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Re-focusing the Gender Lens: Caregiving Women, Family Roles and HIV/AIDS Vulnerability in Lesotho

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Abstract

Gender and HIV risk have been widely examined in southern Africa, generally with a focus on dynamics within sexual relationships. Yet the social construction of women's lives reflects their broader engagement with a gendered social system, which influences both individual-level risks and social and economic vulnerabilities to HIV/AIDS. Using qualitative data from Lesotho, we examine women's lived experiences of gender, family and HIV/AIDS through three domains: 1) marriage; 2) kinship and social motherhood, and 3) multigenerational dynamics. These data illustrate how women caregivers negotiate their roles as wives, mothers, and household heads, serving as the linchpins of a gendered family system that both affects, and is affected by, the HIV/AIDS epidemic. HIV/AIDS interventions are unlikely to succeed without attention to the larger context of women's lives, namely their kinship, caregiving, and family responsibilities, as it is the family and kinship system in which gender, economic vulnerability and HIV risk are embedded.

Keywords

gender; women; HIV; southern Africa; economic vulnerability

Introduction

Gender dynamics are an important factor underlying HIV and AIDS in southern Africa [1], where 2–3 times as many women under age 30 are HIV-infected as men [2]. Existing research highlights the ways that gender inequality enhances women's HIV risk: through men's greater sexual relationship power, women's inability to negotiate consistent safe sex [3], and intimate partner violence [4,5]. Historical factors such as labor migration and family disruption have reinforced existing gender inequalities, rendering both individuals and households more vulnerable to HIV/AIDS [6,7]. The small southern African nation of Lesotho exemplifies these trends: historically a source of migrant labor for South Africa's mining and other industries [8], the country experiences a severe HIV epidemic in which twenty-four percent of the general adult population aged 15–49 is HIV-infected (27% women and 18% men), the third-highest HIV prevalence in the world [9,10].

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In response to the HIV pandemic, global health policy explicitly acknowledges the importance of addressing the gendered needs of women and girls within the HIV epidemic [11–14]. Indeed, the past decade has witnessed an expansion of 'gender and HIV' programs, with diverse objectives including women's HIV prevention, education and awareness, reducing gender disparities in AIDS treatment and care, promoting gender equity, and microcredit lending [14,15]. There are now calls at policy level to 'move beyond gender as usual' [11] to support a 'second-generation' of gender and HIV/AIDS programs [14]. Yet the multiple dimensions of women's gendered vulnerabilities in relation to HIV/AIDS are rarely considered holistically, particularly their intersection with women's kinship and family roles. Few current policies address the realities of women's lives across individual, family and household levels [16–18].

This paper examines women's lived experiences of gender, family, and HIV/AIDS in Lesotho, namely how women enact social and caregiving roles within a gendered family and household context. We argue that efforts to address HIV/AIDS risks and vulnerabilities are unlikely to succeed without attention to the family and kinship systems in which gender, economic vulnerability, and HIV are embedded.

Background

Marriage, Family Dynamics, and the Social Context of HIV/AIDS in Lesotho

In many parts of southern Africa, marriage is symbolized by the customary practice of *lobola* or *bohali*, the payment of bridewealth from a man's family to the family of the woman he intends to marry [21]. The concept of bridewealth, which often occurs as an elongated process over many years, remains central to the socially constructed gender roles that define men's and women's place in society. In recent years, a rising age of marriage has changed household and family roles for men and women, although significant gender inequalities remain both within and outside of marriage [19, 20]. In Lesotho, while the institution of marriage may be changing over time, most all men and women marry. As of 2009, over 90 percent of adult women and men above age 30 were ever-married, with the median age of first marriage at 20 years [10]. Likewise, most women become pregnant and give birth during their reproductive years. In 2009, 90 percent of 40 year old women reported at least one birth [10]. In short, marriage and motherhood are near-universal experiences among women in Lesotho. These experiences, and the gendered family and kinship responsibilities that accompany them, are central to their daily lives and decisions, and thus fundamental to any understanding of gender and HIV/AIDS in this setting.

