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BOPHELO

Dominant discourses: Internalised understandings

An analysis of the dominant discourses of health in Lesotho and how they affect healthcare providers' health perceptions.

Dissertation prepared in fulfillment of the requirements for the Masters in Arts by Dissertation only

by
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ABSTRACT

This dissertation is a study of how Basotho healthcare providers understand health. It leads directly to a discussion of the health discourses evident in Lesotho and the way in which they impact on the perceptions of health that healthcare providers hold.

The approach used was to conduct a case study of nurses, nurse assistants and technicians at Scott Hospital in Morija, Lesotho. The findings revealed that the perceptions of health that these healthcare providers hold are profoundly impacted upon by four discourses that are evident in Lesotho, these being the biomedical discourse, the Public Health discourse, the Christian discourse and the traditional discourse of health. These discourses are evident in Lesotho due to a complex interplay of history, economy, politics, development and culture amongst other factors. They play themselves out at various levels – national, local and individual – and represent the power dynamics that are at play when it comes to health in Lesotho. What is key is that each discourse, regardless of official policy, plays an integral role in the perceptions of health that the healthcare providers hold.

Four elements are discussed in this dissertation. As will be shown, health, development, religion and tradition have a complex history in Lesotho that has led to the current health picture in Lesotho. As such, this dissertation, whilst being broadly a development piece of work, focuses more acutely on the interplay between health, religion and tradition, and through doing this, makes comment about development more generally.

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INTRODUCTION

As you walk up the road, past the police station, the noises filter down to you. They get louder as you get closer. Taxis hooting, loud talking, cow bells jingling and children laughing. These are the sounds of Scott Hospital. No sterile, white, quiet corridors. Scott Hospital is where the people meet, where they say goodbye and hug loved ones hello, where they leave from to make their wage, where they sell vegetables and sweets, where the donkeys and cows wander and where the children play just a stone's throw away. In many senses Scott Hospital is the centre of town. Ask anyone for directions and they'll probably direct you from the common reference point of Scott Hospital. Scott is not just a place of physical healing, it is a place where people congregate, both sick and healthy to begin and end their days.

Scott Hospital, as is evident from the account above, is a vibrant place of healing. It is vibrant not least of all because it displays so many differing ideas around health. The central question that this dissertation asks is, "how do Basotho healthcare providers understand health?" In going about answering this question, it became very clear that there are various factors that influence these understandings of health ranging from tradition, culture, religion, policy and economics. What is evident is that there are four dominant discourses evident at Scott Hospital and that all of these have influenced all healthcare providers to some extent as they have developed their understandings of health. This dissertation presents a discourse analysis of health in Lesotho, with particular reference to the understandings of health that healthcare providers at Scott Hospital hold. This is a first step in being able to more adequately theorise about what influences individual health behaviour and choices.

Scott Hospital is a hospital that brings together the biomedical, Public Health, Christian and traditional discourses of health. These discourses have arisen in Lesotho due to a particular history. I suggest that there are four health moments in Lesotho and that these are closely linked with how development

has been conceived of in Lesotho. The pre-missionary, pre-colonial era saw the dominance of the traditional discourse of healing being present in Lesotho. This was characterised by the preeminence of traditional healers as the health practitioners as well as particular ideas about holism and relationality. This will be expanded on further in Chapter 5. The arrival of the missionaries introduced Christian understandings of healing to Lesotho. This was then followed by the colonial project of development which brought with it biomedicine. Finally, as participatory and assets based approaches to development gain following, Public Health has entered the space of health contestation in Lesotho, predominantly from 1979 when the World Health Organisation made the Alma Ata Declaration on Primary Healthcare.1 What has therefore happened in Lesotho is that at various stages of the development history of Lesotho, new paradigms of health have been introduced so that in the current landscape four discourses contend for dominance in the official policies of health as well as in the minds of individuals. This dissertation aims to examine this contestation. In this dissertation a case study of the local – in particular Scott Hospital – illustrates how these discourses find expression in the understandings of health that the healthcare providers hold.

Discourses by nature indicate power relations. Discourses attain dominance through institutions and social processes, and they are most powerful through the tacit knowledge that individuals hold. Chapter 3 examines this idea in more detail. At Scott Hospital, all four dominant discourses are evident. Scott is a biomedical hospital– the place where the biomedical doctor treats inpatients and outpatients through a careful analysis of symptoms and the administration of drugs. It is also a hospital that advocates primary health care as prescribed in the Health Policy for Lesotho and as such is the common reference point for the training of village health workers and the provision of all awareness materials for the health service area. Scott, like seven other

[1] Germond and Molapo (2006) also suggest that there are four health moments in Lesotho. However, they conceive of them slightly differently. The first is the pre-missionary era in which traditional forms of healing or the traditional discourse of healing are evident. The missionary era introduces the Christian discourse of healing alongside the traditional forms. The colonial era ushers in biomedical discourses of healing and finally, neo-liberalism brings with it reforms in healthcare and the response of the AIC's.

hospitals in Lesotho, is a hospital that was originally established by missionaries and churches and is a Lesotho Evangelical Church (LEC) hospital. As such in addition to the biomedical and public health focus there is an awareness of the role that religion plays in healing. Finally, although not officially recognized, this research demonstrates that traditional healing values also play a strong role at Scott Hospital. Some of these discourses (such as the biomedical and public health discourse) are entrenched in national policy. Others such as the Christian discourse are entrenched through practices at the hospital while others, especially the traditional form, are officially silenced, yet are no less powerful. An analysis of the understandings of health of Basotho healthcare providers illustrates the power that all four discourses have at Scott hospital, as well as at other hospitals in Lesotho. As such Scott presents to us a case where competing discourses of health come together and provides a good site in which to address the key question of this dissertation: "How do Basotho healthcare providers understand health?"

An aim of this dissertation is to illustrate the importance of understanding people's perceptions and beliefs of health. However, I am not interested in only understanding people's health motivations as much of the literature has done before. Rather, I am advocating for the importance of understanding underlying, taken for granted discourses that impact on how we understand health. These discourses, I suggest, have a far deeper impact on how we behave than measures of motivations. I attempt to illustrate the importance from various perspectives. I begin by illustrating the importance of this project from a theoretical point of view and go on to illustrate how this contributes to the literature on lay perceptions of health. I also outline how my research draws on and contributes to the overall African Religious Health Assets (ARHAP) theoretical framework and body of knowledge.

ARHAP was established in 2003 when three academics, interested in religion and its impact on health [Prof. J Cochrane (UCT), Prof. D MacFarlane (Emory) and Prof. G. Gunderson (Emory)] decided to institute an interdisciplinary research programme that would address this exact question. The question they ask (How does religion impact on health?) has been one

that has come to interest many and as such the programme has grown and is now operational in various Southern African universities such as Botswana and Zambia, as well as in at least three South African universities and Emory University. The aim of the programme is to encourage young African academics to pursue the question in their own way whilst being supported by the broader knowledge base and theoretical framework that has already been established by other scholars and the founding members. In so doing, ARHAP aims to address the question in as many African countries as possible. Currently the programme is running in South Africa, Lesotho, Zambia, Malawi and Botswana with interest from many other countries around the continent. In addition it is supported financially and intellectually by the Vesper Society, World Health Organisation (WHO), Centre for Disease Control (CDC) and the Oslo Centre in Norway. How this dissertation contributes to the ARHAP framework will be discussed in more detail later.

1.1. Situation of the dissertation in development discourse

The beginning point and in particular the methodology for this research is rooted in the work of Farmer, Sen and Nussbaum. As a development sociologist working in a developing region, I am fairly critical of the type of development thinking and its impacts thus far. I suggest that development models such as modernization theory, dependency theory and the like have been largely unilateral and have not involved the voice of the so called "underdeveloped"2. In addition, the impacts of many policies evolving out of these theories have been devastating in many respects. The impact of structural adjustment programmes in Africa is a case in point. Neoliberal economic policies, stemming from the modernization theory of development

[2] I use the term underdeveloped in inverted commas to denote that large portions of the world's population have been labeled underdeveloped from a Western perspective. Underdeveloped is a comparative term, necessarily denoting a standard of development. This standard is a Western standard, rooted in industrialisation and technological advancement. Although this standard has through the Bretton Woods Institutions and increasing globalisation become the global standard, one must acknowledge that it nevertheless imposed and many of the 'underdeveloped' people do not necessarily consider themselves as such. For instance, many people in Lesotho who have land and cattle and good family networks are quite happy to sustain this way of life. The word 'underdeveloped' is problematic in and of itself and in many ways reinforces the problems of the current development discourse as critiqued in this chapter. I use the word only for the sake of comprehension. For more on this see Escobar (1997).

(which was dominant as a theory of development in the 1970's and 1980's), had a severe negative effect on most developing nations. Increasing poverty, lack of access to services and declining economies have had a long lasting effect on people who were not able to access the market and its related benefits (Todoro, 2000). This is no less the case in Lesotho where development spending by the state was rolled back in the 1990's (Thomas, 2000).

I go on to suggest (as Farmer does) that health interventions have followed a similar pattern to development initiatives in that they too have defined the "underdeveloped" recipient of treatment and made policy decisions on behalf of the "underdeveloped" without so much as a consultation with the people they aim to help.

I suggest that Sen and Nussbaum's works have contributed significantly to development thinking. Not only have they changed the field of development studies theoretically, but they have also contributed notably in the policy and practice sector. Thus for instance, Sen's work has been instrumental in developing the Human Development Index (HDI), which is the first measurement of development to take aspects other than economics into consideration. The key to Sen and Nussbaum's development thinking is to recognize the role of the agent. They encourage us to shift our perceptions from thinking of the "underdeveloped" as passive recipients of aid and initiatives, to thinking of them as active agents who not only make decisions in their own lives, but have capabilities and assets to contribute to their own survival and personal development and in turn to the development and growth of their own communities. Sen and Nussbaum encourage us to think of how best to deal with the unfreedoms that developing nations often experience in order to allow for these capabilities to reach fruition.

This is an important shift, and one that is reflected on by Farmer (1999, 2005) who, as an anthropologist and medical practitioner in Haiti, spent much of his time documenting the health stories of the patients he saw. In doing this he begins to open our eyes to the realities of these agents, to the motivations

behind their decisions and to the unfreedoms that have impacted on their lives.

The African Religious Health Assets Programme (ARHAP) has recognized this shift in thinking and as such, has developed a research programme that specifically aims at understanding the capabilities and assets that various agents have and how these contribute to health. It proposes to do this from four perspectives. The first is to begin to understand the agency of health seekers and health providers. The second is to look at the material assets that are already available in the health sector. The third is to begin to bring these together and understand what capabilities health facilities have, and what unfreedoms limit these capabilities. Finally, the programme aims to understand how best to align these findings with health policy to ensure that these assets are maximized. This dissertation falls into the first aspect – that of health agency as it aims to understand the discourses that lie behind how people make sense of health. This strategy will be expanded on below.

I propose that understandings of health are constructed by drawing on particular discourses of health that are perpetuated through culture, literature, policy and teaching. A health discourse or discourse of health is a particular body of knowledge that describes and understands health and ill health in a specific way and thus prescribes how health is to be maintained and ill health treated. Of course any discourse, including those that refer to health do not exist in pure forms but are negotiated and expressed through individuals, organisations and policies. Nor do discourses exist in vacuums. They are always in conversation with other contending discourses. However, it is possible to determine common features that are particular to a discourse and may be contradictory to the features of another discourse. This means that we can describe a particular discourse and as such categorise and establish boundaries (perhaps somewhat falsely) around particular discourses for the sake of meaningful discussions about how these discourses impact on individuals and how individuals thus generate their particular understandings of health. A key feature of discourses is that they indicate power struggles. As I will illustrate further, discourses attain dominance in that they are entrenched

in social processes and systems as well as through individual interest. They attain dominance by silencing other voices that advocate other discourses. And discourses are most powerful when they permeate individual minds and are thus acted out. By getting a picture of the understandings of health that Basotho healthcare providers have in relation to the official dominant discourses, one can begin to understand what discourses are evident and how they are drawn upon and internalized i.e. how they come to attain power. Although not the central focus of this thesis, a useful concept that I have used to assist in describing the understandings of health is healthworlds.

In this dissertation I have used the term healthworld to describe the collective body of innate knowledge both theoretical and experiential that an individual chooses as valid and which is therefore drawn upon either consciously or reflexively when decisions are made regarding health. The term healthworld was inspired by Habermas' concept of the lifeworld. The healthworld, like the lifeworld has both a structural aspect and an aspect of agency to it. That is it is a mass of knowledge that continually impacts on our behaviour and how we operate in society but it is continually shifting as our experience (our agency) validates or rejects elements of the lifeworld. The healthworld operates in the same way but refers specifically to health. Health however, can be understood very broadly (especially in Africa) and does not simply include choosing which doctor to visit but also includes decisions about food and family relationships to mention a few.3 Healthworlds draw upon discourses and understanding individual healthworlds enables us to do a discourse analysis of what is happening at Scott Hospital as well as in Lesotho more broadly.

1.2. The contribution of the dissertation to health literature

Many public health practitioners have theorised about lay perceptions of health and have looked at the role that class, gender and race play on both disease susceptibility and health behaviour (Bartley, 2004; Wilkinson, 1996,

[3] It must be taken into account that I present my conception of the healthworld but that this is in conversation with an ongoing debate between myself, Germond and Cochrane regarding the nature of the healthworld. For more information on this please see Cochrane, J. (2006)

Himsworth, 1984; Kelleher et al. 1990). These theorists are discussed in more detail in this dissertation. However, few, if any have looked at how healthcare providers conceive of health – of the discourses that impact on health behaviour. This then is an important contribution of this dissertation in itself. However, what is of greater importance is that this dissertation encourages us to look beyond mere measurements of motivations that lie behind health behaviour. In fact, like Miller (2005: 3) who states, in his study of risk behaviour by intravenous drug users, that "many of the psychological constructs surrounding the perception of risk which focus on individual behaviour are fundamentally simplistic and often unhelpful in understanding the behaviours of this group of people," I suggest that human beings are not nearly as self-consciously rational as many theorists make out. Rather, our actions are reflections of underlying discourses. In addition, human beings have the ability to hold together seemingly contradictory discourses at one time. This too needs to be understood if public health interventions are to be effective. Increasingly the field of public health and the sociology of medicine are embracing this way of thinking and more recent literature has begun to look at the role that socio-cultural factors have on lay health perceptions and how it impacts on behaviour. This too will be discussed in more detail below.

I have chosen a small case study of healthcare providers at Scott Hospital in Morija, Lesotho. The reasons for this are outlined in more detail in the Methodology chapter. At this point however, it is necessary to point out that Lesotho is fascinating from the perspective that there are many competing discourses of health and this in a country that is relatively homogenous in terms of culture, in relation to other African countries. At least four of these discourses (biomedical, public health, traditional and Christian) are all clearly evident at Scott Hospital. However, this pluralism in understandings of health is not limited to Scott Hospital, or even to Lesotho in general. Rather this pattern can be seen everywhere. Every individual, regardless of where they are located is influenced by varying discourses of health and must make some kind of sense of them all in their own understandings of health. This is

increasingly so as recognition of traditional healers4 grows and the popularity of homeopathic and natural healing methods increases. These have come to influence people that have predominantly been influenced by a biomedical perspective. Turner (2004: xiv) indicates that "from 1910 -1970 scientific medicine enjoyed a golden age of increasing influence, status and wealth," that is, the biomedical discourse of health was dominant. However, "patient rights and consumer demand have pressured healthcare professionals to provide more holistic care" (Ibid.) and more importantly, to recognise the value of what has come to be called complementary or alternative medicine.5 Thus this research could arguably be conducted anywhere with similar results, although different dominant discourses would be evident.

This is the direction that public health thinking needs to go. We need to take cognizance of the fact that the biomedical perspective of health no longer satisfies people living in a pluralistic world (Gilbert, Selikow & Walker, 1996). Increasingly we need to understand the competing explanations of health and disease and recognize that people are profoundly motivated by these discourses. If we want to make meaningful comment about how to deal with the modern day scourge of HIV and AIDS, amongst other threatening illnesses, particularly in Africa, with its myriad of cultures and its complex history, we need to take this research further and understand where these agents of their own health are coming from.

This dissertation presents only a small step in that direction. As such the focus of the research is on a particular hospital chosen for the fact that it presents a workable case in which at least four competing discourses are evident. In particular the research targets nurses, nurse assistants and medical technicians and the reasons for this are outlined in Chapter 2.

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[4] Lesotho recognises the role of traditional healers through the Medicine Men and Herbalists Order 1978 and the Natural Therapeutic Practitioners Act of 1976. South Africa recognised the role of traditional healers much later through The Traditional Health Practitioners Bill which was passed in South Africa in September 2004

[5] The use of the terms complementary and alternative still suggests that these health discourses still defer to biomedicine. This indicates that these discourses have not yet attained dominance but are still to a certain extent silenced by the systems that entrench the biomedical discourse.

As has been stated, because of the particular history of Lesotho, at least four contending discourses of health are evident in Lesotho. A historical background to Lesotho is given in the theoretical framework which provides an understanding of how the discourses came to be introduced in Lesotho. However, it is necessary to understand the background to this particular case study. Thus while the broader background about Lesotho will be presented later, a background to Morija and in particular to Scott and the target sample – the nurses, nurse assistants and technicians – will be in the introduction and expanded on later.

1.3. Background to Morija

Lesotho is a 30 355 km^2 country landlocked within the boundaries of South Africa (Hall & Gay, 2000). It has a population of approximately 2.2 million people (MOHSW, 2003).

Lesotho is a particularly mountainous country which means that physical access to certain villages is limited. Morija however, is easily accessible by car and is only half an hour's drive from the capital Maseru on the main road. One of the reasons the research was thus located in Morija is because of the ease of access. The Morija Health Service Area (HSA) is one of the HSA's that is run by a Christian owned biomedical hospital. As Morija was the first village that the missionaries settled in, it has a strong Christian tradition that competes with the traditional outlook. In addition, as with most hospitals in Lesotho, there is a strong emphasis on public health or primary health care. Morija thus presents an interesting village, with Scott Hospital being of particular interest due to the prevalence of the four dominant discourses at the hospital. Morija is also one of the fastest growing villages in Lesotho and one health seeker stated in an interview, when asked what a healthy village was that, "a healthy village is like Morija." It is thus important to understand the history of Morija as well as its current status in order to better understand Scott Hospital and the healthcare providers that work there.

1.3.1. A brief history of Morija and its relationship with the PEMS

As has been stated, prior to the arrival of the missionaries, the traditional discourse of health has been the only way that health was understood in Lesotho. A closer understanding of the missionaries is necessary as they played a fundamental role in introducing the biomedical model of health as well as a Christian understanding of health to Lesotho. They must also be understood for their contribution in Morija and to Scott Hospital.

In 1832 three young French missionaries boarded a ship headed for the Cape of Good Hope. Thomas Arbousset, Eugene Casalis and Constant Gosselin, all in their early twenties landed in the Cape in March of 1833. From the Cape they traveled to the mountains of what was then known as Basutoland to meet the "King of the Mountain at Night," – Moshoeshoe (Couzens, 2003). The king, on the advice of his teacher, Mohlomi, welcomed the missionaries into his stronghold at Thaba-Bosiu. For Moshoeshoe this move was a tactical one, to learn the ways of the white man, who were becoming the biggest threat to his kingdom. Moshoeshoe allowed the three missionaries to choose a place for their mission. "Some eight leagues (about forty kilometers) from Thaba-Bosiu, they came across 'one of the most beautiful valleys in the country,' entirely uninhabited. After the mountain that overlooked it, it was called Mokoarane. Arbousset, Casalis and Gosselin decided to call it Moriah, the land where Abraham offered up Isaac for sacrifice, to express their gratitude to God for past mercies and their confidence in Him for the future. Later it would be known as Morija" (Couzens, 2003: 83). The missionaries settled into their new home and began their work in Lesotho on the 9 July 1833. The Paris Evangelical Mission Society (PEMS) had planted its first base in Lesotho.

Between 1833 and 1964, when the Paris Evangelical Mission Society (PEMS) handed over autonomy to the Lesotho church, the generations of missionaries and their children did much work both positive and negative. The missionaries in their time built a church (which still stands today) (see fig 1), a printing works, two schools, a Theological Seminary, a book depot and various shops in Morija. They also established the first Sesotho newspaper called

Leselinyana and captured the language of Sesotho in writing while translating hymns and the bible (Germond, R, 1967). Many of the children of PEMS missionaries, a number of whom stayed in or returned to Lesotho, followed careers in education and healthcare. Biomedicine and Western education came to be valued in Morija through their influence. One such child was Dr. Eugene Casalis, son of the first PEMS missionary Eugene Casalis and his wife Sarah, who established and maintained the dispensary on the site where Scott Hospital would be built 73 years later.



Figure 1: The LEC church in Morija

However, in their quest to bring the 'natives' to salvation, the missionaries also began to break down the dominance of the traditional systems of understanding the world, including the understandings of health. The missionaries often fought amongst themselves over which traditional practices presented the biggest threats to Christianity and which should be suppressed (Couzens, 2004). Most of the missionaries tended towards conservatism and as such any 'natives' that practiced polygamy, circumcision and ancestor worship were cast out of the church. This was especially hard on women in polygamous marriages who had to ask for divorce from their husbands if they wanted to belong to the church. The decisions that were taken by the missionaries at this time represent the introduction of a particularly Christian challenge to the traditional Basotho way of life.

In 1964 PEMS officially handed autonomy over to the many Evangelical pastors they had trained and the PEMS in Lesotho became the Lesotho Evangelical Church (LEC). Its headquarters are still in Morija and people still

worship in the church that was built under the direction of Casalis, Arbousset and Gosselin. Scott Memorial Hospital is run and maintained by the Lesotho Evangelical Church (LEC) which also employs a pastor at the hospital chapel.

From the outset, PEMS missionaries experienced the conflict between traditional practices and their own beliefs. This led to much concern for the missionaries over polygamy, initiation and beliefs in ancestors. Although the missionaries managed to convert many to their beliefs, they also tended to alienate many others. As Gill states, "Although a vigorous camp of 'traditionalists' led by Moshoeshoe's father Mokochane, and his councilor Makara, began to openly oppose the missionaries from 1841 onwards, Moshoeshoe was, on the whole, quite supportive of them" (1993: 79). Molapo (2003) has done a historical analysis of how Christian rites of passage began to take the place of traditional rites of passage and the tensions that arose out of this. These tensions still exists to a certain extent today and are evident in the discourses that influence people's ideas about health. The arrival of the missionaries introduced two new understandings of health to Lesotho where only the traditional understanding of health had previously existed. This should not be taken to suggest that the traditional discourse of health had existed statically and in isolation. There is no doubt that the traditional discourse of health had been in a constant state of flux and had integrated many competing explanations and methods of healing. Nevertheless, the arrival of the missionaries firmly establishes two contradictory discourses that manage to gain some independent dominance. The first contestations around how health is understood were thus introduced.

1.3.2. A healthy village is like Morija

The legacy that the missionaries left is still evident in Morija. The Leselinyana is still printed at the Morija Printing Works, which provides a source of employment and is also the central printing works for most of the material that is printed in Lesotho. The original printing works building has been modified to commemorate the first building while providing a space for local community members to sell their wares.

Morija is an educational hub in many ways. It has three high schools, two primary schools and a nursery school. In addition the Book Depot has been a feature of Morija since the second generation of missionaries (Couzens, 2004) and continues to supply books to school children as well as adults across Lesotho. Morija is not only a hub for the education of Lesotho's children. The first Theological Seminary is also located in Morija and is still fully operational, training both male and female Basotho pastors for the LEC.

Morija is an important cultural centre of Lesotho. The Morija Museum and Archives is the central repository for artifacts and documents that give accounts of the history of Lesotho from the age of dinosaurs (dinosaur bones can be viewed in Morija), through to the era of Moshoeshoe and then to the missionaries and the current government. The annual Morija Arts and Cultural Festival is also arranged and takes place in Morija. It celebrates the Sesotho culture and traditions and attracts many tourists and is the only one of its kind in Lesotho.

