooded |

## Disaster Preparedness Activities

When asked on how the communities could prepare for the likely disasters, community members explained that some actions can be taken to reduce the impact of disasters although not necessarily to prevent them. There was an understanding that certain actions could be taken to reduce the impact of disaster and their role in the action. Through the use of tools such as community maps, timelines and discussions, communities identified their own coping mechanisms, which they can employ during various disaster situations. They were very much aware of what can be done but needed support in terms of resources to start sustainable community development activities.

In cases of droughts and resultant food insecurity, people employed a variety of coping mechanism such as; gathering of wild vegetables and preserving them for consumption, sale of their livestock and other assets to buy food, reduce number and quantities of meals, do some piecework for money/food or seek assistance from the Government and other agencies. Table 9 indicates some of the disaster prepared actions that communities highlighted.

**Table 9 Disaster Preparedness Activities**

| Type of Hazard | What can be done before the disaster | What can be done during disaster |
|---|---|---|
| 1.Drought – food insecurity | ▪ There is a need for communities to have sufficient storage facilities for storing surplus production as a reserve for future consumption.<br>▪ Winter ploughing should be implemented<br>▪ Drought resistant crops<br>▪ Preservation of seasonal foods should be adopted as a coping strategy, these are foods like peaches, maize, and vegetables<br>▪ Dam construction for irrigation<br>▪ Ploughing of drought resistant crops<br>▪ Cutting of maize & sorghum stock and store for fodder.<br>▪ | ▪ People engage in casual labour such as peace [?] jobs, selling, food for work<br>▪ Informal trading mechanisms like selling firewood, local brewing.<br>▪ Gathering of wild vegetables...<br>▪ Communities feed their animals on aloe plants, which are in abundance when the maize-sorghum stock is finished. |
| 2. Diseases – TB & Diarrhoea | ▪ Health & Hygiene education as a preventive measure - continuous process<br>▪ Immunisation against common diseases for children e.g. Measles, BCG(?)<br>▪ Water and Sanitation projects<br>▪ Construction of latrines | ▪ Seek medical help at both traditional and western institutions<br>▪ Continuous health promotion |
| 3. HIV/AIDS | ▪ Increased focus on prevention activities especially through the youth programmes.<br>▪ Scale up activities for care and support for PLWHA and OVC<br>▪ Promotion VCT and change of behaviour<br>▪ Participation of men, church and traditional leaders so as to reduce vulnerability.<br>▪ Advocate to incorporate HIV/AIDS awareness into school curriculum | ▪ Expand HBC programmes<br>▪ Care and Support<br>▪ Provision of treatment e.g ART |

| | | |
|---|---|---|
| 4. Environmental degradation | ▪ Growing of supplementary fodder to minimize overgrazing and overstocking<br>▪ Rotational grazing<br>▪ Environmental management education<br>▪ Chief to be educated on environmental issues | ▪ Donga rehabilitation<br>▪ Re-vegetation<br>▪ Environmental management education |
| 5.Pests | ▪ Scarecrows for the fields to scare birds away<br>▪ Grow repellent crops like onion | ▪ Use of pesticides |
| 6.Early frost | ▪ Heed meteorology department early warnings.<br>▪ Plant frosts resistant crops | ▪ Ploughing different crops suitable for the weather conditions. |
| 7. Flash floods | ▪ Build houses on high grounds<br>▪ Make water catch furrows<br>▪ Don't use steep terrains for fields or housing | ▪ Provision of temporary shelter<br>▪ Seek accommodation from relatives or friends<br>▪ Reconstruction of shelter |

**Use of Local Capacities and Resources**

Through community mapping, timelines and discussions the communities identified their own resources and coping mechanisms, which they employ during various disaster situations. (Initially there was an element of not revealing any resources or capacities just in case they would not qualify for assistance!) They were very much aware of what can be done within their capacities. In many of the villages visited communities had taken initiatives establish crime prevention committees to safe guard their animals from theft. Crime prevention committees are responsible for the safe upkeep village property and animal stock in the village. During the night hours some men are responsible for kraal watching and also the committee is responsible for strangers that may enter the village. Animals are kept in one community kraal and they are watched by anti stock theft committee overnight

Through the new local authority structures, villages have local councillors who work closely with the chiefs and headmen.