For decades, marriage and family dynamics in Lesotho were influenced by the 'oscillatory' labor migration common to southern Africa [8, 21–23], whereby men moved back and forth to South Africa's mines on a regular schedule that required long – sometimes semi-permanent – absences from home [22, 24]. The negative impacts on family cohesion, household dynamics and well-being included high levels of marital and family instability [8, 19, 25–29] that continue to this day [7,30]. Labor migration and the spousal separations that resulted also contributed to sexually transmitted infections [31–35], creating a 'near-perfect environment' for HIV infection to spread [36].

Recently, patterns of labor migration have changed [37]. Although as many as half of Basotho men were migrant laborers in South Africa in the 1960s and '70s, economic decline in the mining sector and increased layoffs since the mid-1990s have restricted those opportunities. Somewhat surprisingly, the large-scale return of men to Lesotho has not occurred, signifying the difficulty of reversing such entrenched and longstanding patterns. Increasingly, employment opportunities have shifted away from younger to older men, as well as to female migrants, who may work as domestic laborers or in South Africa's

informal economy [38] and within Lesotho, generally in the textile industry [37]. Thus, present-day households are often characterized by intermittent earnings from multiple members, both male and female, rather than the steady, long-term employment of a male household member. The economic consequences have been considerable: poverty, household-level inequality, and food insecurity have all increased in Lesotho in recent years [37].

Gender, Sexual Partnerships and Women's HIV Risks

The semi-permanent absence of men from Lesotho is sometimes credited with expanding women's roles and autonomy [25,26,39]. However, this increased autonomy occurred within a broader system of legal inequality and disability, economic dependence on men, and widespread sexual violence and discrimination [39], and has been specific to the household domain [40]. Certainly, male out-migration increased the number of 'female-headed households', but real bargaining and decision-making power was often retained by men, who remained property owners and household heads even during long periods of absence [23,25, 30,41].

Fifty-six percent of Lesotho's HIV-infected population are women [42]. Unlike most southern African countries where marriage rates are falling [43,44], and a late age of first marriage is associated with high HIV prevalence among women [45], young women in Lesotho marry early - but still experience high levels of HIV infection. In addition to migrant labor and family disruption, explanations for Lesotho's high HIV prevalence include multiple partnerships, both before and after marriage [46,47], gender inequalities, and high levels of gender-based violence [48]. About 20 percent of young women experience a teenage pregnancy [10], indicating high levels of premarital sexual activity [49].

The disproportionate impact of the HIV/AIDS epidemic on women's caregiving burdens and economic vulnerability has multiple consequences for families and households. HIV/AIDS may lead to an expansion of household size through the addition of orphaned or other vulnerable children [50–55], or through absorbing and caring for sick family members [56,57]. Further, HIV/AIDS may increase household fluidity, via children's migration, parental death and other mechanisms [58,59]. Overall, households may face increased household needs in the face of HIV/AIDS, at the precise moment when there are fewer economic resources available [52,60].

Using data from household interviews with caregivers of young children in Lesotho, we consider whether and how women's multiple social and caregiving roles – as wives, mothers and caregivers - within families and households, influence both individual risk for HIV infection, as well as broader social vulnerabilities, creating circumstances in which women both affect, and are affected by, HIV/AIDS.

Data and Methods

Study Setting

Lesotho [population: 2.2 million] is a small nation located within the borders of South Africa [61]. In spite of its proximity to South Africa, the African continent's wealthiest nation, Lesotho is among the poorest countries in the world, with annual per-capita income of about US $500. This study was conducted in two sites in the southwestern lowlands of Lesotho. These sites included a 'town' village close to the main road and a rural mountain village, about two hours from the town village by foot. The 'town' village had numerous amenities, including shops and regular transport. Residents had diverse economic profiles, from subsistence agriculture and modest homes, to highly furnished multi-room homes,

generally supported by family members working elsewhere. In the rural village, residences were generally small and without electricity or running water; most residents were farmers.