Morija is a village with access. Not only is it easily accessible from the capital city, it also sits on the main road through Lesotho. Access to the shops and banks in Maseru is important for the people that live there, but access also means that supplies are far more readily available than for most other villages in Lesotho. Roads also have significance as migrant workers obviously travel home on them. Morija is also home to a well equipped post office – equally significant as it is the source of communication with and money from loved ones in South Africa and elsewhere.

Thus Morija is an extremely interesting place to conduct this research. It has a deep religious heritage and also celebrates Sesotho tradition. It is a village that still shows much evidence of subsistence living and strong social bonds, but is also increasingly being touched by urbanization and modern technology. It is a village that illustrates the typical history of Lesotho and presents a case in which the dominant discourses of health can best be analysed.

1.3.3. The current state of health in Morija

The missionaries had a profound impact on health in Lesotho generally and in Morija in particular. The arrival of the missionaries, as has been outlined, introduced new discourses of health that still compete for dominance amongst the Basotho. However the years since the arrival of the missionaries have also seen the introduction of more modern ideas about health and healing and development. A discussion of the historical introduction of the Public Health discourse as well as the entrenchment of the biomedical discourse around health will be discussed at a later stage. At this point the focus will be on how health has been and is dealt with at Scott.

Although missionaries have had a profound impact on Lesotho in general I would like to focus on their impact on health in particular. The PEMS missionaries brought with them clinics, mission doctors and their own ideas about health and healthcare. Prior to this introduction of the Christian understandings of health alongside some biomedical work, health was understood predominantly through the traditional lens. Germond & Molapo (2006) have done work in trying to analyse the traditional mode of understanding health and has come up with three dominant forms of traditional healing. They are quick to point out though that the traditional discourse cannot be seen as being unchanged since time immemorial. Rather it is a dynamic field that not only changes over time, but also from individual to individual. Patterns have emerged in their research, which enable us to understand the traditional health discourse a little more. This will be discussed in more detail in Chapter 3.

There are key dominant themes of the traditional view of health. The first is that health is inextricably linked with an individual's surroundings. An individual does not exist in a vacuum thus social relations are seen as having a clear impact on an individual's health and must be taken into account when assessing illness. Secondly, health is linked to the spiritual realm and thus the ancestors are play an important role in the health of an individual. For diviners a key treatment is to invoke the ancestors. Finally, health is seen in a broader

sense, with the physiological ailment simply a symptom of the greater cause of the illness. These themes that are evident in traditional forms of medicine have been well documented by theorists such as Janzen (1982, 1992), Vaughan (1991), Junod (1978) and Turner (1968) among others.

With the missionaries' challenges to the role of the traditional healer, the face of healthcare in Lesotho began to change significantly. As initiation rituals were banned for Christians (Moshoeshoe in fact, according to Couzens (2004) closed initiation schools and refused to send his sons for initation) and anything to do with ancestors was discouraged, the traditional healers began to feel that their role in society was being threatened. As Couzens states, "naturally, the diviners and witchdoctors resented professional competition" (2004: 92). A new discourse around health was being introduced.

Biomedicine was introduced through mission doctors and colonialism. Biomedical doctors began to encroach on the space of being able to determine the causes of illness and subsequently treat them. However, their explanations were often very different to those that the traditional healer offered. Scientific study and the role of germs in causing disease (the doctrine of specific aetiology) (Gilbert, Selikow & Walker, 1996) came to compete with consultation with the ancestors and witchcraft as the cause of disease.

Missionaries also brought another aspect of healing to Lesotho. They introduced the notion of Christian prayer and healing and the role of God in healing. All forms of religion are interested in healing at some level. Christianity is no exception. However, different groupings within Christianity have differing understandings of the role of religion in healing. Mainstream churches have a conservative approach to healing, seeing a role for prayer and faith in conjunction with other forms of healthcare, most likely biomedical. More charismatic churches would believe far more in miracles and the laying on of hands for healing. Explanations of these various forms is outside the scope of this paper, however, it is important to point out that in many parts of Africa, Christian ideas have been adapted to traditional ideas and various forms of African independent churches have flourished (Pfeiffer, 2005; Meyer,

2004; DaSilva, 1993). Molapo (unpublished), during his fieldwork in Lesotho, found that within these churches and other African-Christian faith communities, healing is understood far more literally with certain people in the community having the ability to heal people through faith. They are called faith healers and use Christian, ancestral and herbal methods of healing. It is clear that this religious realm of healing is diverse in Lesotho. For the purposes of this project, traditional Christian understandings of healing will be the focus.

Morija has had an interesting history that illustrates the introduction of Christian and biomedical views into a landscape that had been dominated by traditional views of health. This history finds expression quite clearly at Scott Hospital and enables us to answer the question "How do Basotho healthcare providers understand health" and what does this say about which discourses have power in Lesotho.

1.4. A Background to Scott Hospital

Scott Memorial Hospital of the Lesotho Evangelical Church was founded in 1937 when Mr. William Scott esq. donated £15,000 to the then Paris Evangelical Mission Society (PEMS). This money was for the specific purpose of building a hospital. His contribution along with another smaller contribution of £3,000 from Miss Helen Robertson, allowed for the hospital to be built. The initial building housed only 32 beds. Prior to the hospital being built, a dispensary under Dr. Eugene Casalis was run on the same premises. The dispensary was established in 1864. (Makara Interview)



Figure 2: Scott Hospital was made possible by William Scott Esq.

The hospital reached its peak in the 1960's, growing to 170 beds, as well as an extensive outpatients department. It was then the hospital of choice for many and was renowned in Lesotho. The current King Letsie II was born at Scott Hospital. During this time primary healthcare was introduced at Scott Hospital primarily through the efforts of Dr Ted Germond (T. Germond interview). It was also at this time that the nurses' training college was established at Scott. At this college intensive courses such as anatomy and biology were taught as well as environmental health and preventative medicine. Thus, at the college biomedical and public health discourses of health were introduced and reinforced to the trainee nurses (T. Germond interview). It was also around this time that the Community alcohol Rehabilitation Programme (CARP) and the Klieniek ea Mathatha (The Clinic of Troubles) were established at Scott. CARP was established in response to a growing trend of alcoholism at the time. Its vision is to treat those dependant on alcohol in an inpatient programme that follows the same principles of the Alcoholics Anonymous (AA) treatment along with a particular Christian focus that includes bible studies and prayer times. The aim is to take affected people out of the household where they may be destructive and treat them while also providing support to the family members (Pitso, I interview). The Klieniek ea Mathatha was established by Dr Ted Germond in response to an awareness that many people came to the hospital with psychosomatic symptoms or simply to offload emotional and social burdens (Germond interview). The Klieniek ea Mathatha therefore provides a social worker for community members. The training centre, CARP and the Klieniek ea Mathatha exist along with the inpatient and outpatient departments. In recent years the hospital has been hard hit by poverty and rising costs and has, due to lack of funds, had to reduce to 102 beds (Makara interview).



Figure 3: Building housing the Community Alcohol Rehabilitation Programme (CARP)

That said, the hospital still provides good primary and secondary care. Secondary care refers to the inpatient and outpatient departments that assess and treat ill patients. Primary healthcare refers to preventative healthcare and includes environmental health, AIDS programmes, and the Community Alcohol Rehabilitation Programme (CARP). Scott Hospital is the reference hospital for all the Health Centres in the health service area and thus is the only hospital in the area to provide secondary healthcare. However, there is a particularly strong focus on primary healthcare at Scott. The community healthcare department is the largest department at Scott Hospital. This emphasis probably stems from dominant thinking in the Public Health sector that primary healthcare is the best way to deal with health, particularly in developing nations (Hall & Taylor, 2003) and reinforced by Lesotho's Ministry of Health and Social Welfare's (MOHSW) emphasis on primary healthcare. This discourse has thus influenced the current health policy quite significantly and is demonstrated in at least the three hospitals we visited, namely Paray Hospital, Scott Hospital and Mokhotlong Hospital.

In 2004 there were four doctors working at Scott, from various African countries, under the supervision of the Medical Superintendent. Scott and its Health Centres employ 90 nurses of various qualifications, whose salaries are paid through the government. In addition, there are four technicians (two pharmacists, one laboratory technician and one radiologist). The support staff includes an accountant, two administrators and maintenance staff. My research will focus on the direct healthcare providers - the nurses, nurse assistants and medical technicians. I have excluded the doctors from the sample for two reasons. The first is a logistical reason in that the doctors, being under pressure to deal with both inpatients and outpatients as well as

the Health Centres were incredibly stretched for time and unable to meet with me. The second reason is that none of the doctors are Basotho and none could speak Sesotho. They no doubt bring with them new discourses of health and healing, in particular their own traditional views of healing. However these discourses have had negligible impacts on understandings of health in Lesotho and as such I did not deem it necessary to include the doctors in my sample. In addition, due to the fact that the doctors are under such immense pressure, the nurses become key in dealing with patients. This is the case in particular at the Health Centres where nurses deal with daily ailments and are allowed to prescribe medication as the doctor is only available once every two weeks at best. In many sense the nurses take on tasks that would usually be the domain of the doctor alone.

As an LEC run hospital, religion is integral to the day to day running of the hospital. As various nurses have stated, Scott's mission is to undertake a holistic approach to healing that includes caring for a person physically, mentally, socially and spiritually. Scott employs a chaplain who conducts morning services each day for the healthcare providers. In addition, each shift in the wards begins and ends in prayer. Many of the programmes at Scott such as the Community Alcohol Rehabilitation Programme (CARP) are run along spiritual lines with prayer and bible study being integral elements of the healing process (Pitso, I interview).



Figure 4: Trainee nurse assistants leaving the morning service

The religious atmosphere at Scott extends to the individual as well. The majority of the healthcare providers at Scott see themselves as practicing religious people and many conceive of their work in religious terms, both in

terms of vocation and in terms of how they conduct themselves in the day-to-day delivery of their service.



Figure 5: Chapel at Scott Hospital

It is important to gauge the opinions and understandings around health that the healthcare providers have formed. As health agents, it is these people that are ultimately providing healthcare for the people of Lesotho. It is clear that their perceptions and beliefs will impact on their agency and on how their 'healthworlds' will be formed.

In order to understand how the nurses, nurse assistants and technicians conceive of health it is important to understand what the working life of a healthcare provider is like at Scott Hospital. All nurses at Scott Hospital have at least two diplomas in nursing, usually obtained from one of the nursing schools attached to a hospital in Lesotho. However, many of them have gone on to further their studies and may have three diplomas (officers) or postgraduate degrees in a variety of areas ranging from primary health care nursing, HIV and AIDS treatment, psychiatric nursing and environmental nursing. One nurse was embarking on her PhD in psychiatric nursing (Pitso interview). Many of the nurses are ward sisters and are responsible for the effective running of the specific wards of which there are five – the pediatric ward, the maternity ward, men's ward, women's ward and ward for those with communicable diseases. Each ward has a nurse managing it and various nurses and nurse assistants working within it, depending on the need at the time.

In addition there is a primary healthcare department. Nurses working in the outpatient department seeing patients that need not see a doctor fall into this category. This ensures that the doctors can deal with only the most pressing needs. Many of the patients seen by nurses at the outpatients department are those managing tuberculosis (TB) or mothers and children needing preventative treatment. Those not involved in the outpatient department at Scott are needed to service the Health Centres. There is a regular team of about ten nurses who visit the Health Centres. They monitor the Health Centres, ensure that supplies are available and provide services such as eye care. They also consult with patients at the Health Centres. The Primary Health Care (PHC) nurses are also involved in providing family planning and education at Health Centres. They train traditional healers around issues of HIV and AIDS and they train village health workers, particularly in childbirth and nutrition. They are also involved in education initiatives in schools and churches that cover various areas ranging from drug and alcohol abuse to management of TB. Environmental nursing officers are also involved in primary healthcare and train villagers around issues of sanitation, nutrition and environmentally sustainable practices that will maintain their crops and their health.

These then are the duties and activities that the nurses are involved in. But what is a day in the life of a nurse at Scott Hospital like? Within the hospital ward sisters and officers are on eight hour shifts. Every shift begins and ends with prayer. The shifts are rotated so that nurses are not always on either a day or night shift. Many of the nurses live on the premises of Scott Hospital. Days off are also rotated. If it is a day shift the nurses will pray with or sing with the patients. Food is served, measurements are taken and medication given. The role of the nurses then is to monitor patients and many find themselves chatting to patients and performing a counseling role.

The day of the primary healthcare nurse is slightly different. As they are involved in outpatient work, they are always on day shift. The shift still begins and ends in prayer. The day begins with checking the books from previous visits to Health Centres and ensuring that all the necessary supplies are

packed. All of the nurses on health centre duty that day are packed into a Toyota Venture with the doctor and driver and spend sometimes as long as two hours getting to a health centre. Once there some begin consulting patients and referring them to the doctor. Others do necessary tests and administer medication. Others are involved in checking eyes and teeth. There is a sense in which these nurses provide much needed support to the nurses heading up the Health Centres and thus time is spent over lunch and before leaving in animated conversation with the health centre nurses. When they return to Scott Hospital the administration of medical supplies and filling in logbooks is completed.

Nurse assistants have similar working days, although they have less responsibility than the nurses. They often assist nurses or attend to the daily ward rounds. Older nurse assistants may have more responsibility such as one sister who heads the TB clinic.

The technicians are involved in the background work. They don't deal directly with patients but are rather involved in testing samples or providing medication and ensuring that the pharmacy is adequately stocked.

1.5. Conclusion

What has been presented in this chapter is an introduction to the dissertation. It has provided the background to the study as well as the necessary information for understanding the body of the dissertation and the site of the case study in particular.

What is clear from this chapter is that Scott Hospital in Morija provides a case study which will enable me to analyse how the discourses of health are used at by Basotho healthcare providers at Scott hospital and as such analyse the power these discourses have. As healthcare pluralism mounts, it is increasingly clear that work needs to be done to understand how these different discourses of health impact on individual conceptions of health and

thus on their health behaviour. This is imperative if health practitioners are to adequately address key health issues.

Chapter 2 will go into more depth around how discourses are created and attain dominance, particularly with regard to development generally. What follows is a discussion on development discourses and how these have impacted on the development and health landscape of Lesotho.

2. METHODOLOGY

ARHAP's methodology and by implication my own methodology stems largely from the importance we placed on getting to understand the agency of people directly involved in health and how religion impacted on that agency. However, understanding agency must be complimented by understanding how that agency then plays a role in the healthcare system. As Sen and Nussbaum advocate, we must begin to see people for their capabilities, their assets. Development thinking and intervention must begin to take an asset as opposed to a deficit approach. This thinking is at the heart of the ARHAP initiative. ARHAP is about understanding the factors that influence beliefs about health so that these capabilities can best be put to use. As will be discussed in this chapter, the Lesotho team's fieldwork challenged many of the ideas and frameworks that ARHAP initially identified and that have been discussed in the theoretical framework.

2.1. Role of this dissertation

It must be pointed out from the start that this dissertation does not attempt to ask why or how questions. It does not attempt to make statements about the direct impact of religion on health; that is it does not attempt to attribute causality, nor does it attempt to explain the nature of the link between health and religion. Rather, this dissertation is descriptive. The purpose of my fieldwork is to describe the situation at Scott Hospital and to alert others to the existence of and the nature of the connection between religion and health for healthcare providers at Scott Hospital. As de Vaus states, "Although some people dismiss descriptive research as 'mere description', good description is fundamental to the research enterprise and it has added immeasurably to our knowledge of the shape and nature of society" (2001: 1). I hope that in the broader ARHAP framework my description of the healthworlds of Basotho healthcare providers at Scott Hospital will form the basis for further explanatory research.

2.2. The research strategy

Working with new concepts and ideas, and conducting research that had never been done before, made the work we were doing both frustrating and exciting. The lack of any major theories to test and the nature of the work meant that we had to continually come up with our own theories and go back to test them. As such my research was in many senses using a theory-building or grounded theory approach (de Vaus, 2001) as opposed to testing a theory. We were using a case study to come up with ideas and theories about the nature of health and religion in Lesotho as this had not been done before.

As Ragin (2000) points out, the case oriented approach has two key advantages over a variable-oriented approach (an approach that explicitly uses and tests theory). The first is that a case study can present a holistic view of what is happening in a particular setting. Secondly, a case is by its nature embedded in a larger macro social world and therefore reflects the nature of that social world but it is also differentiated from the macro world, making it easier to understand the social dynamics at play. Despite the fact that a case may reflect trends of the broader society in which it is embedded, the very fact of it being differentiated from the macro society means that there may be internal factors that account for trends. As such, observations and analysis from case studies can not necessarily be extrapolated. This means that very valuable research on a particular case may be sidelined as anecdotal evidence. In order to counter this, Ragin (2000) suggests that the case-oriented and variable-oriented approach could be used to back one another up, however, as has been previously stated, the nature of the work was such that there were no macro theories to refute or corroborate. As such we had to use another method to ensure that our findings could be generalized. That is, as Ragin (2000) suggests, we used a multiple case approach. My dissertation represents only one of these cases. Each member of the Lesotho team had other cases to investigate and the findings from each of these cases would represent trends that were apparent in Lesotho. On a larger scale, the Lesotho team's research could be seen as one case study in Sub-Saharan Africa, the others being in Zambia, South Africa, Malawi and

Botswana. The hope is that if ARHAP continues, trends that exist across sub-Saharan Africa may become apparent. Thus, this dissertation must be seen as a case study and as a small part of a much broader research project. It does not therefore claim to make any generalisable statements about health and religion in sub-Saharan Africa or even in Lesotho, it simply seeks to describe the relationship of these two elements at Scott Hospital in Morija.

2.3. Why Lesotho?

ARHAP Lesotho was the first ARHAP research initiative. It was chosen as the primary site for a number of reasons. Firstly, Lesotho experiences typical problems faced by other Sub-Saharan African countries. It is a deeply poor country with a high dependence on subsistence farming and on its relationship to South Africa (Gay & Hall, 2000). Like other Sub Saharan African (SSA) countries, it experiences the environmental problems of severe droughts and soil erosion, making it difficult for its population to sustain a livelihood (Ibid.). Like so many Sub Saharan African countries, Lesotho is highly dependant on more developed countries for its income. In this case, one of the main sources of income in Lesotho is mine wages, earned by migrant workers. For this reason Lesotho, like other dependant countries is affected significantly by changes in the core countries it depends on. Major retrenchments on the mines in South Africa tend to have a major impact on families in Lesotho. In fact, in one workshop conducted with various leaders in Maseru, mine retrenchments were classified as major historical moments precisely because of the negative impact they had on the social fabric of Lesotho.

In addition, like other Sub Saharan African countries, HIV in Lesotho is a major problem as is evidenced from Figure 6 below taken from the UNAIDS/ UNICEF/ WHO Lesotho Epidemiological fact sheet 2002.

Estimated no of people living with HIV/AIDS, end 2001

These estimates include all people with HIV infection, whether or not they have developed symptoms of AIDS, alive at the end of 2001

Adults (15-49)	330,000
Women (15-49)	180,000
Children (0-15)	27,000

Estimated no of deaths due to AIDS in 2001

25,000

Figure 6: HIV/AIDS statistics in Lesotho

What is different about Lesotho is that it is perhaps the only Sub Saharan African country that has one heavily dominant language and culture. Only Botswana and Swaziland could be said to be close in this respect. In fact, bar a few exceptions such as the recent Chinese immigrants, Basotho share one culture, one language and one history. This feature of Lesotho means that understanding how beliefs and norms impact on health is a little easier than understanding the same in a country with multiple cultures. It also gave us an opportunity to test out our methodologies in a slightly less complicated setting than another country or region would have offered. It was for these reasons, combined with the relative ease of reaching Lesotho from Johannesburg that ARHAP decided to pilot their project in Lesotho. These reasons, and the fact that Lesotho is such a beautiful country in which to work, are why I decided to conduct my research in Lesotho.

2.3.1. The ARHAP Lesotho team

The Lesotho team was made up of five members, each with unique interests in Lesotho, in the methodology that ARHAP was using, and in getting to know the Basotho culture in relation to health a little more. Paul Germond headed up the team and was interested in understanding Bophelo generally in Lesotho. Sepetla Molapo, as a Mosotho himself had a deeper understanding of the culture of Lesotho and was particularly interested in the role that traditional healers play in constructing ideas around health and illness. Vernon

Vera, a pastor in Lesotho was interested in understanding the role of church leaders in the health context of Lesotho. Evelyn Vera was interested in understanding the motivations behind health care provision, particularly of those working in faith-based organisations. I took on the role of trying to understand how health care providers in a predominantly biomedical setting constructed their ideas of health and healthcare. The process was very dynamic, with each team member bouncing ideas off the others and complimenting their research. As such, at times in this dissertation I have drawn upon fieldwork that has been done by the other team members. Similarly I hope they will have found my fieldwork useful in their work.

In addition to this aspect of the research, it must be mentioned that the work we were doing was very new and initially ill defined. We were in the field precisely to test out ARHAP's ideas and concepts. In addition, we were trying to establish novel methods that would be useful to ascertain the required information, as well as be replicable for other ARHAP researchers in different settings. This made our work a little frustrating at times, but nevertheless exciting.

ARHAP's concepts have developed significantly from the time that we first entered Lesotho to begin our work. This is due to our contribution as well as the contribution of the Zambia team and the Masangane team, amongst other researchers who have had an interest in this project. Some of these results will be commented on. How ARHAP conceived of our task in its initial phases and the theoretical framework we were presented with have been discussed in some detail in Chapter 3 but it must be noted that while the ARHAP framework definitely influenced our methodologies initially, the work we did became far more dynamic and shifted throughout our fieldwork sessions.

2.4. Why Scott Hospital?

My research was conducted at Scott Hospital in Morija, Lesotho. The reason this hospital was chosen was two-fold. Firstly, my supervisor's father used to be the doctor there and thus I had contacts for access to the hospital.

Secondly, and perhaps more importantly however was the fact that Scott Hospital provided the best picture of the diversity of the understandings of health in Lesotho.