The study showed awareness on the need to capitalize on both human and material resources available in the community. Table 10 shows some of the identified local capacities and their uses.

**Table10 Local Capacities and Resources**

| | |
|---|---|
| **Hospital:**<br>There is a district hospital, which serves as a referral centre for the district. This is well stocked with drugs and has qualified personnel.<br><br>**Health clinics**<br>These provide primary health care and treatment of the sick. This includes aspects of community awareness, health education and maternal health However, villages are sparsely populated; hence some people have to walk for long distance to access health services.<br>**Churches:**<br>These provide spiritual and psychosocial support to communities in times of crisis;<br>They also provide counselling for families, to the | **Local shops**:<br>Small shops are available in almost all villages or in all areas under area chiefs in Lesotho. These are important establishments for the availability of basic needs. Despite how small they do provide emergency needs e.g. one get can always get a candle for lighting.<br><br>**Dip tanks**:<br>These are used for animals' diseases control and mainly used for cattle, sheep and goats. The common disease prevented here is scabies(?). |

| | |
|---|---|
| sick and newly married. Churches through the Christian Council of Lesotho provide health services thorough their clinics.<br><br>**Schools:**<br>These have helped to increase the literacy levels in the community. Free primary Education programme implemented by the government. They are distributed in a way that most pupils at primary level can access them.<br><br>**Fields:**<br>The fields are the major source of food crop production for household food security and for commercial crop production and they are also hired out for financial needs or if the household does not have the capacity for ploughing.<br><br>**Stones:**<br>These are locally available material for building houses and kraal building and furrow making above fields.<br><br>**Water tank**: Used as sources of clean water for domestic use and animal watering and for small irrigation purposes.<br><br>**Pastures:**<br>For animal grazing, infiltration of rainwater, provision of oxygen for the ecosystems and good scenery | **Roads**<br>People have access to public transport, they are able to go to the markets, hospitals and visit other places.<br><br>**Animals**:<br>The are horses which are used as a means of transport , cattle for ploughing, donkies for transportation and for carrying heavy loads, sheep for wool and goats for mohair, animal also used for ritual ceremonies. Animals are also used for H/H income through selling<br><br>**Trees:**<br>Used for firewood, roofing and selling to earn a living. Trees are also used for preventing soil erosion<br><br>**Rivers:**<br>They are sources of water for irrigation purposes as well as used for watering animals. Rivers are source of fish, which is used as food and for selling to make money.<br><br>**Playgrounds:**<br><br>Meant for sporting activities and other social events like meetings (Pitsos.) |
| **Crime prevention committee:**<br><br>The role of the committee is to reduce crime from within the community and prevent thefts which are on the rise within the communities | **Village disaster management team**<br><br>The VDMTs in the villages are responsible for identification of local disasters or hazards and report to the Disaster Management Authority. |
| **Local councillors and chiefs and headmen**:<br>This structure is local government system used as entry points to the communities and used for local management of communities: protection and control disciplinary matters. One other core function is facilitating public gatherings and coordinate community issues with central Government departments, NGOs or general service providers.<br><br>**Local court**:<br>Provision of legal services and enforcement of justice as well as protection of human rights. | **Agricultural extension officer**:<br><br>Provide technical assistance and demonstration on agricultural practices as well as a focal person for diseases control.<br><br>**Village health workers, Support groups and HBC facilitators:**<br>There are basically dealing with health information dissemination and awareness rising on some diseases, some activities they do include weighing of under fives, monitoring of patients on the intake of medication, psychosocial support, nutritional support and referrals |

From the discussion held with stakeholders it became clear that there are a lot of gaps in public service delivery and more concerted and coordinated efforts by players is required to mitigate against disasters. The main challenge is to empower communities to recognize their own capacities and utilize them to change their fortunes. Government capacities are constrained by lack of funds and material resources for disaster management.

**Roles and Capacities of Government Institutions and Non-Governmental Organizations**

In assessing the role and capacities of government institutions and non-governmental organizations in disaster management, participants both the community focus groups and service providers agreed that government and NGOs had a leading responsibility in responding to disasters. During the study, communities believed that the responsibility of disaster management was the responsibility of government and other NGOs.