Study Design and Sample Selection

The data were collected as part of the Lesotho Children's Project, a research project which investigated family and household organization, including children's care and outcomes, in the context of HIV/AIDS. As part of this project, interviews were organized around 74 focal children aged 0–14, who were selected purposively to assure variation along three axes: 1) living arrangements, i.e., children who resided with a biological parent and those who did not; 2) diversity of household socioeconomic status; and 3) town and rural residence. Open-ended interviews with children's caregivers (N=68 women and N=6 men), children aged seven years or older, and other community informants, were conducted over an eight month period in 2003–2004. The analysis sample for this paper includes the 68 interviews with women caregivers. These interviews included detailed conversations about relationships, responsibilities, decision-making, and day to day family life.

The women caregivers ranged in age from 17 to 78. Most of the caregivers were related to the focal children as mothers (n=40) or grandmothers (n=19), who were predominantly maternal grandmothers (n=12), but also included 1 great-grandmother, 1 step-grandmother, and 5 paternal grandmothers. Other women caregivers included aunts (n=6), sisters (n=1), and other more distant relatives (n=2) and non-relatives (n=1). Approximately two-thirds of the caregivers (n=46) were married, although only one-third of those lived permanently with their spouses. Six women were divorced or permanently separated, and the remainder – generally younger women, from the group of 24 caregivers aged 30 and under – were never married. About half of the caregivers lived in the 'town' village, and the remainder in the rural village.

Data Collection

Data were collected using semi-structured interview guides by the authors and two research assistants in the language, Sesotho or English, preferred by the caregivers. Most interviews lasted between one and two hours, and focused on children's lives in a high HIV prevalence setting. All caregivers were asked questions about household membership, and the social, health and educational status of resident children. The ensuing discussions, in turn, shed light on kinship, living arrangements, marital and family relationships, including caregivers' own partnerships, and the relationships of the focal child's biological parents. Normative understandings of gender relations and women's autonomy were examined using a short vignette and questions posed about marriage practices and their implications.

Data Analysis

Data management and analysis were conducted with NVivo [62], using a structured, hierarchical coding process. First, primary coding categories were identified, and the range of themes within each category. Next, a structured coding scheme related to 'gender, marriage and family relations' was developed [63]. That coding scheme was then applied to the data in a team process involving three coders (two native speakers of *Sesotho*; one native English speaker), who synthesized the coding list, made analytical decisions, including the addition of new codes, and assessed inter-coder agreement. Following coding, the data were reviewed to distinguish analytical domains and major thematic categories, from which three main themes emerged: 1) contexts of marriage; 2) kinship and social motherhood, and 3) multigenerational dynamics. Two other themes – 'HIV/AIDS' and 'household economic needs' – had relevance across the categories of analysis, and thus were retained as cross-cutting themes. Full transcripts (general level) were used to retain the 'context', while illustrative quotes relevant to each theme (specific level) were extracted. Narratives of

women's daily lives, particularly family and household-level experiences, emerged from the transcripts. The narrative and thematic data were triangulated, to assess similarities and differences across analytical themes, and between different respondents, and to develop thematic analytical pathways. This process elucidated the broader concepts of 'social vulnerabilities', to describe women's physical and symbolic location in households characterized by isolation and poverty, and also the idea of women as both 'affecting' and 'being affected by' HIV and AIDS. In this way, the analytical process revealed the gendered pathways through which women's family roles affected their HIV risk and broader household vulnerability to HIV/AIDS.

Ethical Approval

Research protocols were reviewed and approved by the Brown University Institutional Review Board.

Findings

The study findings address three main analytical domains – contexts of marriage, kinship and social motherhood, and multigenerational dynamics - and the relevance of each domain for women's HIV/AIDS risks and vulnerabilities.