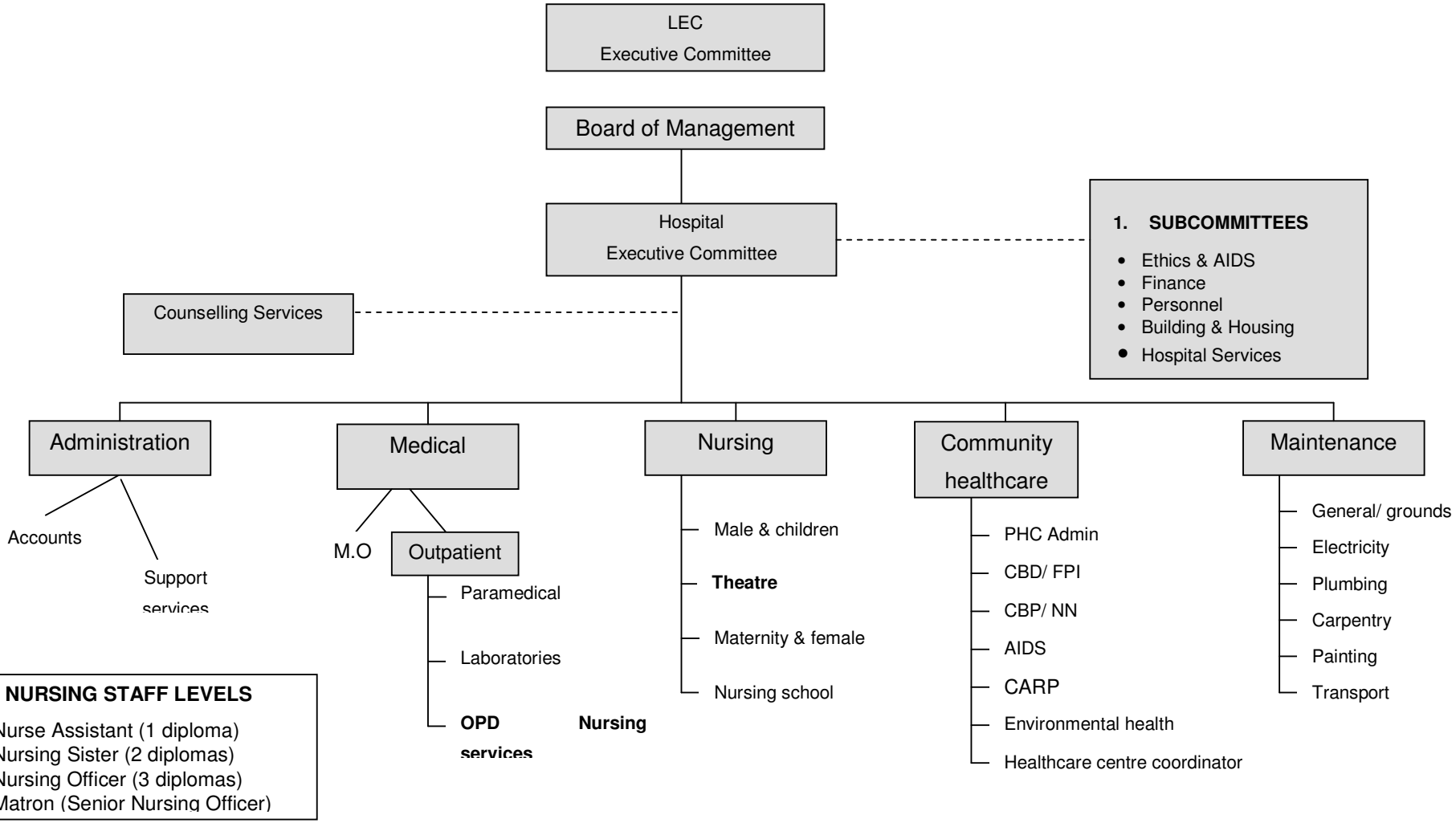
Scott can largely be seen as a hospital following biomedical health practices. The hospital incorporates a nurses' training college at which the nurses are required to study subjects such as biology, physiology and the like. Thus nurses, doctors and technicians are biomedically trained. However, since the 1970's, public and environmental health has become a central aspect of the workings of Scott. There is a major focus on primary health care and environmental health. This incorporates the training of village health workers and educators to teach communities about hygiene, better sanitation practices, nutrition and mechanisms of avoiding infectious diseases. There is also a strong focus on environmentally friendly practices linked with health care such as crop rotation and how to prevent soil erosion (linked with TB). The public health aspect of Scott can also be seen in its focus on emotional or social well-being. Scott Hospital incorporates a Klieniek ea Mathata - the clinic of troubles. This is a section of the hospital focused on counseling and social welfare. It is also linked to the Community Alcohol Rehabilitation Programme (CARP) which is an inpatient rehabilitation centre following the principles of Alcoholic's Anonymous and supplementing them with religious teachings. Added to these dimensions of the healthcare provision at Scott Hospital is a strong religious focus. Scott is a CHAL (Christian Health Association of Lesotho) hospital, meaning that, while it is run by an independent board of directors, it is subject to the constitution and decisions of the CHAL board. It is known as a Lesotho Evangelical Church hospital (see history of Scott). The majority of the nurses and technicians are practicing Christians of various denominations. The hospital is also supposed to have a resident chaplain and it is hospital policy to begin and end the days' shift in prayer. The mission of the hospital is to care for the whole person – physically, mentally, emotionally, socially and spiritually and all of the nurses and technicians know this mission. Finally, although Scott does little overt work with traditional healers, there is still quite a strong recognition of the importance of this aspect of healing. At this point, Scott collaborates with

traditional healers only in providing training around symptoms of particular health problems that will need biomedical intervention and education around the spread of HIV/AIDS. Although it is not official policy, some nurses have been known to refer patients to traditional healers. Thus Scott represents a diverse picture of health care incorporating biomedical, public health, Christian and traditional forms of healing. It was thus the ideal location from which to conduct research into the healthworlds of Basotho healthcare providers.

The organogram on the following page illustrates where Scott Hospital focuses its work. It shows that Scott has a Medical department that deals with both inpatients and outpatients. The focus of this department is largely biomedical. The patients that are attended to in the wards are submitted to various biomedical tests by biomedically trained doctors and most are on medication prescribed by these doctors. In addition to this aspect of healing at Scott Hospital, there is a large Community Healthcare department which is focused on primary healthcare but also incorporates Christian elements of healing (particularly at the Community Alcohol Rehabilitation Programme (CARP)) and the traditional (it is this department that deals with the training of traditional birth attendants and traditional healers).

Although the case focuses on Scott Hospital, a further two hospitals were also selected in order to provide a basis for comparison. A second CHAL hospital was selected and interviews were conducted with nurses and nurse assistants at Paray Hospital in Thaba Tseka – a catholic run hospital. In addition, a government hospital – Mokhotlong Hospital – was selected and interviews were conducted with nurses and technicians. The purpose of this was to establish if the findings from Scott Hosptial could be applied to other hospitals in Lesotho.

Figure 7: Organogram of Scott Hospital



2.5. Why a focus on nurses?

The decision to focus the research on nurses and nurse assistants was partly theoretical and partly about logistics. From a logistics point of view, the choice to interview healthcare providers was largely based on the issue of language. Thus, while Mr Molapo was able to interview traditional healers due to him being fluent in Sesotho, I was hampered by my inability to speak Sesotho and thus had to speak to healthcare providers who would be able to communicate in English. The fact that doctors are not included in the sample, as has been stated previously, is due to the fact that they are not Basotho healthcare providers (the focus of the research) as they originate from other African countries and due to the fact that they were too busy to answer my questions. The focus on nurses and nurse assistants is purely due to the fact that these healthcare providers make up the largest proportion of providers at Scott Hospital. Interviews with technicians were done as a means of comparing the data and in order to get the opinions of some men. The cohort of nurses and nurse assistants is predominantly female. In fact in all of my interviews and focus groups I came across only one male nurse. The focus on women suited the dissertation from a theoretical point of view. As has been stated previously I have situated my dissertation within the framework of an assets-based approach to health development. Nussbaum (2001) in particular advocates for a focus on women when thinking about development primarily because women are generally conceived of and treated as the means to other members of the community's potential rather than as having potential in and of themselves. This is no the less the case when we consider how nurses are generally theorised about. Nurses are seen as means to other people's health and as such are researched with this goal in mind. I propose that it is important to understand the healthworlds of nurses and nurse assistants, not because it influences their caregiving behaviour (although it no doubt does), but because nurses are also active agents in their own well being and as such they are no different to any person who daily deals with health maintenance. My focus on nurses as opposed to lay health seekers was motivated by the fact that they are

located daily within an institution where the four identified dominant discourses are at work and as such they make for a particularly interesting sample.

2.6. Locating this research within the ARHAP framework[6]

As has been stated from the outset, ARHAP was concerned with conducting research that would understand the agency of health seekers and health providers and the assets that this brought to the healthcare system. However, simply pointing this out is not sufficient in and of itself. In order for ARHAP to be an asset and an agent itself, it is also concerned with establishing what the current state of the health systems in Africa are in order to make recommendations to various stakeholders about how best to deal with health and specifically with HIV in sub-Saharan Africa. As such, they came up with a model that would guide the research in these various aspects. This model has been discussed in more detail in the theoretical framework and is shown in diagram format in Figure 10.

As has been stated previously, ARHAP's theoretical framework is based on the distinction between tangible and intangible religious health assets. It further points out that religious health assets (RHA's) have both direct and indirect outcomes. As such they have suggested that RHA's can be understood in four ways: as material assets or tangible assets (RHA-MAT); by looking at health agency assets i.e. those assets that affect the behaviour of both health seekers and providers (RHA-HAT); understanding how religion contributes to the capability of the healthcare center, seeker and/or providers (RHA-CAT); and by analyzing how well the other three aspects are aligned with policy (RHA-PAT).

[6] It should be noted that the ARHAP Framework and Suite of Assessment Tools were were the current theoretical and methodological frameworks at the time of the writing of the dissertation. Due to circumstances related to the delayed marking of the dissertation, these frameworks are no longer current as thinking in the field has developed rapidly.

Once again the rooting of ARHAP's theory in Sen's work is evident. The first two columns are aimed at understanding assets themselves. MAT aims at understanding assets in the tangible sense, while HAT looks at the role of agency as an asset. The third column, CAT is aimed at understanding how effective an asset is based on the freedoms that enable it or the unfreedoms that disable it. In other words, it requires us to understand how capable an agent is depending on the circumstances that either constrain or compel it. These circumstances are particularly important to understand as no matter how much of an asset an agent is, they can make no contribution if their circumstances don't allow it. Thus, a traditional healer may be seen as a useful agent in addressing HIV for a number of reasons. However, that asset can have no impact if the government or prevailing health policy does not value the contribution and instead sidelines his or her voice. Finally, the PAT column requires us to take the answers from the first three columns and point them out to government in order to ensure that public health policies are properly aligned to the assets and capabilities that are evident in the region they serve. In many ways this links to capabilities. In essence policy alignment aims at making all assets and agents more capable in the health system.

My research was initially designed to contribute to the RHA-HAT or Health Agency perspective. As such, my main focus was to understand healthcare providers' perceptions of health and provision of health care and to investigate whether or not and how religion plays a role in affecting this agency. Although I succeeded in at least beginning to understand the broad influences on the agency of the nurses at Scott Hospital, I soon came to realize that it was impossible (within the limits of an MA dissertation or even a PhD dissertation) to fully understand all of these influences. It was also impossible to separate out religion as the primary influence I was interested in. As such my findings give a far broader overview of the dominant discourses affecting agency and further research will be required to fully understand the impacts that religion specifically has on the nurses' views of health.

I have also been able to identify some features of the capability assessment (CAT) aspect. I do this at a discourse level rather than at the level Sen would assess capabilities and freedoms. For Sen, freedoms and unfreedoms are largely a result of institutions and organisations or states of affairs such as authoritarianism. These elements would all be seen as contributing to unfreedoms or as constraining capabilities. The only attention that Sen gives to tradition and culture is his recognition of the debate between those that say that development will wipe out important traditions, and those that assert that it is development is important regardless of its effects in tradition. For Sen, this argument is invalid as it does not look at agency and the role of agents in choosing whether or not to follow certain traditions; that is, in accepting or rejecting their legitimacy. This is most certainly valid. I would assert however, that traditions and culture themselves play an extraordinarily important role in understanding capabilities and thus need to be given more attention. Has been discussed in the theoretical framework, discourses embedded in religion and culture have immense power in influencing people's behaviour. Thus it is clear that understanding discourses is not only important because of its link with agency, but because it also impacts on capabilities. Although I have made some comments on this, more research could be done to understand this impact.

2.7. Methods used

Before focusing on the methods used in this particular dissertation I think it is important to outline the methods that the Lesotho team used as a whole and locate my own methodology within that framework.

The Lesotho team was made up of researchers with backgrounds in theology, sociology and anthropology. As such, the team initially leant far more towards qualitative methods than quantitative methods. This was a major strength within the team as it allowed us to uncover very rich and contextual information to

describe the health picture at the various sites. However, we have also recognized the weakness in this method. The ultimate aim of the ARHAP research is to inform public health policy and it is very clear that the type of analysis we have produced is not necessarily relevant for public health practitioners and policy makers. Thus it was often frustrating to find that we had very interesting evidence but could not articulate it in a way that would interest the key role players. Having stated that, we treated our initial, contextual findings as a basis on which to build further research and in January of 2006 we embarked on testing new research tools.

ARHAP found it necessary to determine a set of tools that could be used to address various target groups across different countries and come up with comparable findings. Once again I outline the tools used below but must credit the ARHAP leadership (Prof. Cochrane, Prof. de Gruchy, Mr. Germond, Ms. Schmidt) for the work behind these tools.

The tool we went into Lesotho with in January of 2006 was called the PIRHANA workshop. PIRHANA stands for Participatory Inquiry into Religious Health Assets, Networks and Agency. In essence it is prescribed set of activities that are conducted with focus groups that encourage the groups to think about their health assets and their religious assets and the intersection between the two. The target groups for each area include community members (as one focus group) and community leadership (as another focus group). The PIRHANA workshops are based on participatory research models and use tangible activities to express ideas. There are various strengths and weaknesses of these workshops however it falls outside of the ambit of this project to discuss these at this point as my own research was not based on this tool. However, I do make one or two references to these workshops and the findings they produced.

My research fell into the first phase of the Lesotho study – understanding the health and religion landscape of Scott Hospital in Morija. As such my case study

uses qualitative methods including interviews, focus groups and observation. I did also design a questionnaire but most of my findings are based on the qualitative methods.

2.7.1. Preliminary investigation

I approached my research by first conducting some preliminary research in Lesotho. This helped me to decide whether or not conducting my research in Lesotho would be useful and it allowed me to begin to understand the health and religion situation in Lesotho. It was only after conducting this preliminary investigation that I began to formulate my research question and methodology.

My first point of call therefore was the Christian Health Association of Lesotho (CHAL) where I was privileged enough to meet with the director, Mrs. Grace Nchee. She was able to provide me with information regarding the relationship between CHAL and the hospitals, as well as how CHAL works with the government. The Christian Council of Lesotho (CCL) was able to give me some pointers as to what was happening in and around Maseru with religious health initiatives. Finally, I visited key leaders in the larger church denominations of Lesotho to try and understand what the picture was in Lesotho with regard to health and religion, and to introduce ARHAP, and specifically my research to them.

Once I had a clearer understanding of what was happening in Lesotho and what the initial attitudes of people were about the topic I could begin to formulate a research question and design. The question stemmed out of the realisation that health was a very contested terrain in Lesotho, one in which the state, the church and the association of Lingaka (traditional healers) had vested interests in and one that was constantly in a state of flux. I wanted to understand this more clearly and chose to do this through a case study of Scott Hospital in Morija Lesotho for the reasons stated above. It was also a good case study to evaluate

how the politics of health plays out. Although many of the seekers at Scott subscribe to cultural understandings of health, and although there are these competing discourses around health, the Western perspective of health, incorporating a socio-environmental and biomedical view, still dominates. I was interested in finding out why this was the case and whether or not it was beneficial.

2.7.2. Key informant Interviews

The preliminary research I conducted in Lesotho was based on key informant interviews with the head of CHAL, the CCL and with leaders from various churches in Lesotho. In addition, upon my arrival at Scott Hospital I requested an interview with the hospital administrator, Mr Makara, to request permission to conduct the research and to introduce our research projects. Mr Makara was most helpful as a key informant and much of the information about Scott Hospital is drawn from this interview.

The interviews with the heads of the various nursing sections were not intended to be key informant interviews but in many ways this is what they became although I have used the findings from their interviews on both a key informant and participant level.

2.7.3. Interviews

The research question was aimed at understanding how providers form attitudes and beliefs around health, and gauging what influenced their perceptions. Although various tools exist to gain this information such as the health belief model discussed by Radley (1994), I felt that they were not ideally suited to my specific question. Firstly I was interested in gaining more detailed data from which I could extract the underlying values. I therefore felt that face to face interviews, in which I could gauge people's body language, intonation and exact wording would be a better method to use. Secondly, many of the tools that are

currently used by public health experts are designed from a Western perspective. As I was trying to gauge the multiple influences that might play a role in healthworlds in Africa, I felt I needed to give the respondents the space to express those values, rather than be tied into specific answers that might not give an option for that expression.

2.7.3.1. Semi-structured interviews

I used a semi-structured interview strategy in which I had set questions to ask but wanted to encourage more in depth discussion and follow up on significant points that were made. I also attempted to structure the interview in such a way that the interviewee would feel as comfortable as possible speaking to me. The order of my questions was based on the idea that the life story and telling ones life story is very important in African culture. As such I tried to elicit the life story of the interviewee by asking them about their families and their upbringing. These questions worked well in that they brought out underlying influences and ideas that would otherwise have not been mentioned.

I also wanted to discourage the interviewees from thinking of health simply in the hospital and work setting and encourage them to think of health more broadly. As such I had levels of questions, based on Germond and Molapo's (2006) work on bophelo that identifies socio-spatial arrangements of health. I thus asked the interviewees to think of health in the workplace, in their homes, in their communities, in their churches and in their country. This worked to some extent but as will be discussed the problem of interviewing them at the workplace often meant that their answers were very much rooted in their day to day work.

Unfortunately, the interviews were somewhat hampered by power dynamics and language barriers. Although all of the nurses and nurse assistants can speak English and are taught in English, they more freely express themselves in their vernacular – Sesotho. There are also various words in Sesotho that do not have

a direct translation into English such as the word bophelo that has been previously discussed. Similarly there are no words in Sesotho that distinguish between religion and health. Thus, meanings cannot be fully understood in one language. This presented more of a problem with the nurse assistants than the nurses. Nevertheless, interviews would have been more effective if conducted in Sesotho.

The power dynamics were also very interesting. There are three aspects to this. Firstly, the hospital administrator required the interviews to be conducted in the boardroom of the hospital offices. The board room is associated with power and is the place where high-level decisions within the organisation are made. It thus affected the interviews, especially with nurse assistants, who I sensed felt the need to say the right thing, rather than what they really felt. This was not such a problem with the nurses, many of whom were themselves the decision makers in the hospital and were thus both used to the boardroom and were confident enough in their own opinions to express them.

Age also played a significant role in the power dynamics of the interview. As an unmarried woman I am seen from a Basotho perspective as a girl as opposed to a woman. Authority comes with marriage for women in the Basotho culture, and most especially with having children. Thus, while I greeted all of the nurses, regardless of age as Mme (mother, denoting a sign of respect), I was greeted as Ausie (sister, or girl, denoting my place in the social system). It was thus strange for a girl to be asking a mother the questions I was asking and it felt strange to have both a sense of authority in coming from a university in Johannesburg as well as a sense of humility in who I was within the Basotho social ladder. It was quite difficult to bridge the two cultural worlds.

Finally, race played a factor in the interviews, more so with the nurse assistants than the nurses. Although I was closer in age to the majority of the nurse assistants, they seemed more intimidated by me both due to my race and due to

my education. This hampered the interviews a bit with many nurse assistants worried about saying the wrong thing despite my reassurances that there were no wrong answers.

2.7.3.2. Informal interviews

Some of the issues around the semi structured interviews were mitigated by the fact that I was able to talk less formally with some of the nurses. This was not an intentional research tool but it did provide some very interesting data. When the nurses went to visit the health centres I would offer to give them a life and chat to them on the way. I was also able to talk less formally with the nurses and nurse assistants when I was with them in the wards.

This provided some mitigation for the problems of the formal interviews and the respondents were far more open with me when we were 'chatting.' It also gave me a chance to sometimes ask their opinions on health when we weren't in a work setting. This encouraged them to open up more about their perceptions of health and in one instance a nurse assistant that had stated that the hospital should not work with the traditional healers in her formal interview, in fact suggested that she would visit a traditional healer herself.

The problem with these informal interviews was that they were spontaneous and by their nature not recorded and transcribed. As such I had to rely on my handwritten notes of the conversation which were sometimes written hours later.

2.7.4. Focus Groups

On analysing my interview data, I noticed that there were some patterns that were coming to light regarding dominant discourses. I decided that these needed to be further tested in a different setting to the one that had been used for the interviews. I needed to test whether these patterns were real and not simply a result of the limitations of the interviews discussed above. Thus, on my last fieldwork visit to Morija I set up one focus group with nurses that I had not

interviewed before and one with nurse assistants that had not been interviewed before. I specifically requested that these be held in the staff room rather than the boardroom to avoid the limitations that were experienced in the interviews. During these focus groups I used two exercises to try to gauge the dominant discourses that were at play for each group. The first exercise drew on a self-reporting health tool that I developed into an exercise for a focus group. I drew a graph line (see figure 13 below) with faces indicating differing levels of health on which the participants had to rate their health and explain why they rated it as such.

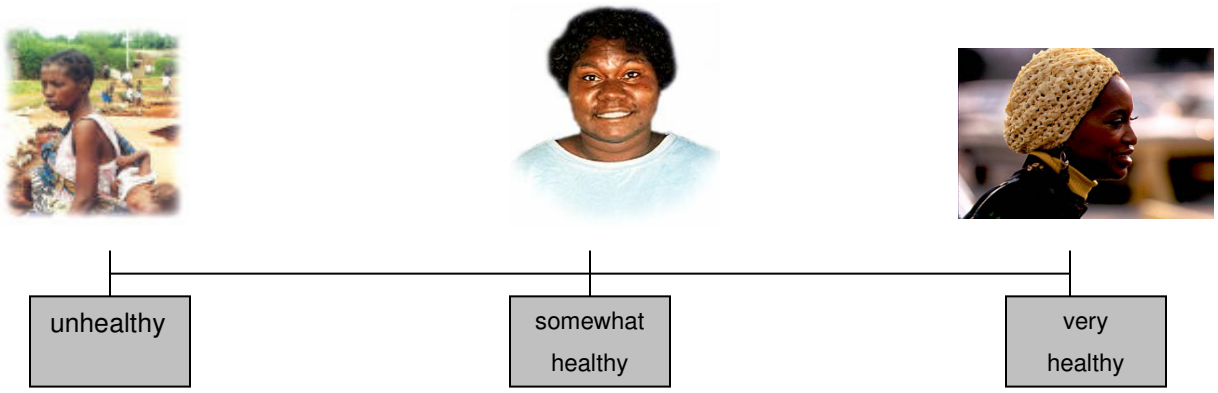


Figure 8: Graph used for self reporting health in focus groups

The second exercise required the participants to identify what was important for the health of their community. I provided a sketch of a map of Morija (see fig 14 below) with some landmarks and asked the participants to fill in what was missing and identify what was important for health.

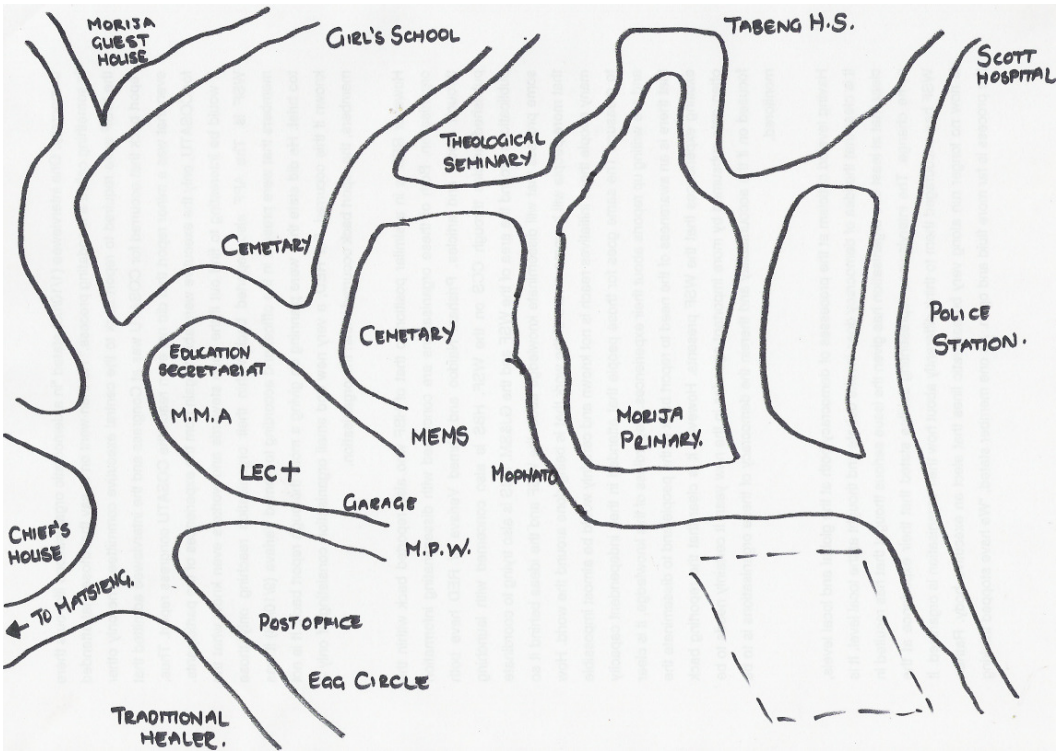


Figure 9: Map of Morija used in focus groups

These focus groups provided some very interesting data. However, as with any method, there were some limitations to these focus groups. Firstly, focus groups need to be managed slightly differently in Lesotho. Despite having booked the staff room for the duration of the focus groups, other staff members still kept wondering in and out. This created the impression that the focus group was simply a discussion that anyone could join and leave as they felt. Thus at times I had six people in the group, at other times ten. Fortunately there was a core group of about six that stayed for the duration of the exercises. I don't think that this element marred my findings all that much but it is something that ARHAP, and other researchers, need to consider when conducting focus groups in certain areas of Africa. The ARHAP Lesotho team experienced the same problem when conducting PIRHANA workshops in Maseru. These meetings are culturally seen as communal meetings from which nobody should be excluded.