The district like many other districts has a District Disaster Management Authority (DDMA), which is part of the government disaster management structure and the District Administrator chairs its meetings. Members are drawn from government line ministries, which include health, education, agriculture, water, local government, and local NGOs involved in disaster management. There are village disaster management committees but participants bemoaned the lack of resources to provide necessary services to the community.

Through the DDMA sub committees, a number of lines ministries by virtue of their respective mandate are involved in disaster management. The Ministry of Health through the office of the District Director of Health is involved in epidemic surveillance and response and information management systems are in place up to community level through clinics. Village health workers have been trained and play a very active role in the communities. Home based care facilitators and support groups are doing a wonderful job supporting the chronically sick

Within the Ministry of Health and Social Welfare, district structures transcend down to community level and are providing some relief assistance to identified vulnerable groups. They have trained community-based organizations in identification and selection of vulnerable people.

**Role of Lesotho Red Cross Society**

**Red Cross Branches - Mafeteng and Quthing**

When people were asked about the role of the Red Cross some people could only associate the organisation with food distributions although it has a good working relationship with other stakeholders in the district. In getting information about Red Cross branches of Mafeteng and Quthing from the Divisional Coordinators, it became clear that the Red Cross was well know in the district areas that received food Aid or have the HBC projects. Dissemination of Red Cross Fundamental Principles and its programmes were taking place at food distribution points and were the HBC projects were operating.

The divisions have plans to scale up their projects and to recruit more volunteers and have active branches throughout the districts. The Divisions have Divisional committees, which oversee the activities of the Division. In Quthing Division there are twelve active branches whilst Mafeteng Division has seven branches, five of which are active whilst two are dormant. Divisional Coordinators are employed to coordinate all the activities of the Divisions and supervision of volunteers implementing activities. The Quthing division has staff complement of five project officers in post and the division has 186 volunteers to implement the project activities. Mafeteng has 235 members, 119 of which are youths and 106 adults.

**Programmes:**

The two Red Cross Divisions are well established and can complement government efforts in humanitarian crises. The Divisions are implementing two main programmes:- Health and Care and Disaster Management.

- **Health and Care Programme:**
  The objective of the HIV/AIDS programme is to reduce the transmission of HIV/AIDS and improve the quality of life for persons living with HIV/AIDS, and orphans and vulnerable children. In Quthing the programme is implementing ICHBC project in the constituencies of Moyeni and Sebapala through its branches. The branches have well-motivated, active volunteers and members who undertake programme activities. The volunteers are involved in various programmes activities such as, youth mobilization HBC, food distributions, hygiene promotion as well as dissemination of Red Cross principles. The integrated community home based care programme incorporates Home Based Care projects, food security project and water and sanitation project is still to be implemented. The Home Based Care activities include assisting families in caring for the terminally ill and provide nutritious food and hygiene products to the HIV/AIDS infected and affected households. In Mafeteng the ICHBC projects are in …?….constituencies.

- **Disaster Management**:
  The disaster management programme objective is to prepare and to respond to disasters affecting the most vulnerable people in the district. This programme has been helping vulnerable communities in the district who are food insecure. Activities undertaken including being a partner for the WFP distributing Food Aid to the following categories of vulnerable people, OVC, HIV/AIDS patients, TB patients and chronically ill people, HBC clients, MCH and Vulnerable groups. The branch has also distributed seeds and fertilizer to the HBC clients through the Federation's Food Security appeal 2005. The Divisions have also started to implement the Disaster Risk Reduction project, which is funded by DFID.

- **First Aid**
  The Divisions have people trained in First Aid skills and are able to give first aid training for the business community, as well as care facilitators.

- Humanitarian Values and organizational development are areas that need to be strengthened

**Branch Capacity**

The branch volunteers and members are equipped with relevant skills through training to be able to undertake the programme activities. Staff and volunteers have been trained in various courses in disaster management, food aid distributions, SPHERE minimum standards and conducting assessments.
In Quthing six volunteers (3males & 3 females) have also been engaged to prepare the demonstration garden for the Disaster Risk Reduction project. The branch has all the markings of a well functioning branch and needs to improve its capacity to be able to scale up the activities of the programmes in the district. The division has two buildings, which are used for office and are rental out to raise income for the Division. There are two 4x4 programme vehicles to assist in the implementation of activities. The division has a computer and a printer.