Contexts of Marriage

Women's narratives explicitly and implicitly emphasized the importance of marriage, revealing it as an institution that shapes gender and kinship, and the lens through which most women experience and interpret their adult lives. Women's narratives emphasized the need to 'have a nice stay' with one's husband, meaning fulfilling a marriage through successful entry into his family's home and the bearing of children, and maintaining harmony in a relationship:

> I: When a person is married how should she work things?
>
> R: She should work things by the way her husband likes.
>
> 58 year-old maternal grandmother

When asked directly about gender relations and female autonomy, women responded similarly, drawing the lines of acceptable behavior and stating the rules regarding marital decision-making, as with this 25 year-old single mother: '*When I'm married I'll listen to my husband and mother-in-law*', thus reinforcing the singular importance of marriage.

For most of the caregiver women, however, the reality of their lives was altogether different. As expected, women's narratives painted a picture of frequent spousal separation related to men's work-related migration. In Lesotho, attitudes and expectations about marriage and family life are rooted in the lived experience of long-term conjugal separation and male absence, consequent uncertainty, and household and family fluidity. Thus, although the institution of marriage remains intact, the disruption of individual marriages and households is extremely common. Indeed, in these narratives, such absences often had the feeling of being semi-permanent. At the same time, and more unexpectedly, women offered explanations of multiple other factors underlying family disruption, including frequent separation between parents and children.

Women's narratives acknowledged the risks for HIV infection that they faced from men's extramarital partnerships. As one 45 year-old caregiver woman said: *I do not want my husband to come back because I fear him now. My husband has been staying with many wives and I do not know now if he has STDs, most especially AIDS*. In addition to these

explicit references to risk of HIV from their husbands, many women's narratives included more implicit discussions of HIV/AIDS, often through references to family members who had died.

Thus, although women's narratives elaborated the centrality of marriage to their lives, stories and accusations of spousal abandonment, separation and divorce were also common. A number of women openly discussed divorce, and some reported leaving husbands who disappeared or were unfaithful, as in this case of a 35 year-old mother:

> I: What's the cause of your divorce?
>
> R: He is naughty.
>
> I: How?
>
> R: He was always running and chatting with women so I just found that I can't cope with that situation.
>
> 35 year-old mother caring for multiple children

Some women reflected a sense of enhanced autonomy through managing their own lives, often including the affairs of a large household. Women's narratives reflected a palpable sense of agency around control over household decision-making. Divorce was discussed as an acceptable outcome when a man was not fulfilling his expected social role; the few divorced women in the study reinforced this viewpoint. These women viewed divorce as a relief, with the permanent severing of ties to a bad marriage, whereas separation – no matter how permanent – could mean a husband's eventual return. Given the frequency of spousal separation and the fact that so many aspects of women's lives are carried out in the relative absence of men, changes in marital status or the long-term absence of a spouse often did not bring about great changes in women's everyday lives,

Frequently, economic realities played a strong role in marital decision-making. One woman explained her separation from her husband as follows: '*The separation came due to the survival that comes about food and clothing*'. In fact, the economic difficulties associated with spousal separation were a constant – and fresh - theme in women's narratives, as in this maternal grandmother's situation:

> Respondent (R): He comes home after 3 months but he still has a chance of coming every month. …
>
> R: It's really bad. … you'll find that I have … basic needs and I become unable to satisfy them because of being without money.
>
> 51 year-old maternal grandmother

Below, a young mother discusses how she copes with her child's financial needs:

> R: My brothers are helping me but even myself, I'm not just resting, I'm doing part time jobs like washing or whatever is available.
>
> I: How are they helping you?
>
> R: They're working in the mine so if I say 'M doesn't have school shoes they just provide the money for them.
>
> 32 year-old divorced mother

Women's narratives frequently conveyed a sense of relentless economic need, compounded by bearing primary responsibility for managing households and raising children.