Secondly, I asked that the participants feel free to speak in whatever language (English or Sesotho) they were most comfortable expressing themselves in. This became both a strength and a weakness. Allowing the participants to speak in Sesotho led to a much richer discussion, however, as I cannot speak Sesotho

myself the task of facilitating the focus group became a little more difficult and I was not able to probe discussions that were occurring. Fortunately, many of the participants did speak in English, allowing for an even balance in the focus group dynamic. The focus groups overall worked very well and provided interesting data in themselves, but also backed up the data that I had gathered in my interviews.

2.7.5. Observation

Although I did not intentionally intend to use observation as a data gathering tool, a lot of information was gauged from simply observing my surroundings and the way nurses interacted with patients and with one another. This was the case primarily because I lived so close to Scott Hospital for the time I was in Morija and because I was immersing myself in the culture for the first time.

Once I realized how much information I was gaining from observation I decided to take full advantage of it. I arranged to go on field trips to the health centres with the nurses and I asked to be allowed to spend time in the wards with the nurses where I could observe them.

I had the advantage of being an outside observer in a very open community. That is, I was able to avoid the subjectivity usually associated with being a participant observer but at the same time the nurses did not seem to be affected by my presence and did not change their behaviour in any way, but rather were very open to having me with them and showing me what their work entailed.

2.7.6. Questionnaire

Having identified some of the common themes that were evident from the interviews, we considered designing a questionnaire aimed at eliciting responses about the discourses that influenced people's attitudes about health. We wanted to distribute the questionnaire to various nurses and nurse assistants at Scott

Hospital as well as at other hospitalswe visited such as Paray Hospital in Thaba Tseka and Mokhotlong hospital. The purpose of the questionnaire would be to corroborate the findings from the interviews and test the findings at both church run and government run hospitals.

The questionnaire was drawn up using hypothetical situations with five response options, each reflecting a different health discourse or value. (see fig 7 below). These were then translated into Sesotho and were handed out to nurses and nurse assistants at the various hospitals we visited. Due to the nature of my research and the difficulty of working with a grounded theory approach, we only decided to use this method on our second trip to Lesotho. As such we were not able to test the tool before using it. Rather, the tool was first tested during my research and subsequently modified. This resulted in some complications with the responses such as hypothetical situations being interpreted differently by the some of the respondents, or certain hypothetical situations being seen as so out of their ordinary experience that they were unable to respond. An additional complication was that many of the nurses, and particularly the nurse assistants had little or no experience with answering questionnaires and thus took a long time to complete the exercise. This made collecting the questionnaire after our trip very difficult and we did not get a good return rate. We handed out 50 questionnaires and received only 32 back. These experiences have been used to modify the tool for future research. Having stated the limitations of this tool it is clear that the results from it would be somewhat misleading. For this reason the findings from the questionnaires are used only anecdotally and no trends were identified form the responses.

6) The rate of stillbirths has risen alarmingly amongst the women in your village. What could be reason for this?

A. There is a drought and the pregnant mothers are experiencing nutritional deficiency
B. This is punishment from the ancestors
C. The clinic nearby has had to close down and they are not able to go for antenatal care
D. People are turning to using traditional birth attendants
E. This is punishment from God for immorality in the village

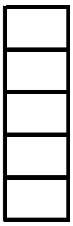


Figure 10: Example of question in questionnaire

2.8. Ethical Considerations

All proper ethical procedures were followed. We asked for permission to conduct our research from the relevant authorities in each hospital and described what the possible outcomes of the research would be in terms of policy implications.

At focus group meetings and interviews the purpose of the research was described and respondents were told that they did not have to participate, could withdraw at any point without prejudice and that if they wished their identities would be kept anonymous. No respondents asked not to be identified. Questionnaires were responded to anonymously.

We were very aware that talking about health issues could potentially be sensitive to some respondents and every effort was made to ask questions as sensitively as possible. Interestingly enough, for some respondents, the interview process became a space in which they could offload and release some of the tensions of traumatic experiences. One respondent in particular had had 2 siblings and a child die and she suggested that it was due to AIDS. The interview became a place in which she could tell her story and cry and in many ways it was a healing process, rather than a traumatic one.

We all experienced a major tension in trying to gain information from people and organisations that were struggling to make ends meet and fulfill their obligations,

without giving anything tangible back. Although we could explain the ARHAP plan to make recommendations to government about how to plan healthcare in a better way, these assurances simply did not feel like enough. I tried to resolve this tension for myself. It was agreed with the hospital administrator that if I shared the findings of the report, he was happy to have the research conducted there. In addition I would often reciprocate by giving nurses lifts home or to other clinics. However, a problem did arise in my focus group meetings. Some of the participants identified poverty as a reason for feeling 'unhealthy.' After the focus group I was asked how I was going to solve their health problem (referring to poverty). It was a difficult situation to be in and one that might have been avoided if I had offered them something in return for their time and input at the focus group. This is something that must be taken into consideration when future research is conducted in resource poor areas.

Although there were some problems with specific methodologies, the strength of this research is that it is able to draw on data from various research tools. That is, the interviews, the focus groups, the observation and the questionnaires together provided very rich data with which to work and the internal problems of each method were mitigated by the strengths of other methods. In addition, I was able to draw on research from other team members in order to compare, confirm or challenge many of my findings.

3. DEVELOPMENT, HEALTH AND RELIGION IN LESOTHO

As has been stated previously, this dissertation aims to contribute to the development literature at a broad level. By calling for a new way of understanding health in Morija, it is by implication also advocating a new way of approaching development in developing nations. Health is a key indicator of development. Similarly, how we deal with health in developing nations can provide lessons for broader development goals. Thus, whilst this dissertation is primarily concerned with understandings of health, this should not be divorced from a broader commentary on development theory. In order to illustrate how health and development are intertwined in Lesotho particularly, and how shifts in development thinking have affected healthcare, this chapter will provide a historical background to development discourse and its impact in Lesotho generally and specifically on healthcare in Lesotho. It looks at the how development has traditionally been understood and the positive changes that have come about with the work of Sen and Nussbaum. It links these development changes to the historical context of Lesotho and indicates how this has led to the particular situation that Lesotho is currently in, in terms of development and particularly in terms of health discourse. Finally, it goes on to consider how health is a development indicator and is intricately linked to development of a community and illustrate why understanding the discourses of health is important.

3.1. Contributing to development thinking

In the era of rising poverty and decreasing health standards for sub-Saharan Africa, and of increasing development in America and Europe, it is clear that development and health policies have largely failed to make a major impact on the lives of the poor and disenfranchised. The recently released United Nations

Development Report on Water and Sanitation indicates that 2 billion people in developing nations live without clean water and 1 billion have no access to sanitation (SABC news report, 23 November 2006). This is happening in an era where development has created a multi-million dollar industry[7].

As a development sociologist, I am keenly interested in understanding what the best way is to approach development, and especially health development. I would suggest that one of the reasons for this failure is the persistence of a discourse of development that systematically continues to disenfranchise the poor by forcing a particular (Western) set of values on those it aims to target. Solutions that are rooted in these values thus tend to fail, as they do not resonate with the target population. As such, it is vital to understand the values and beliefs of people before one can try to make any intervention. All too often, the value systems of the 'underdeveloped' are dismissed as being superstitious or shackles that prevent their development (Rostow, 1960). However, what development practitioners have missed out on is the fact that these value systems influence behaviour quite significantly. As such it is imperative that they are understood.

Many of these value systems are rooted in religion. As such, one needs to understand the religious frameworks that influence target populations. This then has been the major failure of development discourse thus far. A closer look at how development discourse has progressed will illustrate this point with more clarity. Sen and Nussbaum provide a useful theoretical framework within which to consider development – that of the capabilities approach. However, what is missing in their respective work is an emphasis on the social aspect of development. In thinking about development from Sen's perspective, the focus becomes placed on the individual's potential capabilities and his/her agency. What is missing is an analysis of communities, of organisations and the potential

[7] Ferguson (1990: 8), commenting on the development industry in Lesotho in the 1990's, states that the development industry has spent $64 million and employs "expatriate consultants and 'experts' by the hundreds, and churns out plans, programs and most of all paper at an astonishing rate."

and assets that they have as structures. A critical realist approach to development will solve this issue and it is here that the concept of healthworlds becomes so important.

3.2. Development discourse

Development as a discourse has been in existence for around half a century. Since the 'discovery' of the underdeveloped, various practitioners have discussed theories and policies to best address the problem. The area of development has grown substantially as an area of scholarship and of business ventures. Interestingly however, since the development of development as a discourse, the 'underdeveloped' have become worse off than they were 50 years ago. So prevalent is this idea of development and underdevelopment that the statistics have perhaps been exhausted. Since the development of development as a discourse, global poverty has steadily decreased. However, in Sub Saharan Africa poverty increased (despite the focus of development initiatives in this region) until the late 1990's when it eventually returned to the same levels as 1950 (Ferreira & Ravallion, 2008). In addition, if China and India's economic growth is excluded from the data, international inequality has increased quite significantly from a Gini Coefficient of around 0.44 to 0.54 since 1950 (Ibid.). This is the legacy of the development discourse. There are various contributing factors ranging from unequal access to resources, technology, unfair terms-of-trade and internal corruption, depending on what theoretical background one is coming from. However, it is interesting to note that the demise of these countries has occurred at a time when development as a discourse was growing in strength. Despite very few successes, the majority of development interventions seem to have failed, leaving those that development aims to benefit worse off than they were before interventions. Can this observation be called a correlating relationship or is it just coincidence that just when practitioners take cognizance of the underdeveloped and try to impose development theories and ideologies upon them that their situation worsens? And whether this is a relationship or not,

what is to be done about the plight of the poor? These are questions that can only be answered from particular perspectives with particular definitions of what development means.

Before it is possible to analyse what we mean by development, it is necessary to understand the history of development as a discourse and with that to understand how thinking is constrained by the particular ideology of development that has gained hegemony the world over. Once we understand and deconstruct the discourse it will be possible to discern how this discourse, in its various theoretical formations, has failed. The underpinnings of modernisation theory, dependency theory and neo-liberal conceptions of development are all the same and stem from the dominant development discourse. Thus the failures of these theories can be discussed in conjunction.

3.2.1. The development of development as a discourse

Development as a discourse has its roots in the presidential address of president Truman post World War II where he first coined the term 'underdevelopment,' referring to the countries of what was to be called the third world during the cold war. In one speech, large majorities of the world's population were suddenly labeled as underdeveloped – a value judgement that measured them against the goals and lifestyles of average Americans and west Europeans. The coining of the term and the resultant concern for the development of these nations led to a growth in development thinking and theorising. As Sachs (1992: 6) states, "that very day, the day on which President Truman took office, a new era was opened for the world – the era of development." However, because the goal or model of development was initially set up as that of the USA or Western Europe, this thinking and theorising was very much constrained. From the beginning of development thinking, a dominant discourse had been put into place.

Escobar defines a discourse as “a process through which social reality comes into being … the articulation of knowledge and power, of the visible and expressible” (1997: 85). It is psychologically necessary for everyone to interpret, understand and give expression to their experience of the world through the use of specific paradigms. They are the tools through which everyone can make sense of the world efficiently. However, the problems associated with discourses or ideologies must be pointed out. Inasmuch as discourses or paradigms provide the framework for efficient human thinking, they do so by limiting us. They do this by filtering out what is deemed within the discourse or paradigm as unnecessary or invalid information or ideas. Although discourses may seem innocent and often work “tacitly” (Germond, 2003), that is, they provide taken for granted ways of thinking, it is precisely in this tacit knowledge that the power of discourse lies. Whether interested parties use discourses consciously or whether it is simply an outcome of discourse and the way we think, discourses remain powerful tools in the way they limit thinking and dictate what is important and what is not. As Escobar states, discourses “create a space in which only certain things could be said and even imagined” (1997: 85).

If discourses provide such a tool of power, the relationships of power that exist within these discourses must be unpacked and analysed. This is a typically Foucauldian project. It requires us to analyse the dominant voices and seek out the voices that have been quieted or denied the opportunity of voice along the passage of the creation of the discourse – in this case the voices of those at whom development programmes have been aimed. It is in this process that the power dynamics at play can be understood. This understanding provides the impetus for the deconstruction of the discourse in order that the unheard voices may be given an opportunity to state their case. The power of reflexivity is perhaps the most powerful aspect of discourses (Germond, 2003) and aids in their perpetuation. Later, a look at the dominant discourses of health will illustrate how powerful discourses can be at both a systems level as well as, if not more so, at the tacit level.

However, discourses are also entrenched in the institutions, social processes and interested parties that subscribe to using them. The more powerful the institutions and processes are, the more powerful the discourse is. The social processes establish the underlying rules and regulations of the discourse – who can speak, at what time, the subjects that can be addressed, the perspectives that can be used.

> "These relations – established between institutions, socio-economic processes, forms of knowledge, technological factors, and so on - define the conditions under which objects, concepts, theories and strategies can be incorporated into the discourse" (Escobar, 1997: 87).

Governments may for instance push the agenda of Public Health while sidelining traditional forms of healing. Missionaries and colonists certainly tried to suppress traditional forms of healing while pushing the biomedical discourse in Lesotho. It is thus imperative that the institutions and processes around the discourse also be analysed. It is the power of the institutions and processes around the discourse, as well as how well it is able to perpetuate itself and how watertight the argument seems that determines how powerful or dominant the discourse will be.

Discourses gain hegemony by claiming to explain a lot, explaining away or denying refutations, blaming anomalies on implementation rather than the discourse itself, and creating ad hoc arguments that explain falsifications thus making the discourse seem holistic and extensively explanatory. How does development discourse use these elements to gain and maintain hegemony?

The institutions and social processes around the history of the development discourse are a major factor in how it has come to gain hegemony. A brief history was given of the development discourse at the beginning of the dissertation. However, this needs to be extended. Development as a discourse has its origins

in America, and thus from the start, the model or goal for development was America – that is economic growth, rapid industrialization and technological innovation. Other models were never even conceived of. Whether this stemmed from a patriotic or nationalist motive or whether other development models were just not imagined is irrelevant. What does matter is that the result was that America was set up as the goal. This had profound implications for the development discourse. Furthermore, because the roots of development as a discourse were in America, much of the academia around development was American or western in origin. Thus, the thinking was very much removed from the reality. The result was that the subjects of the thinking were just that – subjects, with all of its colonial connotations and power implications.

Another point of history that must be considered is that development discourse has its roots at the same period of history as the demise of colonialism. While colonial powers relinquished control of their territories, a neo-colonial relationship in varying degrees began to take root. The underlying thinking behind this neo-colonial relationship was that for the newly independent countries to have a chance at development, they would have to model themselves on their colonial predecessors. There was very little room for new ideas or conceptions of development or progress. The goal was once again the West. Ferguson (1997) and Molapo (2005) contend that the dominant discourse of development in the postcolonial era was such that it served to silence the voices of those it aimed to address by labeling them “less developed” or “underdeveloped” and by implication unable to actively contribute to their own development. For Ferguson this was a feature of the dominant development discourse – “to portray developing countries in terms that make them appropriate targets for such packages” (1997: 224) Thus the already power laden relationship of colonial master and subject continued as a development project.

The same can be seen happening when it comes to health discourses. The colonial project served to entrench the biomedical discourse of health in Lesotho

and elsewhere. It did this by ensuring that the traditional discourse of health was silenced. I have already illustrated how this was done by missionaries. The colonial governments continued this silencing project by ensuring that traditional healers were not recognised in official health policies as legitimate healers. To replace them, more biomedical hospitals were built and it was only later (in 1978 in Lesotho) that traditional healers were once again given a voice in national policy. As Turner (2004) points out, traditional healers are still relegated to the realm of alternative or complementary (i.e. secondary to biomedical) medicine, this despite the fact that "some 80% of Africans use traditional healing methods" (Airhihenbuwa, 1995: 47).

Another factor in the gaining of hegemony is that development discourse took root at around the same time as the establishment of the United Nations and the Bretton Woods Institutions. These institutions held power in the arena of development. Furthermore they were dominated by the West and were used to dictate how development was to occur. All of these occurrences around the same time, worked to ingrain the development discourse as it was theorised at that time.

> "The development discourse was constituted not by the array of possible objects under its domain but by the way in which, thanks to this set of relations (between new ideas and the establishment of new institutions), it was able to form systematically the objects of which it spoke, to group them and arrange them in certain ways, and to give them a unity of their own" (Escobar, 1997: 86 – 87 italics mine).

This unity of the discourse was further entrenched through the above-mentioned use of ad-hoc arguments. The discourse claimed to explain everything and provide a holistic solution to the whole problem of underdevelopment. However, there were failures that threatened to falsify the discourse. These were theorised and refuted by using ad hoc arguments or drawing on the theory. Thus if a development intervention failed, it was not the theoretical underpinnings of the

interventions that were questioned but how well it was implemented. This technique is summed up by the statement 'if it works, it's because of the theory, if it doesn't work, it's because not enough of the theory was put into place.' Thus, development discourse has taken on a specific shape and has managed to gain and maintain hegemony over a period of 50 years. An analysis of the specific ways in which this discourse shapes thinking (highlights some arguments and diminishes others) is possible only through looking at the specific ways in which development has been conceived of over the years.

3.2.2. Specific Development theories and their failures

Development discourse has taken on various forms since 1945. Each theory has constructed the route to development differently. However, the theoretical underpinnings of each have not changed.

> "In other words, although the discourse has gone through a series of structural changes, the architecture of the discursive formation laid down in the period 1945-1955 has remained unchanged allowing the discourse to adapt to new conditions. The result has been the succession of development strategies and sub-strategies up to the present, always within the confines of the same discursive space" (Escobar, 1997: 89).

Escobar reflects the same idea that Rist (date) discusses when he states that the west's belief in progress and development can be called the religion of the west. Keeping this in mind, three dominant development theories will be discussed. Each of these theories illustrates the dominant development discourse, which can be criticised on various counts, for its failures to lead to comprehensive development. Through a discussion on these dominant theories I will look at how these development discourses have impacted on Lesotho and in particular on healthcare in Lesotho.

3.2.2.1. Modernisation theory

The early roots of modernisation theory can be seen in the works of two of the fathers of sociology – Durkheim and Weber. For both theorists a clear distinction between traditional and modern forms of society could be seen. For Durkheim, society could either be classified as organised by mechanical solidarity (traditional) or organic solidarity (more modern) while for Weber, there was a clear distinction between the "'traditional', 'leisurely' pre-capitalist culture to the diligent hard working ethos of 'modern' capitalism" (Webster, 1990:46). From both perspectives, modern society is conceived of as better than traditional society. This is perhaps because both Weber and Durkheim were writing in the period of modernity when the aspects of science, rationality and individualism were (and still are) upheld as the virtues to follow. Thus the modern society that is based on scientific laws and rational organisation that encourages individual expression is seen as better than the traditional society usually characterised by such terms as lazy, backward, shackled by tradition, superstitious or primitive. This then forms the basis for modernisation theory.

Like these theorists, modernisation theorists also draw the distinction between traditional and modern society. Traditional societies were defined as those societies that had a "restricted capacity to solve social problems and to control the physical environment" (Coetzee et al., 2001: 28). Within a traditional society, the kinship system is at work and provides the basis for social relations. A person's position within the kinship system is ascribed at birth (Webster, 1990). It is not achieved and therefore, it is said that there is no impetus to work towards a goal. Traditional societies are superstitious and governed primarily by emotion.

This traditional society is contrasted to the modern society seen as a society with the capacity to control the physical environment for its benefit and able to reproduce itself effectively due to its capacity to handle internal and external pressures (Coetzee et al., 2001). It is based on rationality and science rather than emotion or superstition. These societies are based on the meritocratic

system and therefore individuals are driven to achieve goals and progress forwards. The society has high rates of innovation and this contributes to the entrepreneurial nature of the society. It is characterised by scientific and technological feats, mass consumption and capital accumulation.

The route to development therefore is for the traditional societies to shake off the shackles of tradition and follow the path of the modern societies. The modern society is set up as the goal for development, unquestioningly. And the path that these societies followed is seen as the trajectory for development. Development is thus conceived of in a linear fashion, with certain steps leading closer and closer to development in the form of the modern society. If this theory is applied to health the impetus for the silencing of traditional discourses of health is clear. Traditional healing is labeled as superstitious and unscientific. As such, people should be discouraged from using traditional forms of healing. Traditional forms of healing are synonymous with tradition, backwardness and primitive and the modernisation project requires people to be unshackled from tradition in order to modernize. Healing therefore must come from the scientific, rational premise that biomeidicne in particular encourages. Modernisation theory is used as a basis on which traditional discourses are silenced.

The main theoretical critiques of this theory will be returned to later. What is important at this stage is the theoretical underpinnings of the theory. For modernisation theorists development is conceived of as a linear project that will take a traditional society (undesirable) to a state of modernity (desirable). The modern society as set out above is seen as the goal. The modernisation theory derives from the functionalist approach and is thus based on a conception of society that sees every part of society as working together harmoniously. The presumption is that all societies can look and work in the same way and thus one theory of development will solve the problem of underdevelopment.

a. The Modernisation project in Lesotho

As Molapo (2005: 3) states, there are “three key moments that inform the current configuration of Lesotho.” The first is the pre-colonial, pre-missionary era, followed by the missionary era and the colonial era. For most Basotho, any recalling of their history must begin with the king of Lesotho, King Moshoeshoe (Thompson, 1975; Machobane, 1990). He is accredited with having united the Basotho and creating the Basotho nation by attracting other chiefs to him at a time of upheaval called the Mfecane. Moshoeshoe became a chief in 1820 and developed a stronghold that had its headquarters at Thaba Bosiu. Moshoeshoe chose this area because it acted as a natural fortress. His achievements in unifying the Basotho nation can be attributed to his wisdom as well as his intelligence in war. At the time of Moshoeshoe, Lesotho incorporated what is today Lesotho, as well as much of the current Free State. In the 1830’s missionaries began arriving in Lesotho and Moshoeshoe welcomed them. It is generally accepted that his invitation to the missionaries to stay was a wise step that in many ways prepared Lesotho to stand their ground in the colonial wars that affected his rule.



Figure 11: Moshoeshoe



Figure 12: Map of Lesotho in Moshoeshoe's era (Couzens, 2004)

As has been stated previously, the first missionaries to arrive in Lesotho were from the Paris Evangelical Missionary Society (PEMS) (Couzens, 2004) and had an enormous impact on the Basotho nation through introducing what were Western values of religion and healthcare. This ushered in the second key moment.

This is not to say that it was only missionaries who brought Western values to Lesotho. In the 1840s the boer farmers began encroaching on Lesotho's land, leading to various battles and changes in boundaries. In fact it was during these wars that Lesotho lost almost half of its arable land. (see fig 3). This ushers in the second historical moment that impacted on Lesotho's current situation.