Mafeteng division needs to improve its resource capacity, the division does not have vehicle of its own to enable monitoring of projects neither does it have computers nor office telephones. However, the Red Cross has a good working relationship with other stakeholders in the districts but limited visibilities in the communities except in areas were Red Cross has programme activities.

Limitations of the branches are lack of financial and material resources to expand their activities.

However, the two districts have received funding to enable them to implement disaster risk reduction programmes guided by the needs of the community identified through the VCA process. There are a host of other NGOs who complement Government effort in humanitarian assistance and community development work.

**Table 11**

**Roles and Capacities of Government Institutions and Non-Governmental Organizations**

| | |
|---|---|
| **DDMA**<br>This is a government department responsible for disaster management in the districts. The department works with other stakeholders in coordinating disaster preparedness and disaster respond.<br><br>**World Vision**:<br>Increasing the capacity of life of the rural individuals who are living in poverty through the distribution of food commodities, procurement of tanks for water harvesting and introducing income generating projects<br><br>**Lesotho Red Cross Society Capacity**<br>HBC programmes, Disaster management train care givers at the village level, distribution of food parcels, seeds, medical supplies, as well as paying school fees of orphans<br><br>**MOAFS**:<br>Decentralized agriculture services such as dispensation of agriculture assistants, construction of dip-tanks.<br><br>**MFLR:** supply of forest trees, supervision of dams and soil conservation measures<br><br>**Local councillors**<br>This structure is local government system used as entry points to the communities and used for local management of communities: protection and control disciplinary matters. One other core function is facilitating public gatherings and coordinate community issues with central Government departments, NGOs or general service providers.<br><br>**Local court**:<br>Provision of legal services and enforcement of justice as well as protection of human rights. | **WFP:**<br>Distribution of food commodities in response to emergencies as well as supporting economic and social development.<br><br>**RSDA**: assist in self-reliance projects<br><br>**Teba/Care**: homestead gardens and food distribution<br><br>**UNICEF:** the world's leading agency on child rights. It works for health, education equality and protection for every child.<br><br>**Agricultural extension officer**:<br>Provide technical assistance and demonstration on agricultural practices as well as a focal person for diseases control.<br><br>**Village health workers, Support groups and HBC facilitators**:<br>They basically deal with health information dissemination and awareness rising on some diseases, some activities they do include weighing of under fives, monitoring of patients on the intake of medication, psychosocial support, nutritional support and referrals<br><br>**Local Government Ministries:(Agriculture Health Natural Resources, Works)**<br><br>Provision of Agricultural technical assistance.<br><br>Training on HIV/AIDS and other related diseases.<br><br>Establishment of clinics or mobile clinics.<br><br>Construction of protected springs and<br>Road construction and good roads |

## Chapter 5 RECOMMENDATIONS:

The recommendations emerging from the study are based on the ideas expressed from all group discussions including key informants interviewed. The recommendations are made for the consideration of Lesotho Red Cross to share with all stakeholders.

**Drought (Food Security)**

LRCS needs to work closely with other partners such as Ministry of Agriculture and Food security, MFLR, FAO and WFP and other relevant agencies to assist communities in sustainable livelihoods through food security interventions:-

- Agricultural based livelihoods will need reliable water sources there is need to adress water shortage by fully utilizing the water resource potential from the mountains to be able to develop irrigation farming and livestock water points as well as, promote harvesting of rainwater for domestic use and home garden irrigation by user-friendly small-scale irrigation techniques, such as simple garden drip kits
- Support community empowerment through training on different agricultural techniques such as, conservation farming and use of organic manures. Provide targeted agricultural support with inputs such as, seed packs for home gardens and other field crops, as well as small garden tools
- Greater promotion of agricultural diversity and growing of drought resistant crops and increase crop management by involving the Ministry of Agriculture Extension workers.
- Empowerment of some families who have no agricultural assets to practice communal farming that would enable the sharing of fields and other agricultural resources.
- Provision of training on food utilisation and preservations to ensure continuous food supply e.g. Peaches, vegetables and other cerealsIn case of livestock care communities should grow supplement fodder (ts'aane for animals to improve pastures. Wool shed for sheep and goats should be located within easy reach of communities to avoid long distance travel for animal. Animals travelling travel long distances may cause death of animals on the way and/or affect the quality the wool.
- Deep eroded gullies dominate the landscape of the country therefore concerted efforts of all stakeholders on land reclamation through building of silt traps in the gullies as well as grass and trees planted to prevent and control soil erosion