Kinship and Social Motherhood

As a primary means through which women perform kinship duties, the status of motherhood – denoted by the respectful Sesotho term *'ma* – is vested with enormous social importance. Motherhood is a social rather than a strictly biological role. In the caregiver interviews, women frequently referred to the presence of *'a child who is not our own'*, making clear the child's relationship to the household, including the absence of biological parents. Whether a woman serves as a child's mother is determined not only from their biological relationship, but also from a woman's personal characteristics, including age, marital status, availability of material resources, and overall suitability, including her own marital and household situation. The caregiver women emphasized how their performance of 'social motherhood' was linked to their status as married women. Many explained that being suitable as a mother is contingent on a woman's marital status, as only a married woman should fulfill this role. Thus, when women spoke about the meaning of their role as mothers, they often referred specifically to marriage:

> I: What does being a mother mean to you?
>
> R: It means that I'm married.
>
> 61 year-old maternal grandmother

Or:

> I: How did it come that K stays here?
>
> R: Her mother isn't married…
>
> I: Who decided that she should stay here?
>
> R: Her maternal grandparents decided.
>
> I: Why?
>
> R: Because her mother wasn't married.
>
> 40 year-old aunt, primary caregiver

Women's narratives focused on the multiple family-centered, caregiving activities that formed their daily responsibilities, generally associated with their husband's family. Many of the 'older' women caregivers - on average in their fifties and sixties - discussed their substantial responsibilities for raising children within households that often included their own adult children and sometimes grandchildren, the children of unmarried family members, including their own daughters or nieces, and an extended family group that included both kin and non-kin members. Women's narratives offered three main mechanisms through which such household expansion occurred: a daughter's premarital pregnancy; parental deaths, generally due to AIDS; and inclusion of adult members in need of care or support, often due to AIDS.

The expansion of women's kinship duties due to HIV/AIDS was evident, as most households had additional children and adult members in need of care. One caregiver in her forties recounted a story of caring for paternal kin: '*It's hard because many things occur in life, like now my husband's sister got sick for 13 years, and she died, so I am now responsible for my children and her children because in their family, there's no one who cares for them'*. In many such stories, references to AIDS were implicit rather than explicit, but conveyed the clear understanding that a child's parents, or other family members, had died due to AIDS.

The accommodation of an extra child or children in a household through social mothering, although undertaken willingly, often raised economic concerns, as discussed below by a grandmother:

> R: The reason I am saying that the father is not working … I sometimes get parttime jobs to ensure that they get what they need.
>
> I: Who is helping you to bring-up the children?
>
> R: My brother is the one helping me. … He is in Maseru. He makes sure that my children get food, clothes and go to school, but I don't have to wait for him. I still have to look for jobs.
>
> 68 year-old maternal grandmother

Women's caregiving burdens also expanded with a daughter's premarital pregnancy, as responsibility for the infant frequently fell to them. In spite of the increasing pressures on households related to HIV/AIDS, caregiving women often spoke first about premarital pregnancy when asked to discuss their increased household size. These situations were common; at least 20 of the caregivers were responsible for a child – sometimes their own – whose mother had a pre-marital pregnancy. Kinship rules dictate that a maternal grandmother is considered a child's mother if the biological mother is unmarried, or if she is otherwise unavailable or unable to care for the child. As one maternal grandmother noted: '*there's nothing that I know [about the boy's father], so this has become my child forever*.' As a member of the mother's family, the child will adopt the maternal family name, not the father's name, leading caregivers to describe the child by saying '*that child does not have a father'*, a reference to the parents' unmarried status.

Frequently, women's narratives linked an unplanned pregnancy to the topic of marriage, often faulting a young man not for making his girlfriend pregnant, but rather for not marrying her, as in this 45 year old woman's story about her daughter and the grandchild she now cared for: '*that's what happens … when you meet with a boy who won't marry you*'. Young women with pre-marital births are expected to marry eventually, even if they do not marry the father of their first child. Usually, any child born prior to her marriage will stay with a young woman's family when she marries, as she is expected to adopt a primary commitment to her husband's family. This may also mean that she no longer sends money or other resources to her child at home. Such examples illustrated the ways in which a daughter's marriage – although strongly valued – could lead to resource constraints in her parents' home.