> "This moment dates back to 1869 and to the final victory of the immigrant Dutch settlers over Basotho. This moment is significant in that it marks the loss of Basotho of their arable lands and, therefore, of their livelihoods. It marks the death of Moshoeshoe, whose death symbolizes the end of an era of independence and prosperity and the beginning of tutelage as Basotho come under colonialism" (Molapo, 2005: 4).

The British colonial administration played an important role in Lesotho's health system, particularly in establishing the hospitals and reinforcing the biomedical conception of health as well as reinforcing the place of the missionaries and the Christian religion in Lesotho.

Following Moshoeshoe's death, and despite being a British colony, Lesotho was run by smaller chiefs with a continual rivalry for the throne. In the 1960's Lesotho began to negotiate for independence and in 1966 its independence was declared marking the final historical moment. Various political issues arose thereafter, including a coup and a reign of authoritarianism by Leabua Jonathan for 16 years. It also ushered in an era of development which saw the dominance of the modernisation theory coming to the fore both in the development sector generally as well as in the health sector.

Modernisation theory is presented in development practice as a "standardized development package" (Ferguson, 1997: 224) which included financial and technical assistance aimed at delivering economic growth that was based on better agriculture and the growth and diversification of industry. As Molapo points out this is exactly what happened in Lesotho. Development experts recommended focusing on "increasing agricultural productivity in both the crop and livestock sectors" (2005: 23). Better crop and husbandry techniques were therefore imported from developed nations in order to increase cash cropping. The ultimate aim of the development project at the time through was to "develop non-agricultural productive activities. This related to the development of manufacturing industries and tourism as a further basis of economic growth" (Ibid.). The clear assumption as both Molapo (2005) and Ferguson (1997) point out is that Lesotho was constructed by the development discourse as a nation which was an economically backward largely peasant nation and that the necessary skills for economic growth and thus development were lacking.[8] The focus is clearly on the implementation of development policies without regard for the culture and values of the people it targets. The human aspect and particularly human agency does not come into the development picture.

[8] As Ferguson (2007) points out this was clearly not true as Lesotho had been an active player in supplying the Cape Colony and white farmers with grain, cereals and livestock since at least 1910 as is documented by Kimble (1978) and Wilson & Thomson (1969). The construction of Lesotho as a traditional and backward nation thus serves to present Lesotho as a target for development assistance and the imposition of development programmes.

It is clear then that the modernisation project found a development home in Lesotho as it did in many post colonial countries in the 1960's onwards. However, at this time the modernisation approach was beginning to be challenged quite significantly from a neo-Marxist point of view. In particular theorists in developing nations (especially in Latin America) took offence to the way in which 'non-modern' societies were conceived of and began producing a school of thinking around development that came to be called the dependency theory. Interestingly, although dependency theorists critique the relationship of dependence between the postcolonial state and the First World, it was conceived of quite differently in Lesotho and this in fact served to reinforce the modernisation project.

3.2.2.2. Dependency theory

The main criticism of modernisation theory from the dependency theorists was that development was conceived of as occurring endogenously with no external influence besides, speeding up the process of development by presenting the goal as Rostow suggested (Blomstrom & Hettne, 1984). The dependency theorists pointed out, quite rightly, that since World War II, nations were inextricably interlinked and this fact could not be ignored. The global relations between nations had an effect on the development of some nations and the underdevelopment of others. These relationships have their roots in the colonial project. Not only do modernisation theorists fail to consider the role of colonialism in creating a completely different history for underdeveloped countries in comparison to developed countries, but the exploitative role of colonialism is also ignored. As Gunder Frank states, "our ignorance of the underdeveloped countries' history leads us to assume that their past and indeed their present resembles earlier stages of the history of the now developed countries" (1966: 17). Thus, dependency theorists look at the role of colonialism and later terms of trade between different nations to establish how underdevelopment came about. For these theorists there are two categories of countries – the core countries and

the peripheral or satellite countries (Frank, 1966). The core countries are the richer, more developed and technologically advanced countries, while the peripheral or satellite countries refer to those countries that are underdeveloped. The terms core and periphery point to the relationship that has been established between core and peripheral countries over history. The dependency relationship systematically weakens the colonised states, whilst strengthening the colonising states.

Due largely to colonialism, the colonised nations, especially the peasant based colonial states' production was based largely on agriculture. Furthermore, it was based on cash-crop agriculture. The process of raw material extraction had impacts for agriculture in Africa today in that many African countries still depend on cash cropping and luxury items leading them to be susceptible to market volatility. The relationship of dependency thus points to the dependency of the core countries As Leys states, "The development of the latter (developed market economies) involved a closely associated course of development for the former (less-developed countries), a process of subordinate development or underdevelopment" (1996: 99 italics mine).

While the dependency theorists introduced a very different way of conceptualizing the reasons for underdevelopment that had thus far been ignored, they did not fundamentally challenge the goal of development. As such dependency theory can be critiqued for a number of the same reasons as modernization theory. For dependency theorists, there still exists a distinction between two types of societies. Whether these societies are conceived of as traditional and modern in the modernization framework, or core and periphery in the dependency framework is irrelevant. The fact is that the dependency theorists still create mutually exclusive categories of societies. Furthermore, the development goal is still seen as the rich, developed nation, characterised by technological advancement and capital accumulation, i.e. development is seen as economic growth. Furthermore, development is conceived of as occurring in a

linear fashion. That is a country can move from the position of peripheral to semi-peripheral and core in its own right. The only idea that actually changes in the dependency theory is how that development takes place. Rather than occurring endogenously as the modernisation theorists suggest, it occurs due to a weakening of the ties with the metropolis (Frank, 1966).

b. Dependency theory and Lesotho

Dependency theory was in fact used by development experts to reinforce the dominant modernisation project in Lesotho. Rather than analysing the dependency relationship between Lesotho and Britain or other First World countries, the dependency relationship that was targeted was the one that existed between Lesotho and South Africa.

Despite being politically independent, Lesotho is nevertheless economically highly dependant upon South Africa, and specifically upon the mining industry in South Africa (Murray, 1981; Ferguson. 1997). The Ministry of Health and Social Welfare states that “an estimated 32% of the male labour force has migrated to South Africa to look for employment” (MOHSW, 1993: 1). This has provided the majority of income in the economy for many years. The effect of this is that a very high percentage of households (51.9%) are headed solely by women and as is well documented in the literature (Huisman, 2005; Katapa, 2006) female headed households are typically more susceptible to higher vulnerabilities. As layoffs occur in the mines, more and more Basotho families feel the brunt of unemployment, and the economy of Lesotho is now primarily dependant upon the South African Customs Union and increasingly on the production of textiles for export. In fact, only recently the textile industry surpassed the government as the leading employer in Lesotho (TRC, 2005).

This was seem as a key problematic for development experts in Lesotho and one that needed to be addressed by ensuring economic growth and diversification of

industry in Lesotho. The World Bank's Country Report on Lesotho (1975 in Ferguson, 1997: 25) is a key text that makes this case for development experts.

Few developing countries faced such bleak economic prospects and were so ill-prepared as Lesotho when it gained independence in October 1966. In few countries of the world was economic independence more remote from political independence than in Lesotho. In site of the fact that Lesotho is an enclave within highly industrialised South Africa and belongs with that country, Botswana and Swaziland to the South African Customs Union, it was then virtually untouched by modern economic development. It was and still is, basically, a traditional subsistence peasant society. But rapid population growth resulting in extreme pressure on the land, deteriorating soil, and declining agricultural yields led to a situation in which the country was no longer able to produce enough food for its people. Many able-bodied men were forced from the land in search of means to support their families, but the only employment opportunities were in neighbouring South Africa. At present, an estimated 60 percent of the male labour force is away as migrant workers in South Africa.

Note in the text how overstated the dependence is. This is not to say that economic dependence on South Africa does not exist - it most certainly does. The point is however overstated in the above text. The claim is that 60% of the labour force heads to South Africa. This is in contrast to the MOHSW report that reports the figure as 32%. As Ferguson (1997) points out, the mutually beneficial trade in grain and wheat that was in existence between Lesotho and South Africa since 1910 is not mentioned at all. This is not simply a gross mistake that the experts at the World Bank made but rather a rewriting of the history of Lesotho to reinforce the need for the modernisation project. In this way, the dominant development discourse of modernisation is retained in Lesotho.

3.2.2.3. Neo-liberal development model

The third dominant development dissertation did not offer much challenge to the theoretical underpinnings either and in fact simply extended them by focusing increasingly on the economic sector and rolling back the role of the state in development.

In response to the failure of third-world nations to develop, there was a reexamination of development strategies. Post-WWII there had been a new faith in Keynesian economics. These strategies involved state commitment to economic growth in the form of investing in worker education, health, social benefits and subsidies in order to aid the economy through periods of economic depression or recession. The role of the state in the third world was also a concern for development theorists. Theorists had been speculating about how the state was to be involved in development. Various hypotheses were developed. The success of South Korean development suggested that a strong state was necessary for development. However, in many countries in Africa, the state had failed to lead to development. This was not least in part due to the corruption of the state officials involved in what came to be termed the "predatory state" (Evans, 1989: 569). The result was that development came to be seen as an issue of the state's involvement in the running of the economy. Thus, when it came to nations asking for aid from the World Bank or International Monetary Fund, strict agreements were put into place in the form of Structural Adjustment Programmes. In return for the funding, nations were expected to comply with strict neo-liberal policies. The actual processes will be discussed, but what is important to note is that this model of development was based on the notion of a free market. Neo-liberalism is the ultimate example of the "veritable faith in man's secular salvation through a self-regulating market" (Polanyi, 1957: 135). In terms of development the free-market development theorists believe that with a strong bourgeoisie accumulating capital and reinvesting it in the economy, and with little state intervention affecting the rules of free competition thus encouraging foreign direct investment, the market will effectively distribute resources to all members

of society. Following from this belief in the market to solve all social ills, development was reframed in the form of the imposition of neo-liberal policies and specifically through structural adjustment policies (SAP's).

The specifics of SAP's ranged from country to country. Although the specifics of SAPs varied, the underlying principles were all the same. Neo-liberal policies required that the state withdraw almost completely from market affairs. Thus nationalized corporations and conglomerates were required to be re-privatised, and traditionally state-owned assets were to be subjected to the laws of the free-market in order to avoid the operating of inefficient organisations (UNRISD, 2003; Todoro, 2000). Similarly, state control of services was to be gradually given over to the market. The state was to aid only the poorest of the poor. All other members of society were required to operate according to the laws of the market – that meant paying for health, education and other basic services that the majority could not afford. The markets of the underdeveloped nations were required to reorient to export production as opposed to production for the domestic consumer. Subsidies and tariffs had to be removed so as to create an investment friendly market. For the same purpose, labour market flexibility was encouraged. The overall policy was one of recommodification – everything was up for sale and those that competed most effectively for the market space won. The ideology behind this model of development is perhaps best represented in Sklar's words, "The spirit of capitalism has now emerged from a long shadow of ideological distrust, attributable mainly to its historical association with colonial rule. Its growth will surely invigorate the African bourgeoisie and shape its nature as African societies begin to free themselves from oppressive statism" (in Graf, 1995: 86).

c. Neo-liberalism in Lesotho

Structural adjustment programmes were implemented in Lesotho just as they had been in other African countries (Thomas, 2000) and as Molapo (2006) points out they are well reflected in Lesotho's development plans in the 1990's. Lesotho

since 1970 has had 5 five year development plans followed by a National Development Plan that was introduced in 1996. The dominance of particular development discourses is evident in each of these development plans and this is no less the case in the five year development plan of 1992 as analysed by Molapo (2005: 28).

> "It coincided with the implementation of the Enhanced Structural Adjustment Programme and was thought to compliment that programme. It comes as no surprise then that Lesotho's fifth development plan saw the private sector as the sole engine of growth. Consequently, it can be said that beginning from the early 1990's the private sector had virtually come to replace the state and was becoming the more trusted trustee of development."

SAP's resulted in crippling failures in Africa and elsewhere. They led to increase in poverty and unemployment made all the more difficult to bear due to the lack of social spending and safety nets (UNRISD, 2004; Bello & Cuttal, 2006; Akyuz & Gor, 2001). It also led in some countries to political upheavals (Todoro, 2000). Lesotho's experience was not as negative as other African countries and SAP's actually led to some positive economic changes after implementation (Foulo & Grafton, 1998). This may have to do with the fact that Lesotho did not roll out SAP's as extensively as other African countries did. In fact, according to Ali (2006) Lesotho could be characterised almost as a non-adjusting country as opposed to 'intensively-adjusting" countries such as Kenya, Malawi and Tanzania; and "other adjusting" countries such as Mali and Gabon. Ali observes that in the case of intensively adjusting countries, poverty rates increased 45.1% in 1965 to 60.7% in 1988. In contrast Lesotho's number of people living in poverty remained the same. What can be concluded is that although poverty levels did not increase under SAP's, the poor did feel the impact of poverty harder due to the lack of state spending on the poor. Despite these failures the neo-liberal model of development continues to be dominant. This can only be

explained by the fact that the underlying principles of the neo-liberal policy are the same as those underlying the modernisation and dependency dissertation and that these underlying principles continue to perpetuate themselves due to the hegemony of the development discourse.

Documentation of Health Plans prior to 1990 are difficult to access and as such it is not possible to state with certainty how the health plans were influenced by the introduction of Structural Adjustments and the related cut in social spending. Although SAP's weren't introduced at the same intensity as in other African countries (Foulo & Grafton, 1998), leaders at the PIRHANA workshop in Maseru did identify the late 1980's and early 1990's as key historical moments that impacted on health (WHO, 2006). It is likely that Lesotho experienced at least some of the same effects of SAP's as Colombia and Mexico did. Homedes and Ugalde (2005) point out that neoliberal reforms have in fact increased inequity in access to health and reduced quality of services. This corroborates research done by Pfeiffer (2005) which indicates that at the time of structural adjustments use of faith healers increased due to the inability of people to access basic healthcare. An assessment of the health changes due to SAP's in Lesotho would be beneficial to the health literature.

Interestingly spending on health from 1988 – 1992 (the period of Structural Adjustment in Lesotho) actually increased (MOHSW, 2003). However, no data is available on health spending prior to 1988 and as such comparisons of spending on health before and during Structural adjustment cannot be made. Health seems to be one of the key areas of focus for the Government of Lesotho and as such there is a concentrated focus on making health more equitable and accessible to all in Lesotho. This will be expanded on further.

The dominant development discourse is thus summed up by a few key principles as evidenced in all three dominant models of development. The first principle is that development is equated to economic growth and thus the solution lies in

correcting the market, in whichever way the dominant model sees as most useful. The second is that the goal of development is still held up as the developed, modern, core countries as epitomised in the lifestyles of the west; and that this goal is desirable to all. Thirdly, development occurs on a trajectory from underdeveloped to developed – it is conceived of as a linear process. Finally, all underdeveloped nations can be grouped together as having similar contexts and problems. Similarly, all developed nations can be seen as forming a developed model. These principles thus constitute the dominant development discourse. This discourse has managed to gain and maintain hegemony for over half a century. Returning to how discourse becomes hegemonic, it is evident that the dominant development discourse has gone through the same procedures.

Institutional structure and social relations play a primary role in maintaining discourse hegemony. As was seen in the analysis of neo-liberal policy in particular, the institutions of the World Bank and the International Monetary Fund have had a huge impact on entrenching the ideals and principles of neo-liberalism across numerous countries. And these institutions upheld the dominant discourse before the imposition of SAPs. In the same way, scientists and Western qualified doctors, through universities have maintained the dominance of the biomedical model of health.

Ferguson (1997) presents an excellent analysis of how local politics is written out of or silenced in the dominant development discourse in Lesotho. Molapo (2005) also illustrates how local conceptions of development as expressed in the concept of Bophelo are not seen as viable by the simple virtue of being traditional. The use of ad-hoc arguments is prevalent in the dominant development discourse and is used to reinforce the dominance. As can be seen by tracing the development of the discourse, the underlying principles of the discourse are never questioned. What is questioned is implementation - whether it should occur endogenously (modernisation), or through cutting relations with the core (dependency), or through increased market expansion and withdrawal of

the state (neo-liberalism). Thus for development experts, the problem of development is not a problem of the discourse, but of the implementation of the discourse. Neo-liberal policy is an excellent example of this circular argument. If development is a success, it is because of neo-liberalism. If it fails, it is due to not enough neo-liberalism. Thus the discourse in itself needs to be critiqued. Perhaps it is time, looking at the failures of development thus far, to go to the fundamentals of the discourse and deconstruct it from that point.

3.2.3. Critique of Development discourse

The first critique of the discourse goes to the heart of how development is even conceived of. As has been illustrated through the analysis of the three dominant development models – development is erroneously equated with economic growth. This assumption derives from the belief in the market that provides and distributes resources, and places within the individual the impetus to achieve. In practice however, the market economy has led to a distortion in distribution with the gap between rich and poor gradually growing. Development cannot be equated to economic growth. Despite attempts over the years to integrate new indicators of development; including literacy rate, mortality rates and access to services; at the end of the day as Latouche states, development indicators are "always a question of variations, more or less subtle, on the theme of standard of living, thus of numbers of dollars per head" (1997: 135). The implication is that nations and populations are classified as underdeveloped due to their low income per capita. Other aspects of life and humanness such as integration with community and environment are not taken into account. As a result, people are labeled poor, even if they do not see themselves as underdeveloped. As N'Dione et al. state, "poverty is above all a cultural phenomenon: individuals are poor if they see themselves as such" (1997: 369). Another problem with conceiving of development in terms of economics is that development models necessarily then do not meet the needs of people. If development is about money only, a multitude of needs will never be met by these models. Thinking about

development differently will have profound implications on how development models are thought of.

Nyang (1992) makes the case for this approach to development which has seen some successes in developing nations and its effects are evident in some of the more recent development plans in Lesotho. Nyang (1992) criticizes development processes in Africa for not taking culture into account. Like Ferguson (1997), Nyang (1992) critiques the idea that there is one solve-all development plan that will take all developing nations (seen as largely homogenous) to the goal of industrialization and economic growth. Differences in history, culture and ethnicity are therefore never given the attention they deserve in planning for development. This critique seems to have met with some support from development practitioners in the late 1980's and 1990's who began to recognize that a new way forward was needed. This coincides with the rise in popularity of participatory development practices which attempt to involve the local population in their own development.

Participatory development was introduced in Lesotho in the 1980's and included the establishment of village based production cooperatives, farmer's associations and the like (Molapo, 2005). It must be noted however that participatory development was linked closely with the dominant development discourse. Thus, rather than give a space for the voice of the Basotho, participatory development projects were designed to contribute to the overall goals of the dominant development discourse and were foisted onto the local population. Thus, as Molapo states, rather than creating a place for local alternative voices on development to be heard, "participatory development came to form a key component that expanded the strategies of neoliberalism in Lesotho" (2005: 27).

Where participatory development did make a significant impact was on the health scene. It was in the 1980's that public health models came to be strengthened in Lesotho, particularly through the extension of primary health care to all. This was

done by training village health workers and strengthening the links between health centres and the local community (Interview with Dr. Germond). However, it must be stated that once again this was done from a Western perspective where the dominance of primary health care models as the best form of provision of healthcare was reinforced while traditional health practice continued to be marginalised on the ground. Although traditional healers were identified as being valuable health resources in the Medicine Men and Herbalists Order 1978 and the Natural Therapeutic Practitioners Act of 1976 (Lesotho, 1993), it is clear that referral of patients to traditional healers was and still is very much frowned upon by healthcare practitioners working in hospitals and health centres (Interview with Dr. Germond).

The second critique of development discourse stems from the creation of categories. Within the modernisation dissertation the categories are set up as traditional and modern. Dependency theory sees it as core and periphery. Whatever the labels are, they are fallacious. Firstly, they create the notion that nations are homogenous and can thus be classified. It suggests that all developed nations have the same characteristics and the same goes for underdeveloped nations. In reality, every country has specific contexts and histories that have profound effects on how the country operates in the present. These cultures, contexts and histories cannot be overlooked when it comes to development. In creating homogenous categories of nations, the outcome is that it is presumed that one development model will fit all nations. If one underdeveloped country has the same characteristics as the next, then one solution will solve all the problems of underdevelopment. This can never work. Even in countries that are similar in make-up, one model can never solve all of the problems in each. The implementation of the model will very much depend on the context, the cultures and the history of the nation.

Categories also create value-judgements. In setting up the contradiction between traditional and modern or developed and underdeveloped the developed nations

are held up as the goal. Thus capital accumulation, material possessions and money are the goals. The more environmentally friendly, community based, societies are labeled backwards, despite their significance in addressing people's needs. The Heinrich Boll Foundation produced a video before the World Summit on Sustainable Development that pointed to the fact that if every nation were to pursue the goals of the West, five planets would be necessary to sustain their needs. Their suggestion is that development models need to "shrug off copycat development" (Sachs *et al*., 2002: 18) and seek new ways of addressing basic needs. The discourse of development needs to relook at the goals of development and the value judgements that extend from them.

The final problem with categorisation is that development is conceived of in terms of deficits. The traditional or underdeveloped category is given expression through terms such as lazy, backward, inability, lack of education amongst others. These are all words that convey the deficits that plague underdeveloped populations. For one reason, almost all definitions given to the word are woven around the concept of 'lack' or 'deficiency'" (Rahnema in Escobar, 1995: 21). There is little effort given to looking at the assets that these communities and societies bring to their own development. A development model that actually values what people have to offer is far more likely to be successful.

The third critique of the development discourse is that development does not occur on a simple linear scale from one undesirable point to another desirable one. In actuality, development takes a few steps forward, and a few more back. There is no trajectory. Models will affect different communities differently (Patel, 2007). People are not inanimate objects that obey the laws of the model. Their actions and reactions will determine how development occurs. Their development may not be attributable to the model at all. Rather, development may occur in pockets where certain societies create their own livelihood strategies and others fall deeper into the cycle of poverty. There are numerous role players in the construction of development strategies. Political climate,

international relations, human relations, communities, culture and religion will all have effects on development creating differing levels and strategies of development or underdevelopment. Development practitioners need to recognise that development can occur differently with some successes and some failures.

Finally, development in the last half century has been approached from a top-down notion (Patel, 2007). That is, the practitioners sitting in their institutional offices, have little to no contact with the people they create policies for. They create policies that are then imposed either through the state, agencies or global relations. The needs, contexts and assets of the people are often not taken into consideration leading to the failure of development policies. It is ironic that development has become a business in itself with agencies extracting money that should be used for development as profit. A new development strategy that incorporates the voices of those who are the experts on their own lives, rather than simply the removed 'experts' should be given ample consideration.

One critique that is only recently receiving some attention through thinkers like Nussbaum (2000) is the fact that none of these theories consider the fact that the 'underdeveloped' have their own beliefs, ideas and values around how to live their lives. They are not simply passive recipients of development aid and ideas. Rather, they are active agents. They make decisions, they pursue opportunities and they live according to principles and guidelines. The 'underdeveloped' need to be given more credit for the assets that they have and use, and time needs to be spent understanding the motivations and value systems behind actions.

3.3. A possible way forward

While Post development thinkers will have us throw out the development programme altogether, this is simply not a possibility. In reality, the Bretton Woods Institutions and the G8 nations are still intricately involved in development, and need to continue to be involved. The recent moves of the

African Union to secure major funding from rich nations for its NEPAD project testify to the continued third world dependence on first world money. Furthermore, the millions of people that live in poverty, conflict and sickness point to the need for a new development strategy. Throwing the baby out with the bath water is simply not the answer. Far more realistic is a new approach. Amartya Sen (1999) and Martha Nussbaum's (2000) capabilities approach is an excellent step in the right direction and it is for this reason that I locate my dissertation in this theoretical framework of development.