**HIV and AIDS**

HIV/AIDS is the most important challenge facing Lesotho today and needs to be addressed with a scaled up response on all fronts.

- HIV/AIDS awareness through targeted messages for behavioural change
- Strengthening and supporting community –based responses
- Increased focus on prevention activities especially through the youth programmes.

- Promotion of proper and consistent use of condoms.
- Promotion voluntary counselling and testing (VCT) to enable change of behaviour
- Promotion of anti-stigma campaigns should be intensified.
- Scale up activities in the Integrated Community Home Based Care for care and support of PLWA and OVC
- Involve traditional leaders to change people's cultural beliefs/practices that fuel HIV e.g. wife inheritance – 'a woman whose husband dies the brother to that husband is entitled to inherit the widow'
- Advocate to incorporate HIV/AIDS awareness into school curriculum
- Empower women by supporting them in developing income generation activities
- Formation of people living with HIV and AIDS (PLWHA) support groups for information dissemination and care and supporting to those affected.
- IEC materials supported by personal testimonies of those living with HIV/AIDS should be encouraged.
- Integrate HIV/AIDS prevention strategies into poverty reduction and employment opportunities.

**Diseases:**

- Promote sanitation health, and hygiene practices through health education about personal hygiene and how to keep the environment clean as well as proper handling of the food and how to keep the water clean.
- Educational campaign to educate the communities on the link between various illnesses and drinking of unsafe water and how this could be overcome
- Encourage and support construction and use of VIP latrines
- Support and facilitate the protection of water sources- springs, deep wells, boreholes
- Increase sensitization for communities to take more responsibility for their health by creating a culture of public sanitation and proper waste management. E.g. competitions that foster a culture of cleanliness - tidiest village, keep your village clean!
- Improved pit latrines and protected springs should be constructed.
- Encourage child immunization of common childhood ailments within communities through, Red cross volunteers, village health workers and care facilitators

**Environmental Degradation**

- Awareness of environment issues is very low within the community, which makes it difficult to address on going environmental degradation. A sound environmental management education accompanied by rehabilitation activities like donga rehabilitation, planting of trees and reseeding of grass could prove beneficial.

**Lessons learned and challenges**

- There was poor attendance in two villages so no interviews took place at Sixondo and Ha Peete villages. In one of the villages participants spoke of the conflict of interest between the counsellor and the local chief who do not see eye to eye.
- Time allocated to the process was too short and this put great pressure on the team
- Preparations for similar study should be done well in advance and involve all stakeholders
- Stakeholder involvement from the onset is vital
- Community ownership of the process with the involvement of local leadership is important to get the community support and participation.

**Conclusion:**

This study was received with enthusiasm from all participants and they are eagerly waiting to receive the study results. The results of this study provide a unique opportunity for stakeholders to work in partnership on programmes that reduce people's vulnerability to disasters. The idea is that the programmes would be developed with a more integrated and participatory approach enabling actions in areas of prevention, mitigation, community-health and community development to reduce people's vulnerability to the hazards. For the community to sustain efforts that reduce their vulnerability they need to be able to change any of the limiting beliefs they may have about their capacities. Organizations should provide support that enables the communities to develop and improve their own community resilience to hazards thus changing mindset on dependency.

## Annex 1. References


1. UNDP December 2004, Common Country assessment of Lesotho
2. Palestine Red Crescent Society, 2000, Vulnerability &Capacity Assessment
3. IFRC 1996, Astrid von Kotze and Alisa Holloway, Reducing Risk
4. IFRC 2000, Vulnerability and Capacity Assessment.