Multigenerational Dynamics

The caregiver women's narratives balanced carefully between their expressions of support for marriage and the patriarchal domain, and their more practical assessments of the day-to-day management of their households and lives. Few women lived in households with a male head present on a permanent basis, and few absent spouses were able to provide regular remittances. Consequently, many households relied upon married women for primary maintenance of the family and household domain, a reality that contributes to the general impoverishment of many households. In these multigenerational households, women appeared to make strategic decisions regarding household caregiving and economic needs. In some households, younger women – often possessing greater education and skills - took paying jobs, sometimes working away from home as migrants.

For some younger women, then, intergenerational relations were shifted through a new role as a wage-earning member of a household. In some instances, young women pursued paid labor to provide economically for a child, especially in the case of a premarital pregnancy.

In such cases, the responsibility of 'caring' for a child took on multiple meanings, in this case an economic one. Younger women's roles also emerged out of their unmarried status, which relieved them of some formal kinship responsibilities, but also increased pressure to contribute economically. The narratives of younger women in the sample shed light on their economic difficulties, living as unmarried daughters in their parents' home. Young, unmarried mothers faced particular pressures around working to support their own child and to provide for their family, and were acutely aware of the economic difficulties facing their children:

> I: What do you dislike about the way you live?
>
> R: I do not want her to live the way we live now. I don't have money but life is money now a days.
>
> 34 year-old single mother

The narratives of both the younger and older women made clear the substantial consequences of a premarital pregnancy. First, the costs of raising the child are often borne entirely by an unmarried woman and her family. Second, experiencing a premarital pregnancy as a teenager pushes a young woman very early into responsibility for a child, which may take multiple forms, including leaving home to find work, which may in turn increase their HIV risk. And third, premarital pregnancy signifies potential exposure to HIV infection from unprotected sexual intercourse at a young age. Most young women – or the grandmothers who spoke about their daughters' unintended pregnancies – did not have ongoing relations with the child's father and would not have known his HIV status. The fact that many young fathers simply disappear reinforces the gendered nature of young women's family and economic roles, leaving them with the responsibility of care and upbringing, as well as significant personal and social consequences.

Discussion

These household-level interviews with women caregivers yield insights into women's lived experiences of marriage, and the accompanying social roles of mother, wife, and household head, and the ways that each of these primary social roles enhance women's risk for HIV/AIDS. In the present era, two new social phenomena - a sharp decline in economic circumstances for many households, and the advent of the AIDS epidemic – have been layered onto the established fluidity of many marital and household arrangements. Through examination of the study's three central themes – marital contexts, kinship and social motherhood, and multigenerational dynamics - these findings illustrate the multiple ways in which women's gendered HIV risk is conferred, as well as the gendered consequences of the epidemic itself, elucidating the mechanisms through which women both affect, and are affected by, HIV/AIDS. We use the concept of caregiving as a central lens through which to view these themes in women's lives.

Women's narratives provided a snapshot of marital relations that emphasized men's symbolic as well as physical absences, a reality sharpened by the frequent lack of social or economic contact. Married women's roles as caregivers and de facto household heads are correspondingly isolated, and often impoverished as well. Thus, women's individual HIV risks are increased *within* their marriages, through spousal absence and the increased likelihood of extramarital relationships, and also *because of* the circumstances of their marriages, in which women are responsible for family and household well-being, including a greatly expanded caregiving burden related to HIV/AIDS. Women's place in the gendered family system thus simultaneously increases their caregiving load, HIV risk and economic vulnerability.

These findings support and extend a wide range of studies on households, families, and well-being in the context of southern Africa's HIV/AIDS epidemic. Our findings from Lesotho reveal, in effect, a second generation of 'stretched households', in which household life is centered around caregiving women and a growing number of dependents [52, 64,65], in a setting where most individuals and their households are affected either directly or indirectly by the AIDS epidemic [66]. Yet the context of Lesotho is unique. The co-incidence of the AIDS epidemic with reductions in male migrant labor remittances has been devastating to the economic foundation of most households and families. Throughout the interviews with caregiver women, there is a palpable sense of men's absence from women's daily lives, and the ways that women manage within this daily reality. In contrast to other settings where extramarital partnerships may represent an economic survival strategy for women, in rural Lesotho communities, men and wealth are both noticeably absent, a reality with important social and economic consequences for women and households.