3.3.1. The Capabilities Approach

The capabilities approach to development is rooted in an assets-centred way of thinking about development. Kretzmann & McKnight (1993) in their book *Building Communities from the Inside Out,* first introduced the idea of assets-based development or development that focused on identifying the assets of a community that would enable them to work towards their own development, rather than focusing on the deficits within the community. As de Gruchy states, "The traditional solution, or needs-driven approach sees communities as full of problems. … The simple truth that Kretzmann & McKnight identify is that you cannot build a communitiy on what people do not have. Succesful commuity development grows out of policies and activities based on the capacities, skills and assets of poor people and their neighbourhoods" (2003: 31). The assets-based approach was later theorized as an assets-centred approach by Sen and Nussbaum and taken further into the development of the capabilities approach.

For Sen, "development can be seen, …, as a process of expanding the real freedoms that people enjoy" (1999: 3). Thus, rather then seeing development as a measure of GNP, Sen advocates a much broader view of development. This view insists upon creating the circumstances under which people can be free agents in their own lives. Freedom thus is a means to development. However, Sen is insistent upon the fact that freedom is also an end in itself. Thus freedom

becomes a “constitutive part of development” (1999: 4). Freedom in this context is understood as being a state in which people are able to fully realise their capabilities. This is opposed to a state of “unfreedom” which can include situations of political tyranny, famine, hunger, under nutrition, inadequate access to education and health and premature mortality amongst others. These unfreedoms are common in that they limit the ability of individuals to pursue their capabilities. Thus the premise for development is that freedoms are important in and of themselves due to the fact that every human being is deserving of them. In addition however, freedoms are essential in so far as when they are present, individuals are able to use their agency and pursue their capabilities, thus fostering development. Freedom is thus a means to development and a developmental end.

The key issue here is that Sen moves from thinking of the ‘underdeveloped’ as passive recipients of development, to a place where we think of the ‘underdeveloped’ not as the ‘underdeveloped’ but as human beings deserving of the freedoms enjoyed by so many, and able, active agents in their own future. This is a key starting point for the way that this research was conducted in that the healthcare providers are seen as able active agents in their own health. It is these agents that are key to their own health and that of their communities and as such they need to be understood.

Sen also recognizes the importance of values as he states in the following extract from Development as Freedom (1999:9),

> “Such an approach allows us to acknowledge the role of social values and prevailing mores, which can influence the freedoms that people enjoy and have reason to treasure, Shared norms can influence social features such as gender equity, the nature of child care, family size and fertility patterns, the treatment of the environment and many other arrangements and outcomes. Prevailing values and social mores also affect the presence or absence of corruption, and the role of trust in economic or social or

> political relationships. The exercise of freedom is mediated by values, but the values in turn are influenced by public discussions and social interactions, which are themselves influenced by participatory freedoms. Each of these connections deserves careful scrutiny."

This approach therefore gives a far more humane face to development practice and allows development practitioners to understand that people, in the right circumstances of freedom, are capable of and have the assets to pursue their life chances. Sen's call for "each of these connections" to be deserving of "careful scrutiny" provides the rationale for this dissertation in that it aims to carefully scrutinise the health agency of health practitioners in Lesotho. This will then give an indication of the underlying values and discourses that inform the views of the health practitioners in particular and more generally of lay people. This then opens the space in which Basotho can express what their conceptions of health are in order to better determine the best was of dealing with the promotion of health.

Nussbaum (2000) takes this thinking further by focusing specifically on the plight of women as people who are particularly susceptible to the consequences of unfreedoms. She points out that in many nations women are seen as being the means to another person's end, as mothers and wives and daughters, rather than as being ends in themselves. For Nussbaum, development must begin from a point that understands all individuals and particularly women as ends in and of themselves and thus important. Once again this type of thinking moves development thinking into a more humane sphere where we are dealing with important human beings, rather than simply economically productive or unproductive members of the population. Nussbaum advocates an approach to development that recognises that every human being is entitled to a basic social minimum that allows him or her to realise his or her human capabilities. Human capabilities is defined by Nussbaum (2000: 5) as, "what people are actually able to do and be." This thinking is "informed by an intuitive idea of a life that is worthy

of the dignity of the human being" (ibid.). Nussbaum suggests that one can denote a capability threshold beneath which "truly human functioning" (ibid: 6) is impossible. This dissertation contributes to this project in that it aims at seeing the Basotho healthcare practitioner, not simply as a healthcare giver but as a valuable human being with personal values and opportunities that need to be taken into account, not in order to understand how they impact in her caregiving but because they are important in and of themselves. It places the Mosotho as the key agent in his/her own wellbeing and as such aims to understand his/her healthworld. It moves us back to placing the human at the centre of health development as the agent.

It is clear therefore that from both Sen and Nussbaum's perspective, it is essential to recognise the ability of people to be agents, that is to make their own decisions and to pursue their own life chances. However, certain elements need to be in place to ensure that people are free to do this. One of these elements is health. Sen explicitly labels premature mortality as an unfreedom and suggests that life expectancy can be used as one measure to analyse the overall capability functioning of a nation. Nussbaum also lists "bodily integrity" and "bodily health" (2000: 78) as two of ten central human capabilities. In fact, since Sen's work was published, the United Nations has developed (in conjunction with Sen) the Human Development Index (HDI) that includes life expectancy and literacy as key measurements of development. Health of a population is thus recognised as a key feature or measurement of development.

3.4. Conclusion

Having discussed how development discourse has impacted the development and health trajectory of developing nations generally, and in Lesotho in particular, it is important to consider the health literature and understand the intricate connection, not only between health and development but also how health is linked to underdevelopment.

4. HEALTH AND DEVELOPMENT

The previous chapter considered development theory and its critique in order to place this dissertation within the development literature. However, the research focuses on health as an aspect of development and it is thus key to also consider the literature on health insofar as it pertains to development thinking.

4.1. Health as development indicator

Over recent years, as development thinking has evolved, health has come to be recognised as a key development indicator. Specifically, this has been entrenched with the introduction of the Human Development Index (HDI), which specifically includes life expectancy as one of its components. Life expectancy is in turn, directly linked to health considerations such as access to healthcare, maternal morbidity and mortality and infant mortality rates

4.2. Health and inequality

Social epidemiologists have been interested in the life expectancy, infant mortality data and the patterns that it demonstrates. It is from this point that explanations for the patterning of health and disease stem.

Social epidemiology literature will be dealt with more fully later on in this dissertation. However, at this point it is useful to look broadly at what social epidemiology has had to say about the patterns that exist. There is no doubt that, as the HDI indicates, low rates of life expectancy are associated with poor countries while high rates are associated with more developed nations. This in itself is not a major revelation. After all, where there is famine and lack of access to resources, there will inevitably be a lower life expectancy. What is telling is the differences within countries, rather than between countries, and the specifics of disease epidemiology. This will all be dealt with in more detail later. However, social epidemiologists have had a lot to say about the link between class and

disease. This has been done largely at a regional level, but can equally pertain to the international level. Broadly, their explanations of the differences in disease between classes fall into 3 main groups (Bartley & Marmot, 2003):

- There are patterns of disease that are linked with class because of learned behaviour.
- There are patterns of disease that are linked with class because of lifestyle.
- There are patterns of disease that are linked with class because of genetics.

According to Wilkinson (1996) research that looks into the link between race or ethnicity and health from a genetics point of view continues and many researchers (Himsworth, 1984; Kelleher et al. 1990) have tried to establish that there are certain genetic differences between classes and races that determine health.

All three of these explanations have merit, are based in sound research and are corroborated by other articles. There is no doubt that the actions of people, their behaviour, lifestyle choices and genetics all contribute to certain disease patterns. However, all of these explanations can be grouped under one heading. Namely, they lay the blame for disease at the foot of the individual. A person dies of lung cancer because of his/her choice to smoke. An individual dies of heart disease because of his/her choice to eat badly.

The introduction of HIV/AIDS onto the landscape has done much to challenge these conclusions, although they do still persist. There is still a major stigma attached to HIV/AIDS that links the carrier with ‘unsavoury’ sexual conduct. However, at the same time questions around mother-to-child transmission, rape, access to treatment and perhaps most controversially president Thabo Mbeki’s statement that HIV does not cause AIDS, have come to the fore and have pushed the public and health professionals to consider the external factors that impact on the transmission of AIDS and of disease generally. This is not to say

that such research was not conducted before but AIDS pushes the health community to make this kind of research a priority.

As such more and more health professionals are looking at the role of inequality in patterning of disease. One of the most interesting studies to be done is one that looks at a comparison of India and the United States. India has a very low HDI, while the USA sits 6th from the top on the HDI ranking. However within Kerala, India the life expectancy is significantly higher than that of the Bronx in the USA (which in turn is significantly lower than the average for the USA). (Mechanic, 2002) This illustrates the fact that the key issue is inequality within countries, and between classes rather than of individual behaviour.

4.3. The political economy of health: Farmer

One of the major proponents of this type of thinking is Paul Farmer and his work needs to be looked at more carefully. Farmer is a medical doctor and anthropologist who works in rural Haiti and is based at Harvard University as the Professor of Medical Anthropology. He witnesses the effects of inequality daily. It is for this reason that he is so passionate about understanding and educating about the role that social inequality or social injustice (Farmer, 1999), plays in determining disease. He is adamant that health professionals need to follow in Sen's path and ask questions about equality. For him the key issue is "inequalities in the distribution and outcome of infectious diseases" (Farmer, 1999: 4) and he asks the question of why poor people must suffer from infectious diseases that are, in more developed countries, well controlled or completely eliminated. Farmer thus begins to establish a field of the politics of health and his comments have far reaching implications for the politics of development.

If health is development then the study of the social epidemiology of health can be compared to the study of development discourse in many ways. It is also clear that the dominant development policies will impact on health policies as has been

indicated in the discussion above. In the 1950's the dominant development thinking was that of the modernisation theorists (Frank, 1970). In the broadest sense, this type of thinking can be compared to the dominant conclusions of social epidemiology around class. Modernisation theory largely lays the blame for lack of development at the people themselves, pointing to the 'shackles of tradition' and inability to compete as discussed above. The external factors are largely ignored. Similarly explanations of class differences in patterns of disease generally point to the explanations discussed above and lay the blame at the individuals, either in their behaviour or in their genetic makeup.

In contrast underdevelopment theory swings the pendulum and lays the blame for underdevelopment at the core countries – those that strategically impose regimes and policies that maintain underdevelopment. Similarly Farmer urges us to look at the role that broader political situations and choices play in determining disease. He by no means discounts the lifestyle and choices of individuals but believes that these causes are far outweighed by the systematic political impacts such as policies around access to treatment and healthcare.

In examining the external impacts on people's health Farmer has four key issues that he deals with and which I will deal with, illustrating their significance for a study in Lesotho.

4.3.1. Broad political implications for health

Although Farmer is concerned primarily with actual disease and illness, disease can also be defined in a broader sense as –'dis-ease'. This links with the WHO definition of health, which states, "health is a state of complete physical, mental and social well-being and not merely the absence of disease of infirmity" (WHO, 1988: 1). While Farmer looks at the impacts of broad political situations and decisions on medical health outcomes, I have taken into consideration the broad

understanding of health as well, primarily because this was so often discussed in my interviews in Lesotho.

While Farmer has been more concerned with specific American policies with regard to Haiti, and in particular with regard to the military dictatorships and the democratically elected president Jean Bertrand Aristide, (Farmer, 2002) the issues he raises in connection with this can equally be applied to broader policies such as those of the World Bank and IMF as well as to South Africa's policies and actions towards Lesotho. In addition, international economic policies, condoned by local governments, also have a major impact on the health of communities.

Farmer illustrates this by looking at the development of a dam in the Ka-Dora region of Haiti. The construction of the dam by wealthy companies did not take into account the effects it was to have on the people of the region. People were dispossessed of their land, on which they had survived through subsistence farming, and were not offered any real alternatives but to move onto land that was overcrowded and not arable. This forced many of the villagers, particularly young girls to head to the city (Port-au-Prince) to look for work, usually as domestic workers. It was here that many of them were infected with HIV and TB, through rape, adverse working conditions or simply the allure of the city. Closer living quarters brought about by overcrowding led to the increased spread of diseases such as TB. It is this kind of unchecked economic intervention that is often condoned by governments, most particularly desperate governments, that has these often unforeseen health impacts.

Similarly, the pervasiveness of Structural Adjustment Programme's (SAP's) in Africa had implications on health in the broadest sense of the word as well as more directly (Bello & Cuttal, 2006; Bussmann, Schneider & Wieschomeier, 2005; Akyuz & Gor, 2001). SAP's led to huge job losses in various sectors which would have had major impacts on the sense of well being of individuals as well

as on their ability to afford healthcare as public spending was drastically cut back. The ARHAP Zambia team noticed this in the Copperbelt region when it was noted by community members that church hospitals and schools started to open in the early nineties precisely when public spending on healthcare and education was cut and the public could not afford healthcare that was previously provided by the state. This corroborates Pfeiffer's findings where he points out that African Independent Churches and Pentecostal churches that offer healing have "rapidly spread throughout central Mozambique in the midst of structural adjustment programmes" (2005: 255)[9]. It is clear that broad policies, whether political or economic, may have enormous health impacts that are often unforeseen, most especially for the most vulnerable of communities, who are almost always the victims rather than the benefactors of these policies.

The effects of broad international, regional and historical trends can most definitely be seen in Lesotho. This dissertation is not one on the history of Lesotho, or on international policies and can thus only comment broadly on these impacts. One of the aspects of the current economy that impacts on health significantly in Lesotho is that of mining. The dependence of Lesotho on the South African mining industry means that numerous Basotho men have become migrant labourers in order to earn some income (Ferguson, 2004; Murray, 1981). The link between AIDS and migrancy is evident. However, a further impact of migrancy is that many women are left to head households and is pointed out by Turner (2000), they often supplement their income with prostitution. This of course also increases the levels of HIV transmission. This is a good example of the direct effect that economic livelihoods and development strategies have on health.

[9] Germond & Molpo (2006) also assess how SAP's impacted on health and religion in Lesotho during the 1990's.

4.4. Universal healthcare?

The effects of broad economic decisions can also be seen in the healthcare system itself. Health systems increasingly follow a capitalist approach, most especially as SAP's are enforced and public spending is cut. More and more, good healthcare is the domain of those with health insurance or those that can afford the high costs of treatment.

For Farmer (2003), this situation is unacceptable. Since access to good healthcare is a necessity for the sustenance of life, it should be seen as a human right and therefore enforced. Farmer is highly critical of the American healthcare system that provides good healthcare only to those who can afford it and praises the Cuban system that ensures everyone has access to adequate healthcare. All too often healthcare is inefficient and inaccessible for many people, not only those living in rural areas, but also those in urban and peri-urban areas. Even where there is access, if there are inadequate doctors, insufficient equipment and lack of access to treatment, access to the hospital does not necessarily help. As Farmer (2003) suggests, one of the key resources needed if infectious diseases are to be eradicated from developing countries is access to adequate healthcare.

Access to healthcare in Lesotho seems to be a priority for its government (MOHSWb, 1996). This is aided by the intervention of churches, which provide 9 hospitals and numerous health centres. In order to reach the MOSHW's goal of every person being within 2 hours walking distance of facility (Lesotho, 1994), explained Lesotho is divided into 18 health services areas (HSA's). Each HSA contains one hospital and various health centres. The health centres in turn train village workers. The 19th HSA is the flying doctor's aided by the Mission Aviation Foundation, which services the most remote and inaccessible areas of Lesotho's mountain range. From this description it is clear that the government is concerned about reaching even the most isolated members of its population. However, to say that access to adequate healthcare is not an issue in Lesotho would be very misleading. Although hospitals are available many do not have the

staff and resources available to provide adequate healthcare. This can be attributed to the fact that Lesotho as an LDC does not have a lot of money to spend on health in its overall budget. Similarly CHAL (previously Private Health Association of Lesotho of PHAL) hospitals are dependant on donor funding as well as government expenditure. As was noted in 1993, "The expenditure of PHAL hospitals and hospitals amounted to some M14m in 1993. Income from donors, fees, and Government was only around M11m, which is why the PHAL hospitals are almost permanently on the verge of closing down" (Lesotho, 1993: 17). At Scott Hospital alone (one of the better resourced hospitals in Lesotho) four doctors service an outpatient capacity of about 150 people per day as well as an inpatient capacity of about 60. In addition these doctors are required to visit the nine health centres in the area once a week (Makara interview). Another complication is that these doctors are foreigners and don't speak the vernacular, making communication very difficult. Needless to say, the health centres in the area are often not visited leaving the sick in those areas to depend on nurses and, if their situation is worse, to walk for days to get to the clinic. Scott Hospital is fairly well resourced in comparison to other hospitals with access to an X-ray machine and incubators (Makara interview). However, it does not have a four by four vehicle with which to access its health centres, nor an ambulance for emergencies. It is clear therefore that for many who do not necessarily live close to Morija, accessing healthcare may be problematic. In addition, the Scott HSA is the best resourced and run HSA next to Maseru (Makara interview, Ramatla interview). This leaves one to wonder about the state of the other HSA's. And, although the flying doctors and MAF do a wonderful job in accessing remote villages, many village are only accessible by horseback and often access is severely hampered by weather, particularly in the snowy winter months. At these times, access to healthcare for theses villagers is simply non-existent. The healthcare situation in Lesotho is impacted upon by the nature of the terrain, making access to some villages particularly difficult. However, this is not the only factor. As has been discussed, Lesotho is an extremely poor country that simply does not have the resources to invest in making healthcare accessible to all. This

is not necessarily the fault of the government, but results largely out of the development situation it finds itself in within the global context.

However, for Farmer, lack of resources is not a good enough excuse for failing to deliver healthcare. As he states, “the wealth of the world has not dried up; it has simply become unavailable to those who need it most” (1999: xxvi). He adds, “market utilitarianism is a strange beast, since it seems to permit all sorts of inefficiencies as long as they benefit the right people – namely the privileged. But if the goal is to heal or to ease the suffering of the destitute sick, we are asked to jump through hoops to finance what was once felt to be a public good” (1999:xxiv). The key for Farmer is that inadequate healthcare needs to be understood within the larger context of a neoliberal development agenda that privileges the West over the rest and that this is an “assault” (2005: 29) on the poor.

4.5. Access to treatment

Access to treatment is therefore a key issue for Farmer. The international health sector - pharmaceutical companies, healthcare professionals and public health experts - has to a large extent spent much time justifying why they refuse to provide more advanced treatments for infectious diseases such as TB and any treatment at all for HIV. Their excuses range from these treatments not being appropriate technology in a low-tech setting (Farmer: 1999) to arguments about the ability of the poor to maintain the treatment regimen. Once again, the blame is laid at the feet of the poor rather than at those that stand to benefit from such excuses. These excuses were challenged when South Africa’s Minister of Health, Minister Zuma took the issue up in the international courts and won the landmark case that now forces pharmaceutical companies to provide cheap alternatives or generics to those people that can least afford HIV treatment (Talbot, 2001). The Treatment Action Campaign’s fight to have the state provide free drugs to prevent Mother to Child Transmission of HIV and to roll out affordable ARV

treatment are other successes in South Africa. This is the kind of thinking that needs to happen if infectious diseases are to be eradicated in the world's poorest regions.

Lesotho does have an anti-retroviral rollout programme. However, it is limited by resources and is really only effective in Maseru (Pitso interview). ARV treatment only became available at Scott Hospital in January of 2006. In order to assist with this roll out, the World Health Organisation (WHO) has commissioned research to look at alternative sites for rollout such as home based care organisations and churches, which often have more ability to access those that need treatment than doctors and hospitalsdo. ARHAP was one organization that was commissioned with assisting in gathering this data. This is a novel idea and one in which the results are eagerly awaited as a possible model for the rest of Africa. It is one of many methods that could be used to ensure Farmer's call greater access to treatment is met.

4.6. Politics and explanations of disease/dis-ease

Farmer understands the cultural complexities of working in certain environments. As many theorists have discussed (Kleinman, 1979, Helman, 1995, Janzen, 1973) culture plays a major role in understanding health and illness for any person. However, it is more pronounced in a setting where the cultural beliefs are seemingly incompatible with scientific or biomedical approaches. While Farmer does acknowledge how people make cultural sense of their illness in rural Haiti, as a medical doctor he is inclined more towards the biomedical model. As such Farmer himself falls into the trap of the politics of health and disease.

The dominance of the biomedical explanation of health is a political statement in and of itself and is testament to the huge influence that Europe, along with its science and technology had on the rest of the world and particularly in Africa, particularly through missionaries and later colonialism. This is not to say that it is

a solely negative influence. There is a major role for biomedicine to play in Africa and it certainly has had major positive impacts. However, this does not subtract from recognising that biomedicine is a particular discourse and its dominance is a political issue. Biomedicine has to a large extent tried to suppress and redefine cultural or traditional understandings of health and disease. While this may be helpful in some respects, in others it has been detrimental. For many people access to healthcare is through traditional healers only. Where there are no hospitals or doctors there will most certainly be a traditional healer. Biomedicine has tried very hard to eliminate the legitimacy of traditional healers. Fortunately they have maintained their status to a large degree in Lesotho, and have come to be recognised by the government through the Medicine Men and Herbalists Order 1978 and the Natural Therapeutic Practitioners Act of 1976 (Lesotho, 1993). This is important as they have an extremely important role to play in healing the sick. In addition they have an integral role to play in the maintenance of culture and thus the maintenance of well being in its broadest sense. One illustrative issue that has been identified in our research in Lesotho is the fact that traditional healers had an important role to play in initiation and thus in the rites of passage for both boys and girls. It was at this stage that children were educated about sex and healthy sexual relations. As biomedicine along with Christianity worked to undermine the role of the traditional healers, this began to fall away, and was never replaced. Hence there is now a relative silence around sexuality that has only come to be replaced in the wake of the HIV pandemic by committed NGO's. It is clear therefore that the politics of discourses around medicine and health in themselves need to be understood and recognised, something that is evident in Lesotho, and not addressed by Farmer.

4.7. The importance therefore of understanding health agency

It is clear that Farmer is concerned with the fact that within the politics of health, the poor don't have a voice. Frequently they must experience the often negative consequences of international decisions, both at a broad international economic

policy level, as well as at the level of intervention initiatives. Generally speaking, public health experts, pharmaceutical companies, and government health departments speak for the poor without listening to them, rather than giving them a voice. Sen would agree with Farmer in this assertion. However, Sen looks at it from a broad development perspective. For him, addressing the current development problems of deprivation, poverty, oppression and hunger is inextricably linked to understanding the voice of those that suffer and seeing them as agents responsible for their own lives. “Individual agency is, ultimately central to addressing these deprivations” (Sen, 1999: xi).

This criticism of the way public health has dealt with infectious diseases, and most particularly with HIV is a similar criticism to the one raised by Sen in his criticism of the way development planning has been carried out. The critical issue therefore is to give the poor a voice, to listen to their concerns and to give space for their own understandings of their situations. It is important to understand the assets they have and the capabilities they use (and by implication how best to maximize these assets and capabilities) before concluding that certain treatments don’t work. Thus, instead of saying that it is impossible to give ARV treatment to a community due to their inability to stay on the treatment (Farmer, 1999), ask members of the community why they have rejected the medication and how it can be dealt with. An ARHAP study focusing on the Masangane area in the Eastern Cape did just this. They researched a church based ARV programme that provided ARV treatment to people that the government refused to because their CBC count was too low. These people were put onto treatment whilst being placed in a support group, provided with home based care and given religious teachings to support them. The most astounding finding was that their rate of adherence to the programme was startlingly high, and was in fact better than most government programmes leading to greater recovery rates (Thomas et al. 2006). Using the capabilities approach revealed the assets that the community uses and further interventions could be focused on maximizing these assets.