## Annex 2

## Quthing District

### Key Informants interviewed

| Name | Institution | Position |
|---|---|---|
| S.Lekoeneha | Public Health | Health Inspector |
| M.Mosenene | Police | Regipol |
| T.Mojaki | Forestry | District Coordinator |
| L.Moletsane | DMA | DDMO |
| M.Tsoaeli | Hospital | Matron |
| M.Matsabisa | Tsatsane Health Center | Nursing assistant |
| P.Masoetsa | Local Government | Councillor |
| P.Nkuebe | Local Authority | Chief |
| S.Hareeng | Local Authority | Chief |
| N.Moshoeshoe | DRD | Development |
| M.Portas | Local authority | Chief |
| K.Sekotlo | Crime Prevention | Secretary |
| M.Matooane | Local government | Member |
| M.Sekhonyana | Local authority | Chief |
| M.Lekhooa | Local government | Chairperson |
| M.Mpiti | Local government | Chairperson |
| M.Mothibeli | Local authority | Chief |
| M.Hlalele | Health | VHW |

## Mafeteng

**Key Informants (insert)**

**Annex 3** **VCA Study Groups**

## Mafeteng District VCA Data Collection Team

| Name | Position | Organization/Ministry |
|---|---|---|
| Maine Makula-**Team Leader** | Disaster Risk Reduction Officer | Lesotho Red Cross Society |
| Mamoqeli Malea-Sekhonyana | Disaster Management Coordinator | Lesotho Red Cross Society |
| Thembikaya Tyali | FFA Monitor | World Vision |
| Lebohang Mokuena | FFA Monitor | World Vision |
| Thabo Rajoele | Executive Director | CDPPM |
| Matoka Moshoeshoe | District Conservation Officer | MOFLR |
| Khosi Sehobai | Volunteer | Lesotho Red Cross Society |
| Motlatsi Mothibeli | Volunteer | Lesotho Red Cross Society |
| Bokang Sebele | Volunteer | Lesotho Red Cross Society |
| Pule Mothibi | ICHBC | Lesotho Red Cross Society |
| Nyakallo Mohapi | NAC | Peace Corp Volunteer |

## Quthing District VCA Data collection Team

| Names | Organization | Designation |
|---|---|---|
| **Mamoipone Letsie** | **DDMA** | **DDMO** |
| **Tiisetso Lekhooana** | **Ministry of Health** | **EHT** |
| **Bonang Let'sela** | **Ministry of Agriculture** | **TA** |
| **Relebohile Lebenya** | **Ministry Forestry** | **RMO** |
| **Puleng Mohajane** | **Quthing Wildlife DT** | **Volunteer** |
| **Seithati Charles** | **Agriculture** | **DFR** |
| **Lieketseng Masunyane** | **Lesotho Red Cross Society** | **Volunteer** |
| **Seeiso Seeiso** | **Lesotho Red Cross Society** | **Volunteer** |
| **Marelebohile Ntsukunyane** | **Lesotho Red Cross Society** | **Volunteer** |
| **Mookameli Mohlokonya** | **Lesotho Red Cross Society** | **ICHBC- Officer** |
| **Kopano Masilo** | **Lesotho Red Cross Society** | **Divisional C** |

## Annex 4 Mafeteng District Focus Group Discussions

| Location | Males | Females | Total | Total village participation |
|---|---|---|---|---|
| Tajane | 8 | 0 | 8 | 73 |
| Ha Seitlheko | 4 | 8 | 12 | 45 |
| Ha Turupu | 6 | 6 | 12 | 80 |
| Mapotu | 0 | 10 | 10 | 32 |
| Tsaeeng | 12 | 0 | 12 | 97 |
| Ha Khojane | 7 | 6 | 13 | 78 |
| Matsepe | 12 | 0 | 12 | 54 |
| Ha Sechaba | 0 | 12 | 12 | 102 |
| Ha Nthonyana | 13 | 0 | 13 | 137 |
| Matlapaneng | 8 | 3 | 11 | 47 |
| | 70 | 45 | 115 | 745 |