This analysis has aimed to further the discussion of gender and HIV/AIDS through attention to the broader and often-neglected dimensions of women's daily lives and experiences of kinship, caregiving and family. To do this, we deconstruct the idea of gender to examine how women 'perform' gender through daily responsibilities related to expected kinship and social roles. While a number of studies have examined the links between poverty and HIV [6,67], or between gender and HIV [1–3], as well as a substantial literature on gender and poverty [18, 68–70], most research has not incorporated the broader perspective of gender, family and kinship. Increasingly, scholarship on Southern Africa across a range of disciplines examines the *impact* of AIDS on poverty, women, or households [7]. In this work, we expand the focus to examine how women's individual risks for HIV are linked to gendered family roles, which remain centered around marriage, as well as how AIDS itself impacts women's ability to fulfill these roles [17,18].

Although our specific findings are not generalizable beyond the context in which the data were collected, the centrality of kinship, caregiving, and family responsibilities to women's lives and women's experience of HIV/AIDS, the larger message of this paper, has broad relevance. Notably, research on HIV risk and management does not conventionally draw on interviews organized around caregiving; it is precisely this focus that provided a vantage point from which to elaborate the relevance of women's family and caregiving roles in conferring individual level-level risk and broader social vulnerability for HIV/AIDS. We illustrate this point in Lesotho, where the HIV epidemic is severe and the caregiving needs are deep.

Policy Implications

With recent analyses highlighting the importance of using a 'gender lens' to formulate global health policy [12], now is a good time to expand the focus on gender within the global AIDS response [15]. Further, the mandate to build economic opportunities for women is now an explicit component of US global health policy. An evidence-based consensus now supports the idea that changing gender role norms is an important HIV prevention strategy, and that strengthening the enabling environment via a multi-pronged gender strategy will yield important desired results [71]. Yet few HIV/AIDS programs address women's kinship, caregiving, and family roles, or the influence of these roles in shaping economic vulnerability.

Lesotho's forward-thinking response to HIV/AIDS seeks to address both those 'infected' and 'affected' by the epidemic [42]. At policy level, passage of Lesotho's 2006 legislation granting equal status to married women, and recognizing their social, political and financial rights, was an important first step [42], although societal perceptions of men's power and rights within marriage remain [30]. Lesotho has also achieved gender equality in measures

of health and literacy [72], even with low overall levels. It is important to ask how existing programs target the gender-defined needs and realities of women, and how to build on initial strengths.

To start, focusing on 'women-centered caregiving' would recognize the reality of expanded household membership, a declining or unstable economic resource base, and an increased caregiving burden for individual women in HIV endemic settings like Lesotho. Providing support for men's renewed involvement in families could also strengthen households by alleviating gendered constraints to men's participation [73,74]. Further, with over half of adult HIV infections in women, attention to the gendered dimensions of women's individual risk is important – including HIV prevention messages specific to the demographic group of married women, an often overlooked risk group [67,75]. Lesotho's program to provide 'child grants' for caregivers of vulnerable children, initiated in 2009, is an important step toward recognizing the importance of economic and livelihood strategies for women, and providing needed resources to some of the country's poorest and most AIDS-affected households [76]. However, more evidence is needed regarding the relative benefits of household economic support, microcredit schemes, income generating activities, and indirect measures such as food security and assistance [6,77]. How to link financial resources to HIV prevention, and target them directly to women caregivers should be a top policy research priority. Evidence now supports holistic, integrated gender programs that include at least some of these options. Adopting an integrated strategy focused on building women's 'protective assets' could reduce HIV risk and social vulnerability [78], as well as gender inequalities more broadly, and provide a more concerted response to the gendered factors underlying the HIV/AIDS epidemic in Lesotho and similar settings. Such efforts would support calls to strengthen the enabling environment, building support for the 'gender foundations' of the AIDS response' [15] in pursuit of a better individual, family and household-level response to HIV/AIDS.

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