So far, HIV interventions have been abundant in sub-Saharan African countries but have nevertheless had little impact on infection rates. One of the possible reasons for this is that little research has been done into exactly how people in specific countries, and adhering to specific cultures, actually understand this relatively new disease. Is it seen as a result of witchcraft? If so then messages about safe sex may not have the desired impact. Do those that design the adverts know that in some places those with HIV are treated with ultimate respect as they will lead the way to the ancestors (Coplan interview)? This belief may or may not impact on messages about HIV. However, it is important for public health experts and government consultants to recognise that the agency of the individuals they claim to treat are as important as all the scientific research that backs their initiatives.

It is clear that, increasingly, the role of norms and values is being understood as vitally important when any development work is done. This is enshrined now in South Africa's policies around Sustainable Development, which require public consultation. Although public consultation may not always be used as it is intended to be used[10], the underlying principle is that the community voice is important and needs to be given space.

This is no less important when we are dealing with health initiatives. At the end of the day it is the health seekers and providers that are at the battle front and know their key issues. It is only through consultation with them that we as professionals interested in doing something to combat the HIV pandemic and ensure that health outcomes are realised, can make a positive impact.

This is the reason why it is important to begin to understand how health seekers and providers understand and practice health – their health agency. It is

[10] Although the principle of public consultation is to hear and address community issues, often it is conducted simply to meet legislative requirements and the community issues are often not dealt with at all.

important to understand why they make the decisions they do, see the doctors they see and give they treatment they do. It is important to understand what they see as important for health, where they would go when they are sick and how their families cope in times of illness. Some of the answers may be predictable, but more than likely one will uncover beliefs and customs that impact on health behaviour in small ways, but my have major effects in the whole population. This is the rationale that ARHAP has used in its methodology throughout its studies of Masangane, Zambia and Lesotho, and it is one that will continue to be used as more sub-Saharan countries are analysed. ARHAP is not alone in the work they are doing. Gilson (2003) is currently doing work that aims at understanding relationships of trust, how they are built, maintained and destroyed, and the importance of trust in the health provider-seeker relationship. It is clear therefore that this is an emerging approach that needs to be taken seriously and used more often when health initiatives are being considered. While it may take longer, and be more expensive, in the long run it is likely that the benefits will outweigh the costs.

4.8. Healthcare in Lesotho

In order to understand the perceptions of healthcare providers about health, it is necessary to understand their place of work and the environment within which their understandings of health are influenced.

4.8.1. The current situation in Lesotho

The situation that Basotho find themselves in, with extreme levels of poverty and the associated health issues, may partly explain the prevalence of the primary health conception that is evident amongst healthcare providers.

The textile industry in Lesotho (upon which many Basotho are dependant for livelihood) faces many of the same issues that the South African textile industry faces as is discussed by Mosoetsa, (2003). Trade liberalization and the Africa

Growth and Opportunity Act (AGOA) has meant that wages are very low and that employees are vulnerable, not only to low wages, but also to job cuts and negative working conditions (Gibbs, 2005).

Turner (2001) analyzes livelihoods in Lesotho and states that Basotho depend on multiple livelihood strategies because of the "high vulnerability context" (2001: ix) they find themselves in. Because of such a high level of poverty, high dependence on volatile sectors of the South African economy, and the fact that Lesotho is prone to humanitarian crises, the Basotho must diversify their livelihood strategies to ensure some form of income. Thus, while much income is derived from the mining sector in South Africa, women heading up households also tend to migrate to urban areas to find employment in factories, while other family members may maintain subsistence farming. In addition, extreme poverty has led to an increase in women depending upon prostitution as a form of income. The impact of this, in addition to the impact of migrant workers, on the HIV rates in the country is a major cause for concern.

According to Turner (2001), the majority of Basotho people see subsistence farming as their primary source of income or survival. Even those that are relatively well off will still invest in land and stock, often making a loss for themselves. The ties to the land and to their cattle indicate that the traditional way of life and the values and culture associated with it is still very prevalent, even for those that have the means to live an urban, middle class life (Turkon, 2002). The problem with this high dependency on farming is that the resources with which to farm are gradually diminishing. Lesotho experiences high rates of drought and soil erosion which affect farming significantly. This means that Basotho are subject to high rates of poverty and vulnerability. In addition to the poverty experienced in the low lands and urban areas, poverty is even more extreme for those living in the mountainous areas.

Health in the country is managed by the Ministry of Health and Social Welfare (MOHSW), which sees its objective as "providing an efficient and compassionate health care and social welfare system, with particular emphasis on the prevention and eradication of priority health and social welfare problems that are amenable to cost-effective interventions. There is need to implement a selective package of health and social welfare interventions that will bring maximum benefit to health and social welfare objectives" (MOHSWb, 1995). The fact that social welfare and health are so intricately linked at the government level is reflected quite clearly in the way that health provision is carried out and in the attitudes of the healthcare providers.

The Ministry has implemented a system of healthcare provision that aims at reaching as much of the population as possible. One of the goals of the Ministry was to decentralize services and this has led to the establishment of a system that is aimed at being based on the role of community health workers that are supported by hospitalsand health centres that then form the Health Service Area (HSA).

Although access to services is limited for most Basotho, it is in the mountainous areas that access to basic necessities and services is severely limited (MAF, 2006). Despite the MOHSW's strong commitment to making healthcare accessible for the majority of the population, research by a fellow ARHAP Lesotho member, Evelyn Vera, indicates that those in the mountainous regions still find it extremely difficult to access healthcare and must wait for weeks before a Flying doctor is able to visit and treat them. It is clear therefore that much work needs to be done in the health sector.

4.8.2. The Hospital

Although the ministry sees the health system as being based on the community health workers, the hospital is central as a referral point and in many respects is

seen as the backbone of the HSA. In most cases the hospital provides the doctors and the training for nurses and community health workers. Thus, at the centre of each HSA is a hospital with both inpatient and outpatient facilities. Many of these hospitals will also have the use of a laboratory, X-ray department and dispensary. Doctors are located in the clinics. Most of the resources, both in terms of staff, supplies and equipment are located at the clinic. Nurses at the hospitals are qualified in various areas ranging from psychiatric nursing to environmental nursing. Although the hospitals are where much of the medical resources are located, this is not to say that they are well resourced. Scott Hospital for instance does not have an ambulance and only has one vehicle for the purposes of visiting the health care centres. There is often a training centre located at a clinic. CHAL runs four training schools for nurse assistants, one of which is located at Scott Hospital and one at Paray Hospital in Thaba-Tseka. The hospital also serves as a referral point for serious illnesses and emergencies. Staff from the hospital are required to visit the surrounding health centres regularly.

Scott Hospital services the second largest health service area after Queen Elizabeth II in Maseru in terms of population. The catchment area for Scott and its health centres is in the region of 156 000 people (Makara interview). It services these people with a staff compliment of 156 people including 4 doctors, 10 technicians and 50 support staff. The four doctors deal with around 100 outpatients daily, as well as ward rounds.



Figure 13: Health Service Areas of Lesotho indicating the Scott HSA in red

4.8.3. The Health Centres

Health Centres are much smaller than hospitals and serve as primary healthcare, outpatient facilities. They are usually managed by a nurse trained in primary healthcare, but where one is not available they may be run by a nurse assistant. Nurse assistants aid the nurse in her duties. The number of nurses and nurse assistants at a health centre depends on its size. Of the two health centres I visited, one, St. Barnabus, had the services of one nurse and three nurse assistants, while the health centre at Ha Mofoka has only one nurse and one nurse assistant. Services offered at the health centres range from family planning, to childhood inoculations and healthcare training. Training refers to primary healthcare education e.g. training mothers on childhood illness and symptoms or training communities in good environmental practices; the training of village healthcare workers who can access people that may not be able to access the health centres; and the training of traditional healers, especially with regard to HIV and AIDS and TB diagnosis. In my visits to the health centres it was apparent that they become congregational points where people meet and more especially where people come to talk to the staff about their problems. One nurse assistant at Ha Mofoka health centre said, “others just come to visit us, to share, just to talk with us even if they are not sick, just to share difficulties” (Mme Nthomeng interview).

The health centres are supported by staff from the hospital who are supposed to regularly visit the health centres in their HSA. One difficulty facing the health centres is that many are very difficult to access. Thus, staff at Scott Hospital tend to visit the closer health centres and the ones that are difficult to access get intermittent visits when the already overworked staff, and unstable vehicle, can manage to make the trip. In these visits staff at the hospital are required to take any medical supplies, equipment and medication that the centre may require and

offer professional services that are not available at the health centres such as eye care. It is also in these visits that a doctor is available to the patients for more serious complaints.

The MOHSW seems to be aware of these problems and is trying to address the issue by entering into public private partnerships and by taking over some of the duties that have traditionally been handled by the Christian Health Association of Lesotho (CHAL).

CHAL is a not-for-profit, non-governmental organisation that brings together all of the church run hospitals in Lesotho. They have six member denominations, being the Lesotho Evangelical Church, Seventh Day Adventist, Anglican, Catholic, Methodist and Anglican (Nchee interview). The Private Hospital Association of Lesotho (PHAL) was established in 1974 and later changed its name to CHAL (Christian Hospital Association of Lesotho). The organisation aids in the smooth running of all the hospitals and health centres that are owned, run or maintained by the churches. It also ensures that there is dialogue between the denominations. It has been funded by various companies including pharmaceutical companies like Bristol Meyer Squibb but is currently finding it difficult to maintain that funding.

As a result, CHAL is currently in negotiations with the government to enter into a purchaser-provider partnership. The aim of this partnership is to ensure that all healthcare facilities are following the same policies. This partnership will also enable church hospitals to reduce costs of medicines. Traditionally, the only expense that the government covered was the salaries of nurses. However, as donations from congregations continue to diminish due to poverty and funding remains unstable, it has become necessary for CHAL to depend more on government. Government now subsidises drugs and other essential equipment as it does in government hospitals. (Nchee interview)

CHAL broadly, and Scott in particular provide cases of the role of religion in health and therefore more broadly in development. Studying the role of religion in development is currently on the increase and is the key aim of ARHAP. However a defense of the role or religion in development may be necessary, particularly in the context of the secularization discourse.

4.9. Religion and development

This chapter thus far has focused on the role of health in development and therefore justified the focus of the dissertation on health. The research also considers the role of religion in developing conceptions of health and thus it is also important to consider the literature pertaining to religion and development.

4.9.1. The importance of studying religion

The rise of the secularization dissertation, exemplified by Bruce (2002), has had a significant impact on the study of religion. Studying religion is often met with some derision as it is seen to be an outdated topic of study. The secularization dissertation, which seemed to hold true, stated that as societies develop and modernize, so religion becomes more of a private than public matter and eventually dies out as is the case in much of Europe, and particularly in the United Kingdom (Bruce, 2002). As such the study of religion in modernizing nations was seen to be irrelevant.

However, over recent years, there has been a resurgence of interest in the subject, particularly as the secularization dissertation has been significantly challenged by the growth of charismatic forms of religion in America, and most interestingly, the rise of conservative religion in developing nations such as Korea (Berger, 1998). Religion is being understood to have a significant impact on people's lives, not only in the private realm, but increasingly in the public sector. This was evidenced by voting behaviour in the United States and the power of the conservative Christian Right movement in swaying public policy,

particularly with regard to stem cell research and homosexual marriages (Gilgoff, 2006). As Seesholtz (2006) states, “Between now and the November elections, Republicans are penciling in plans to take action on social issues important to religious conservatives, the foundation of the GOP base, as they defend their congressional majority.” There is thus increasing evidence that religion is an important element of society for sociological enquiry.

One of the founders of sociology understood this well. Weber (1976) articulates the importance of religion in modern life in his Protestant Ethic and the Spirit of Capitalism in which he attributes the rise of Capitalism to the values of asceticism and hard work introduced by Calvinism. His analysis of the Protestant sects of his time illustrate the important role that religious groups played in economic life.

Germond (2001) suggests that religion is equally powerful today. While religion has been moved out of the public space in so far as the separation of church and state is concerned, it still has an integral role to play in that it has the potential to exert immense power over individuals. While the church no longer has the power to control behaviour directly as it did in premodern times, religion still shapes behaviour significantly. Germond (2001) makes the distinction between four types of power. The first two draw on the Weberian notion of power in which power is intentional and relational. However, religion’s power does not lie in this aspect of power, although the church has historically used its power intentionally both for good and bad. However, more interestingly, in modern times, religion has unintentional and non-relational power. Power is thus contained in knowledge and discourse as Foucault would suggest. It is diffuse. It is discourses that come to define our world-views and our consciousness. Religion creates and promotes a particular discourse and it is here that religion is most powerful for as Germond states, “people’s minds are profoundly impenetrable. But they are crucial, for it is in minds that subjectivity and self-consciousness emerge, develop and mature” (2001: 30). I would add that it is in people’s minds that decisions about behaviour and by implication health behaviour are made.

It is clear therefore that religion still has a profound influence in social life today and as such must be the focus of sociological enquiry. Religion has a significant role to play not least of all in development and development in turn needs to recognize the importance of religion for people. "The failure to recognize the power of reflexive knowledges to construct identity, most importantly through culture and religion, has led to many spectacular failures in development. Development can be severely retarded if the deep structures of identity formation are ignored. Development is as much about how people understand themselves and their worlds as it is about physical and social development. It must work with people's subjectivities. Their identities as social beings and social actors profoundly influence the way in which they regard themselves in the world and construct their sense of agency" (Germond, 2001: 30-31). As will be shown later, the power that religion has to construct ideas around health is significant. In particular, religious identity plays a major role in the way that the healthcare providers conceive of the traditional discourse of health and in how, at least overtly, they dismiss the traditional discourse. The role that religion has to play in development is therefore of great importance and needs to be understood further.

4.9.2. The role of religion in development

Religion must be considered in development for the power that is has in people's lives as Germond (2001) has indicated. Garner (2000) has illustrated this power in his study of social mobility in communities in Edendale, Pietermaritzburg. In his study, Garner compared the members of different congregations and found that those attending more conservative churches such as the Pentecostal or African Independent Churches (AIC's) were more likely to show trends of upward social mobility than those attending less strict, mainline churches. He therefore suggests that the more enveloping and the more conservative religion is, the more it influences social mobility positively. What is interesting is that the

teachings of these churches were not specifically about social mobility. Rather, the values they instilled had an impact on their identities and by implication their behaviour. The upward social mobility was an unintentional, positive side effect of the teachings of the church and this illustrates the power that religion has in development.

However, religion does not only play an indirect role in development. It has also had a far more intentional and strategic role to play as is evidenced by the South African Council of Church's (SACC) commitment to being involved in the development of South Africa. This is reflected in their mission statement which states, "As a National Council of Churches and Institutions, the SACC, acting on behalf of its member churches, is called by the Triune God to work for moral reconstruction in South Africa, focusing on issues of justice, reconciliation, integrity of creation and the eradication of poverty and contributing towards the empowerment of all who are spiritually, socially and economically marginalized" (SACC: 2006). Certainly, many religious groups are involved in development initiatives ranging from soup kitchens, employment creation, HIV/AIDS care, hospices and the like. And their role extends to the social and spiritual if not physical support of congregation members and members of the community who are in need of that support. An integral part of the Christian liturgy is intercessory prayer – prayer for others. Thus in many ways the church exists for development[11]

This is recognized by Ramphele and Wilson (1989) who state that the church is well placed to play a role in social transformation because of the number of marginalized people that subscribe to the Christian faith and attend church regularly. Koegelenberg (2001) also sees the potential for religious institutions to involved in development due to two factors. From a pragmatic point of view, the

[11] At this point it must be stated that much of the research and evidence that has been presented is done so from a Christian perspective. This must not be taken to mean that other religious affiliations such as Islam and Judaism are no less involved in development. In fact, there is no doubt that Jewish and Islam teachings also encourage looking after the poor and marginalized. However, work on these religions and their contribution to development is lacking and perhaps indicates a field for further research.

church has “proved to be the closest to the people in need; they have the best-developed networks; they provide the most effective network at the most affordable costs available” (2001: 101). From a religious point of view, church based organizations cannot be considered as NGO’s because of their different understanding of themselves, rooted largely in their specific beliefs and convictions. Keogelenberg goes on to illustrate how religious organizations have successfully been involved in development initiatives in the USA and Europe. It must however be pointed out that while there is immense potential for the church to be involved in development as Haddad (2001) points out, thus far the church has not been able to harness that potential to actually make an impact for their congregations. In addition, the church has often used its power and position in profoundly negative ways such as its role “in the process of colonizing indigenous people, illustrated by the theological justification to apartheid provided by the Dutch Reformed Church” (Vika, 2001: 53).

Having said this, religion nevertheless has an important role to play, particularly for marginalized women who assert that their faith and prayer have helped them to survive and provide for their families. Religious networks such as Manyano (a grouping of women subscribing to a particular faith that meet to express their faith and prescribe lessons on daily living (Haddad, 2001)) provide important sites of micro-development (Haddad, 2001) that could be further harnessed.

Another aspect of religion that is seemingly contradictory is that these networks may give women a sense of authority and power that they do not get in their homes or through their cultures. I say contradictory as the Christian church has often used theological teachings to advocate marginalizing women in social life. Frahm-Arp gives a good analysis of this in her dissertation Women of Power (2006).

It is clear that religion has a significant role to play in development and health in Africa, and particularly in Lesotho. Increasingly, health is seen as a key indicator

of development. Conversely, development interventions, as has been illustrated, have a profound influence on health in a country. Religion also has an important role to play in development as has been shown. It is also key to understanding health, particularly in Africa where religion has historically played an important role in healthcare. Overall therefore there is an important nexus between religion, health and development that must be assessed.

4.9.3. Religion and health

It is only very recently that work has begun on recognising the role of religion in health and healthcare. Much of this literature focuses on religion as an explanatory variable in individual health outcomes. Koenig et al. (2001) have done a comprehensive review of much of the material in this field. This material is very quantitative in nature and aims to establish through experiments with control groups, the effects that religious belief and prayer may have on the outcome of certain diseases for patients. In particular, heart disease and cancer have been studied extensively. It must be noted that this literature is not looking at how religion influences lifestyle, but rather how religion aids a patient once heart disease or cancer is set in. Much of this research is positive about the role that religion plays in health outcomes of this nature.

Koenig et al. (2001) also review literature that tries to understand the role of religion in mental health. This field is quite diverse and looks at the role of religion as an explanatory variable in individual mental health outcomes, the role of religious counseling in dealing with mental health and the role that religion plays in preventing mental health disorders. Perhaps the most significant finding from much of this research is that religion contributes positively to well being. Well-being is seen as being dependant on a number of factors including family stability, social support, hope and optimism. Various studies (Sethie and Seligman, 1994; Ellison & George, 1994, Peale, 1952 in Koenig et al. 2001) have

linked religion and these indicators of well being. Religion is thus seen as a positive in preventing mental health disorders.

The other major area of research in the field of health and religion is the growing literature on the role that religion plays in HIV and AIDS. Much of this literature has focused on the negative role that religion has played in creating and maintaining stigma around HIV and AIDS. Byamugisha et al. (2002) study the church-based responses of three churches in Mozambique and how stigma negatively affected their congregation members.

However, more recently the focus of literature has moved to studying how religion influences behaviour decisions in people at risk of being infected by HIV and AIDS.

Although ARHAP is very interested in these more established areas of intersection between religion and health, there are many more areas that religion and health could intersect that haven't received as much attention. Areas such as sexuality, gender and behaviour change; blending of African religions, health and culture and spiritual mechanisms of healing require far more in depth research. These areas are broad and present a number of potential minefields in terms of measurements and theories. As such ARHAP had to determine a theoretical framework that would satisfy studying all of these diverse areas. The framework is presented below but it has been the experience of all of the teams researching religion and health in various countries that this framework still needs to be challenged and reworked quite significantly, particularly from an African perspective.

4.9.4. Health, Assets and the African Religious Health Assets Programme

The African Religious Health Assets Programme (ARHAP) was born out of two ideas. The first was the recognition that the assets-based approach or the

capabilities approach, that recognises that people have assets upon which they actively draw in their own development, is currently the best way of thinking about development due to its recognition of people as value-driven agents (de Gruchy, 2003). For ARHAP this was particularly important in the African context where all too often, the multiple and diverse values of people are ignored as Western development values are imposed on a heterogeneous group. From an African point of view, the capabilities approach is a refreshing way of thinking about Africa, traditionally seen in the development discourse as the black continent, incapable of managing itself and shackled by tradition. The assets-based approach has been very useful in the methodology and analysis for this dissertation.

The second idea was that religion can be seen as an asset upon which people in Africa draw and that religion is vital in development and has thus far been largely ignored in the dominant development literature. Thus, ARHAP saw itself as a group of intellectuals who would strive to do research that would point out the role that religion plays as an asset to agents, particularly in the arena of health, as an indicator of development (www.arhap.uct.ac.za). However, ARHAP does not seek only to research religion as an asset but also intends to make informed policy recommendations that will maximize the potential of religious organisations and the people affiliated to them to better provide healthcare in Africa.

4.9.4.1. ARHAP – the initial theoretical framework

ARHAP has been through many phases and each phase brings with it a new way of thinking about the field we are working in. However, it is necessary to describe where ARHAP has come from in order to indicate how this framework has developed thus far.

A - African refers to the place in which the research is located. Although we use the term African, ARHAP initially confined itself to Sub-Saharan Africa. However,

as more and more studies begin, there is every likeliness that it could begin to extend its branches further north. African does not only refer to the location of the research but also to the people involved. ARHAP aims to build capacity amongst students from Africa and ensure that they are the primary leaders and researchers of the various projects.

R – Religious means that the focus of the research is not simply on health in Africa, but particularly on how religion impacts on health in Africa. As has been discussed previously we quickly recognized that health and spirituality are intricately linked in Africa and this needs to be taken into consideration. ARHAP has thus attempted to understand religion as broadly as possible and incorporates mainstream, charismatic and traditional formations of spirituality. As explained previously however, I have, for the sake of clarity, distinguished between religion and spirituality.

H – Health. The focus of ARHAP is to look at health in sub-Saharan Africa and how religion impacts on it. Despite the fact that much research is interested in HIV and AIDS in Africa, for ARHAP health is defined quite broadly. Rather than looking at specific health issues, ARHAP attempts to understand the health picture in Africa as broadly as possible. The main aim of ARHAP is to influence public health policy.

A – Asset. An asset refers to "existing 'goods' or 'services' that can be leveraged; a range of skills, resources, associations, organizations and institutions already present in a local or translocal context; that are linked to effective agency (action) in response to experienced needs, lacks or demands" (Cochrane, 2003).

P – Programme. From the beginning ARHAP has seen itself as a work in progress. Those working on the programme are fully aware that we are working in as yet largely unchartered territory. This is reflected in the title of the ARHAP

literature review – “A Bounded Field of Unknowing” (2005). Thus the word programme reflects that ARHAP is a long term project that involves linkages with academics across the globe and across disciplines. It incorporates the works of established academics while encouraging the development of young, African academics.

4.9.4.2. Thinking about assets

The second phase of defining a framework within which the work was to be conducted occurred in Cape Town in 2004. Those that had become interested in the project met to brainstorm some ideas of how best to go about expressing and defining the work that ARHAP was trying to capture. Thus, it must be stated that while I have given my own interpretation of the framework, much of the thinking was a collaborative effort from the leaders of the ARHAP teams including, Prof. James Cochrane (UCT), Ms Barbara Schmidt (UCT), Dr Steven de Gruchy (UKZN), Mr Paul Germond (Wits), Prof Deborah McFarland (Emory) and Prof Gary Gunderson (Emory) amongst others.

As has been pointed out in the theoretical framework, ARHAP’s focus on assets is drawn from Sen and Nussbaum’s work on an asset based approach to development. In his book, Development as freedom, Sen (1999) identifies the goal of development as being freedom – that is that people have the freedom to live the lives they choose to live without constraint. However, freedom is also a key element of achieving development as it is through freedom that people can be active agents of their own destiny. Thus agency is an important aspect of development. “Greater freedom enhances the ability of people to help themselves and also to influence the world, and these matters are central to the process of development. The concern here relates to what we may call the “agency aspect” of the individual” (Sen, 1999: 18). Thus recognizing the agency of an individual and ensuring that that individual has the freedom in which to practice his/her agency is a key concern for development. The agent is thus the

asset to his/her own development. Equally so therefore, the healthcare provider's agency is an asset to the healthcare system and as such must be understood. Hence, ARHAP's focus on assets.