### Quthing Participants

| Name of Village | Number of Women participants | Number of Men participants |
|---|---|---|
| Seforong | 107 | 68 |
| Peete | 9 | 11 |
| Tosing | 117 | 69 |
| Sixondo | 13 | 8 |
| Tsatsane | 40 | 22 |
| Mohlakoana | 14 | 59 |
| A'Skop | 89 | 52 |
| Mphaki | 43 | 39 |
| Mount Moorosi | 53 | 23 |
| Mosenenke | 51 | 24 |
| | 536 | 375 |

*N.B. In the villages of Peete and Sixondo, the survey was not conducted due poor attendance from the villagers.*

Annex 5

## SEFORONG VILLAGE HISTORICAL BACKGROUND

| Year | Events |
|---|---|
| 1971 | Sheep scab affected goats |
| 1986 | All horses (31) in the village died due to unknown horse disease.<br>Most houses were blown by the strong winds.<br>The number of houses not known |
| 1994 | Drought affected crops hence low production<br><br>Trans-boundary conflicts |
| 2000 | 13 people died due to diarrhoea |
| 1994-2003 | Trans-boundary conflicts loomed over stock theft and a no. of people died. |
| 2002 | Drought affected crops hence low production |
| 2006 | Bollworm attacked the fields |
| 1993-2006 | People begin to die due to chronic illnesses and also the prevalence of STIs begins.<br>Protracted drought which lead to low food production. |
| 1995-2006 | Unplanned teenage pregnancies due to alcoholism and prostitution, which came with road construction and newly, established sheebins. |

Annex 6

SEFORONG VILLAGE SEASONAL CALENDER

| | Jan | Feb | March | April | May | June | July | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Drought | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| Crime | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| Harvest | | | | | √ | √ | √ | | | | | |
| Snowfall | | | | | √ | √ | √ | | | | | |
| Rape | √ | | | √ | | | | | | | √ | √ |
| Bollworm | √ | √ | √ | √ | √ | | | | | | | |
| Promiscuity | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| Heavy rainfall | √ | √ | √ | √ | | | | | | | | |
| Human Diseases | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| Alcohol abuse | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| Hunger | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ | √ |
| Soil Erosion | √ | √ | √ | √ | | | | √ | √ | | | |
| Lack of water | | | | | | | | | √ | √ | √ | √ |
| Strong Winds | | | | | | | | | √ | √ | √ | √ 1. |

**Annex 7** **Guidelines for facilitators**

**Focus Group Guide**
**Target Group: Communities Vulnerable to Disaster Risk**
**(Mixed Group, Men Only, Women Only )**
**Target Area: Quthing and Mafeteng, Lesotho**

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**Resources Needed:**

- Moderator – 1 per group matched on demographics of participants
- 2 note takers per focus group matched on demographics of participants
- Team to analyse, write report/results
- Timeframe start to finish all activities: approximately 2 weeks.

1. **Objective of the Focus Groups:**
   To illicit the community to self-analyze the causes, impact of vulnerable to disaster risk and to prioritize and develop potential realistic interventions utilizing local resources

2. **Recruitment of Participants**:
   Participants for the Lesotho Disaster Risk Reduction (LDRR) focus groups should be recruited from the population at large. They can be randomly selected at large gathering places (ex. Introductory meeting (pitso) according to the specifications of the group desired. Efforts should be to ensure that a mixture of ages are included in all focus groups. In the mixed gender group, a gender balance should be maintained. It should be explained that the focus group will take approximately 1-1 ½ hour of their time. It can be explained in a general way the topic of discussion. . Beverages can also be served to make the setting less formal and therefore facilitate the discussion.

3. **Moderator**
   (note: demographics of moderator should match participants). Additionally it is important that the moderator be perceived as impartial and neutral. In order to facilitate this, no relatives of the moderator should be a participant in the focus group. A moderator's training guide is available separately**.**

4. **Location of the Focus Group:**
   Select a location that is neutral and quiet, preferably indoors. Government offices, health facilities and churches are often not good locations. Schools, neutral community centers that are well accepted to a community are often good locations. Arrangements for a location should be completed BEFORE a focus group is organized.

5. **Introductions and Verbal Consent:**
   Welcome the participants and thank them for coming. Make sure people have stopped jostling around and begin introductions.

   **Do you agree to participate? YES/NO**

7. **Once verbal consent is received, explain group norms**:
   - Everyone should participate
   - Listen to others
   - Do not interrupt when someone is speaking
   - Do not judge someone else's opinion
   - Give others a chance to speak
   - Feel free to say what you think

8. **Documenting the Focus Group:**

The people taking minutes should write down the main ideas of everything that is said in the focus group using phrases and statements exactly as they are worded in the local language. They should NOT use shorthand, or try to fit the discussion into the format of the focus group guide. A focus group is a discussion, and as people talk the group will drift from topic to topic. Documented discussions may not be in the exact order of the focus group guide.

## 9. Moderator Instructions -- How to manage the group

**Facilitation**
Your task is to facilitate discussion and keep it focused on the question. It is essential that you avoid expressing your opinion, displaying non-verbal reactions such as surprise to responses or interacting in any way other than clarification and feedback to participants. All discussions and facilitation should be in the local language and all focus groups facilitators and transcribers should be fluent in the local language. The focus group should be conducted in the local language.

**The Questions**
The questions are designed to elicit general perceptions of the community. If one or more participants start providing personal stories that are off-topic, let them finish their thoughts, thank them for their viewpoint, and then ask them to speak as a spokesperson/representative for their community; and repeat the question.

**Over-participation**
If one or more participants are dominating the discussion, remind them of the group norms. Try to refocus the discussion on the under-participators

**Under-participation**
If one or more participants are not participating in the discussion, try to draw them into it by asking what they think about the issue being discussed.

**Clarification**
If incomplete or vague comments are made, ask the person to explain the point in more detail.

Focus
If the discussion gets off track or strays from the focus group question, remind the participants that the task is to discuss the question. Restate the question to the group to refocus its attention.

**Silence**
Silence can be insightful and should be noted by the recorders when it occurs. However, if participants are not responding, it may be that they do not understand the question or feel uncomfortable responding. In this case, rephrase the question and wait until someone replies.

## 10. Focus Group Guide
Read the focus group questions. This is a guide; and there can be flexibility in the order in which the questions are asked as long as all topic areas are covered. Some questions may not even be asked directly as participants may bring up the questions themselves during the course of the discussion. The moderator should just make sure all topics are covered.

***This form should be filled out for EACH focus group conducted***

**Date:** _____

**Name of Location (Village,Division, etc.):** _____

**Type of Group (Mixed; Men; or Women Only):** _____

**Name of Moderator:** _____

**Name of Note Takers:**

_____ _____

**Start Time**: _____ End Time: _____

Participants **(Should be not less than 8; not more than 12 participants).**

*Please note that individual names are not collected!*

| ID # | Age | Gender (M or F) | Ethnic Group | Village/Community |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
| 11 | | | | |
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**TOPIC CHECKLIST**

| **Topic 1** | **Your Community and Disaster Identification** |
|---|---|
| 1.1 | What disasters affect the community? When and how often? What hazards are there in the community? What are the locations? |
| 1.2 | Who is most vulnerable to disasters in your community? Why? |
| 1.3 | What factors are aiding or fueling disasters? |

| **Topic 2** | **Disaster Risk Reduction Problem Identification**<br>*(A flipchart can be used to facilitate the discussion)* |
|---|---|
| **2.1** | Can disaster be reduced? What factors identified as contributing to disaster risk can be reduced or eliminated? |
| **2.2** | Using the factors as the basis of discussion—Who can improve the situation for each of the factors—Government, Community, Household? |
| **2.3** | Out of all the factors listed, prioritize them in order of importance to the community |

| Topic 3 | **Disaster Preparedness and the Community** |
|---|---|
| 3.1 | **What action can you take – before, during and after disasters?** |
| 3.2 | What are the roles and capacities of local institutions in disaster management (i.e. council, ministries and NGOs)?<br>What is the role and capacity of LRCS in disaster management?<br>What role can local community play in building their lives after a disaster event? |
| 3.3 | **What are your recommendations ?** |

**Wrap Up (about 5 – 10 min.)**

Are there any additional comments? This has been a very nice discussion. We hope that you enjoyed it. **Thank you very much for your help. Thank you again.**