An asset can be said to be religious when it is "based in, derived from, or supported by faith-based agencies or bodies; encompassing a range of skills, resources, associations, organizations & institutions already in a local or translocal context, including hospitals, but also (especially) NGOs, CBOs, SMs, informal sites and agencies that are intra- and inter-faith and include "theology," canon, moral systems and leadership patterns." (Cochrane, 2003).

The first most concrete aspect of religion's role in health is that of tangible assets. Tangible assets refer to the physical elements of healthcare that religion provides – hospital beds, medicines, buildings and equipment. There has been a fair amount of research in this area, particularly by Benn (1999) and work is being done to map the tangible assets in Lesotho through ARHAP.

Intangible assets however are less easily identifiable and measurable. Intangible assets refer to such abstract areas of religion as the teachings of the faith, the impact of the religion on identity and behaviour, the role of rites of passage, hope, prayer and community. Intangible assets may have an equal if not greater impact on healthcare and development and it is in this area that I am primarily interested.

Assets may also be direct or indirect, that is they may have a direct intention or an indirect intention to impact on health. Praying for the healing of someone for instance could be seen as a direct asset as the purpose of prayer is to impact on the health of the person. From a mainstream Christian perspective, rites of passage could be seen as indirect assets in that they do not serve the sole purpose of healing but may contribute to the wellbeing of a community. This

example has been challenged in our work in Lesotho as is expressed by Germond and Molapo (2006) who found that rites of passage such as initiation have a very important and direct role to play in health[12].

Although ARHAP has focused on religious health assets in particular, it must be stated that this framework and this focus sparked the idea for my research and guided the research in its initial phases. In many ways this dissertation has gone beyond the scope of work that ARHAP is concerned with, although there is no doubt that it will contribute to ARHAP's research agenda. A look at the Suite of Assessment Tools will indicate where this research stemmed from after which I will show how it has gone beyond the ARHAP framework.

4.9.4.3. ARHAP's Suite of Assessment Tools

In order to ascertain whether or not religion does in fact contribute to health in Africa, and in order to measure these assets effectively, ARHAP designed a framework that would allow them to look at different types of assets. The starting point of this framework is understanding that the assets that religion beings to health are not simply material assets, although these do exist in abundance (almost 70% of hospital beds in Africa are church sponsored (Benn, 2003)), but they are often intangible. Examples such as prayer, a supporting community of faith and theology around disease and death are all examples of aspects of religion that may or may not contribute to healing. However, these aspects are difficult to measure and analyse. As such ARHAP designed a suite of assessment tools that would allow teams within ARHAP to look at different types of assets. These tools have worked far more as a theoretical framework than actual physical research tools. However, they do guide the research process and

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[12] For more detailed information on the arhap religious health assets matrix see cochrane (2005). "Of healthworlds and health agency: recasting conceptions of health in an african world." *Draft working document.*

have influenced the work of the ARHAP Lesotho team quite significantly. The suite of assessment tools is aimed at bringing out research that will be presentable to policy makers. Thus all elements are connected quite significantly.[13] The overall picture of the framework follows.

As is evident in this model, there are four approaches to understanding assets that ARHAP must follow. The first is the health agency tool (HAT). This section of the research aims at understanding the motivations of healthcare providers and healthcare seekers. It looks at agency and why people make the choices they do. It also aims at understanding how people conceive of health. The assumption behind this section of the model that must be proved or disproved is that religion contributes to how people understand and practice health and that as such religion is either an asset or a deficit. If it does contribute, the task is then to ascertain whether or not it acts as an asset or deficit or both at different times.

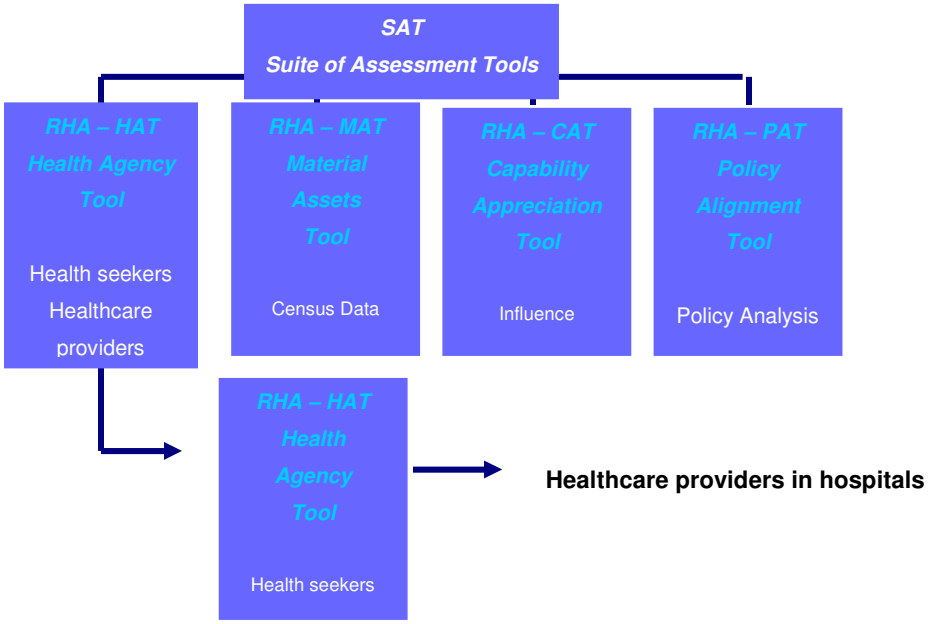

Figure 14: ARHAP's Suite of Assessment Tools

[13] For a more detailed discussion on the framework refer to Cochrane, J. (2003). "ARHAP Concepts and Theories" Powerpoint Presentation. Presented at ARHAP Core meeting. Hout Bay.

It is in the health agency section that much of the Lesotho work so far has been conducted. It was my task to conduct research into how Basotho healthcare providers in a hospital setting understand and practice health, to understand their heath agency. Mr. Sepetla Molapo focused on the health agency of health seekers and traditional healthcare providers. Mr. Vernon Vera is currently researching the health agency of church leaders and Mrs. Evelyn Vera focused on the health agency of those people providing health through Faith Based Organisations (FBO's).

The second element is the Materials Assets Tool (MAT). This element is used to understand what tangible assets religion brings to health. Using Global Positional Systems (GPS), researchers are able to map out where church hospitals exist, how many beds they provide and the medicines and other supplies they provide. Dr. Frank Dimmock of the Malawi Christian Health Association and Dr. Shirley Butcher of University of Cape Town have done most of the GPS mapping in Lesotho. However, researchers on the ground may also carry GPS in order to add in any assets that may have been missed. For instance Evelyn Vera maps any faith based organizations involved in healthcare provision as she continues her research. In Lesotho, GPS will also be used to map where traditional healers are as they are considered tangible religious health assets. This will be the first time that a map will exist denoting where traditional healers are and recognizing them as assets.

The Capabilities Appreciation Tool (CAT) is used to measure the effectiveness of a health asset. This element recognises that churches may provide hospitals and hospital beds, however, they may not be particularly useful assets if they cannot be accessed, or if they are not working optimally. Thus this tool measures the extent to which assets function and tries to understand the challenges that hospitals or other religious health assets may face in providing healthcare services.

Finally, the Policy Alignment Tool (PAT) will bring all of the data together and align it with current health policies at national, local, hospital and church level. The aim of this tool is thus to influence policy makers to recognise the role that religion plays in healthcare in order to maximize the potential of religious health assets.

As has been stated, the work in Lesotho has begun at the HAT and MAT level. My work particularly falls within the HAT area as I focused on understanding the health agency of healthcare providers in a hospital or 'Western' setting.[14] Thus my project represents a small yet significant element of the overall ARHAP Lesotho research project. However, my research is broader than the ARHAP framework. As has been stated, while ARHAP provided the initial focus of this dissertation, through the process of interviewing the healthcare providers this research came to describe far more than religious health assets alone. The assets-based approach and the fundamental focus on the agency of the individual actually revealed much broader themes around health. Religion is a significant element of this thesis, not least of all because all of the healthcare providers interviewed are religious. However, it is not the only focus of this research. Rather, I identify and analyse four key discourses of health that are evident at Scott Hospital and show how all of these discourses play a role in the understandings of health that the healthcare providers hold. Thus, ARHAP provides a significant starting point for the research but while the findings contribute to ARHAP's project they also go beyond it.

[14] The term Western is used to denote an approach to healthcare that draws on scientific or biomedical models and is influenced by public health policy as opposed to traditional healthcare systems. The term Western is problematic, as this type of healthcare has become as much influenced by Basotho culture as it has influenced Basotho culture. Thus whether or not it can still be termed Western is debatable. I use the term for the sake of distinction and clarification.

4.9.5. Other key concepts

In the course of this research a number of key concepts have come up that I have begun to use to understand and explain the understandings of health that the healthcare providers at Scott Hospital have.

Firstly, it must be explained that when I began my fieldwork, certain Sesotho terms came up that were not easily translated. I was at the time working with Mr Molapo, himself a fluent Sesotho speaker, who alerted me to the fact that while he was conducting interviews with traditional healers (in Sesotho) he had found it very difficult to talk of the concepts religion and health as distinct entities in the same way that we do in the English language. He said that the same was true for other words that had come up. This concerned the Lesotho team because it would have implications for how we conducted further research and how we wrote up results. We thus decided to use the Sesotho forms of words in our interviews and in our writings.

There are thus a number of Sesotho words that we have chosen to use in their original form. This decision was also taken to reflect the nature of the research, which as has been stated, is rooted in the capabilities approach to understanding development. All too often, the meanings and intricacies of the vernacular language are lost in translation. It is obvious that the entire dissertation could not have been written in Sesotho, however, key concepts that we felt expressed more in their original form have been maintained.

The first is the title of this dissertation – bophelo. Bophelo is a term that literally translated refers to life. However, it is a much richer term that encompasses health and life in all its aspects and manifestations. Thus, bophelo could refer to the state of being alive and not dead. It is also used to refer specifically to health as it is conventionally understood by the medical profession. But more importantly, it refers to the state of an individual living positively, the state of relationships amongst people and the state of a community in harmony with

others and its environment. In its broadest sense bophelo could be a utopian vision of society[15].

The term bophelo was eventually used in the research because of the difficulty of expressing the distinction between health and religion in the Sesotho language. In a sense, this early revelation shifted the focus of the ARHAP research in Lesotho quite significantly. While initially we had set about to understand how religion impacted on health, or in other words, what assets or deficits religion brought to health; this early observation forced us to take note of the fact that in Lesotho (and these findings were confirmed by teams working in other African countries such as Zambia) spirituality and health are so deeply intertwined that one cannot think of the two separately. Bophelo is the word that best expressed this conception of the world, for if one is truly healthy, that implies that one is living in harmony spiritually – with God and/or with the ancestors. Life and a healthy life cannot be understood or conceive of without thinking of the spiritual aspect. This is in sharp distinction to the traditional Western conception of health that separates out the physical from the spiritual. Molapo and Germond (2006) as well as Molapo (2005) have spent much time trying to understand this conception of bophelo and have written a detailed analysis which gives more clarity on the subject.

Another key concept is that of health discourse which I have defined earlier as a particular body of knowledge that describes and understands health and ill health in a specific way and thus prescribes how health is to be maintained and ill health treated. In Lesotho four dominant discourses of health have been identified through the research. These are outlined below but will be discussed in more detail in Chapter 5.

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[15] This information was derived from informal conversations with people in and from Lesotho, including Sepetla Molapo, Steven Gill and Lindy Gill.

4.9.5.1. Sesotho Traditional Discourse (Bongaka ba moetho)

The Sesotho Traditional Discourse of health preceded the other three discourses of health in Lesotho. Its roots lie in pre-colonial Sesotho culture and although it has evolved over time and been influenced by the history of Lesotho, it has been in existence for as long as Sesotho culture has. In its contemporary expressions it embodies a process in which Sesotho agency has developed conceptions and practices of health that are regarded as uniquely Sesotho, as opposed to other discourses. It must be pointed out that this concept does not refer to a homogenous discourse. Rather, there are considerable differentiations within this broad discourse as will be discussed later. It is defined by the practice of traditional healers and the use of communication with the ancestors and natural medicines as well as recognition of the role of the spiritual and social in health – that is a holistic understanding of health (Janzen, 1979).

4.9.5.2. Biomedical Discourse (Bongaka ba Sekhoa)

The biomedical discourse is the second major discourse of health in Lesotho which was introduced to Lesotho by missionaries in the early 1800's and was entrenched in policy during the colonial rule of Lesotho. Sekhoa literally means white and was used to refer to the white people that missionary work and colonialism brought to Lesotho. However, over time the term sekhoa has increasingly come to refer to anything with a Western or urban influence. Thus medicine or healing that is not cultural or traditional (bongaka ba moetlo) is referred to as bongaka ba sekhoa. As such a Mosotho, Western trained medical doctor may be referred to using the term ngaka ya sekhoa. The term encompasses the biomedical view of health and medicine but it may also include social work and counseling that has originated from outside of the Sesotho culture. Thus this refers to the biomedical discourse of health which is defined predominantly by the separation of the physical and spiritual and by the doctrine of specific aetiology.

4.9.5.3. The public health discourse

More recently, the public health discourse has had a major influence on healthcare providers in Lesotho. This may be for a number of reasons that will be discussed later. However, at this point it is important to clarify what is meant by a discourse of public health. Public health refers to the broader understanding of health, based on the psycho-social environmental model that recognizes the macro influences on health such as the environment and stress (Gilbert, Selikow & Walker, 1996). The Public Health discourse has gained popularity since the World Health Orgnanisation's Alma Ata Declaration on Primary Health Care in 1979. Although the discourse does see health more broadly it does not include the spiritual and social aspect of health in the same way that the traditional view of health does. This will be discussed in more detail. In response to this understanding of health it advocates a primary health care model for healthcare provision that includes the prevention of disease and maintenance of health as opposed to the curing of disease as in the biomedical model.

4.9.5.4. The fourth discourse

There is a fourth discourse that exists in Lesotho. Due to the difficulty of distinguishing between religion and health as was discussed previously, I was initially unsure of how to make sense of this discourse of health. The traditional understanding of health (Bonkaga ba moetlo) includes a deeply intertwined spiritual aspect that may refer not only to the ancestors, but also to man and woman living in harmony with the Christian God. Thus I was not sure if the Christian discourse should be included with the Bongaka ba moetlo understanding of health or if it did in fact represent a separate discourse. I decided that although there is a lot of overlap between the two (as there is with all of the discourses) the Christian understanding of health should be distinguished from the Bongaka ba moetlo understanding primarily because of the historical tension that existed and still exists to some extent between the two as has been discussed by Molapo (2003). Although both discourses have a

spiritual element, in many ways they are in fact distinct and the overlaps are more a representation of how healthcare providers hold competing discourses in their minds, than an overlap of the actual discourses (as will be discussed in more detail). Thus the Christian understanding of health must be defined.

The Christian discourse of health understands health as being intricately linked with God and His plan. In more charismatic and conservative churches this would mean that God is directly involved in the healing process and may be called upon as in when people lay hands on the ill. In addition, disease may be seen as a symptom of sin. This idea has been most profoundly witnessed in the stigma around HIV and AIDS. In more mainstream churches this belief may have been watered down somewhat and God is seen more as a mechanism of support to the afflicted and his/her family and to the doctors. This may be due to the Western separation of the spirit and body where doctors deal with the body while God deals with the spirit. I would suggest that in my sample of healthcare providers in Lesotho, the latter conception of Christian health and healing is more prevalent and this will be discussed in some detail.

I have mentioned the difficulty I had in deciding whether or not to distinguish between the Sesotho traditional and Christian understandings of health. This raises one other distinction that must be made and that is between religion and spirituality. For the purposes of this dissertation when I use the term spirituality, it will, unless otherwise indicated, refer to traditional spirituality – that is a relationship with the ancestors and the implications of that, including the practices and rites of passage associated with this understanding. The term religion or religious will refer to the spiritualities introduced originally by the missionaries and originating from Europe. In Lesotho, these are generally Christian forms of religion that involve a relationship with God, Jesus and the Holy Spirit and the associated practices and rites of passage. Having made the distinction it must be pointed out that religion is no less spiritual, and that traditional spirituality is no less rigorous in terms of practices for me having used

these terms. Secondly, in Lesotho it is evident that there is a lot of overlap between the two ideas and many people embrace both Christian and traditional conceptions of spirituality and practice them without any tension. Thus the two are not necessarily mutually exclusive.

Having distinguished between four broad discourses of health, two qualifying statements must be made. The first is that these by no means represent all of the discourses that are at play in conceiving of health in Lesotho. The number of different Christian groups, such as AIC's and Zionists; and the number of different traditional practices of health indicate that there are a multitude of discourses at play in Lesotho that simply cannot be discussed at this level. Secondly, these discourses can be spoken of as distinct but should not be seen as homogenous static discourses, completely unaffected by other discourses. The bongaka ba moetlo discourse for instance has been significantly impacted upon by the bongaka ba sekhoa and Christian understandings of health and is increasingly being affected by the public health discourse. The same can be said for any of the discourses and this is the nature of the interplay between healthworld and discourse as I will later suggest. Thus, these distinctions should be seen as representations, as patterns and as concepts that make it easier to understand the health landscape in Lesotho, rather than as real distinct, boxed ideas.

4.10. Conclusion

This chapter has provided the theoretical concerns and concepts within which the dissertation should be read. It has outlined how the dissertation proposes to contribute to both the development and health literature through the deconstruction of the dominant development model and the advocating of a development model with a human face. This development model can then be used to motivate for the importance of understanding individual healthworlds – in this case those of Basotho healthcare providers. In so doing it has also provided

an analysis of the socio-economic history of Lesotho. The next chapter will illustrate how the dominant discourses of health are expressed in Lesotho. This will be followed by an analysis of how these expressions relate to the four literature regarding the four dominant discourses.

5. HEALTH IN THE PERCEPTIONS OF HEALTHCARE PROVIDERS AT SCOTT HOSPITAL

The previous chapter outlined how development has been conceived of and practiced in Lesotho. In doing this, it also made mention of how health has come to be understood and practiced in Lesotho. This chapter will present the findings of the research as they relate to the dominant discourses of health in Lesotho. As has been stated in Chapter 2, this research followed a grounded theory approach. As such, the interviews and focus groups were designed around a theoretical insight that has since been published by Germond & Molapo (2006). In this work they discuss the importance of socio-spatial arrangements of Bophelo in Lesotho, stating that bophelo not only exists at the individual (motho) level but also at the familial, community and nation level. Each level impacts on the next level. Given this discussion, the interviews were designed to get the respondants to think about their understandings of health at each of these levels. The findings are presented to reflect this approach. I have presented the findings in this way as it is interesting to see the differences that arise as I encourage the participants to think of health more widely. The more I pushed them to think about health outside of the workplace, the more diverse their understandings of health became. Some of the key themes that arose in the various sections include relationality as a key element of health; holistic views of health; socio-economic aspects of health; as well as the expected physical elements of health. I conclude the chapter by looking more closely at some of the more unexpected trends including the prevalence of traditional understandings of health. This leads into the following Chapter which will look at how these understandings link in with the dominant discourses of health as expressed in the literature.

Before doing this it is important to understand the profiles of the participants. Three levels of healthcare providers were interviewed. Nurses are defined in the Lesotho healthcare system as having their basic nurses training plus at least 2

diplomas in various aspects of nursing. In general nurses are trained at different colleges to nurse assistants as the qualification for nurse assistants is more basic (although nurse assistants can go on to become nurses). Of the 11 nurses that were interviewed, one had 2 diplomas, seven had three diplomas and three had postgraduate training (including one who was embarking on a PhD). All 11 were female and most (seven) were based at Scott Hospital or its health centres. Three were based at Mokhotlong and one at Paray Hospital. Nurses at Scott are more senior and are tasked with monitoring and managing the five wards, assisting doctors by seeing outpatients who are not in need of major treatments, and perhaps most importantly coordinating the many projects that Scott runs such as the Community Alcohol Rehabilitation Programme, the HIV/AIDS programme, the Environmental Health Programme as well as ensuring that Primary Health Care is running effectively at all of the health centres. Many of the nurses are also involved in training of village health workers and traditional healers. Nurses at the health centres often take on what is traditionally a doctor's role as a doctor is minimally available. They thus prescribe medication and conduct treatments, allowing for only the most serious cases to be dealt with by a doctor.

This is in contrast to the nurse assistants who are tasked with the day to day activities in the wards as well as assisting the doctors in the outpatient department. At the health centres nurse assistants are often required to take on the responsibilities of nurses due to a shortage of qualified nurses to run the centres. Nine nurse assistants were interviewed all of whom were qualified with the nurse assistant diploma and all of whom were female. It must be stated that although nurse assistants can go on to become nurses, many of them choose to remain at the nurse assistant level. Seven of them were located at Scott and its health centres while another two were working at Paray Hospital.

In addition to the interviews with the nurses and nurse assistants, I also conducted focus groups. In the nurses' focus group, there were eight

participants, all of whom were female. None of them had been previously interviewed. The nurse assistants' focus group also had around eight participants, but this kept varying as other members of staff joined the group and then left. This has been discussed in the methodology chapter. In this focus group all but one participant were female.

Finally, the technicians were interviewed in order to try and gain a male perspective to see if there were any major gender and occupational differences. Two pharmacy technicians were interviewed at Scott Hospital. They had degrees from the National University of Lesotho. They were both male and their task was to ensure the smooth running of the pharmacy including ordering of stock and filling of prescriptions. The laboratory technician at Mokhotlong hospital also had a degree from the university and his task was to analyse all samples that came into the hospital.

This then gives an idea of the group of people that took part in the research and whose ideas are reflected in the following pages. A schedule of interviews is attached as Appendix 1.

5.1. Understanding of the healthy person

The question, "what is a healthy person?" was asked to stimulate the discussion around how health is understood. It was asked in order to take the discussion around "What is health?" from an abstract level to a more practical level and to gauge what all the healthcare providers associated health with in their daily lives. In general the nurses still kept the discussion at an abstract level in response to this question while the nurse assistants drew far more on their daily experience and generally spoke about a healthy person in terms of their patients. Some of the responses are from the focus group in which the question was asked slightly differently. The participants were asked to plot their perceived health in relation to pictures of people (as described in Chapter 2) and questions were then raised

around why they plotted themselves where they did in order to determine attitudes around health.

5.1.1. Holistic view of health

One of the most striking findings was the extent to which health is understood holistically for the healthcare providers. Health is understood as functioning well physically, socially, mentally and spiritually. For them, an individual can only be healthy if they are healthy in mind, body, spirit and community. Thus there is a definite understanding of the interconnection of people both with the inner body (spirit) and the outer body (community and the ancestors). This makes it difficult to talk of how they understand health at the different socio-spatial levels (individual, family, village) as they are all interlinked. Nevertheless for the purposes of clarity these categories will be maintained with this interconnectedness in mind. This understanding of health was found across the board but is expressed more strongly from the nurses. This may have to do with the fact that Scott Hospital's mission and vision incorporates a holistic view of health. However, even the nurses at Mokhotlong hospital understood health in this way which makes it likely that it may also have to do with the predominance of the primary healthcare approach to health in Lesotho generally. Whatever the reasons, what is clear is that health is understood very broadly for many healthcare providers. This understanding of health was best expressed by Mme Ramatla, head of the primary healthcare department at Scott.

> *"Somebody who is healthy is mentally, physically and socially ok, because if your mind is not ok. Then you are a sick person.*
> *Question: Are we talking about mental health?*
> *Answer: If you do not relate well with people, how can you be well? You get mad. If you don't have money you will not be well" (Mme Ramatla, nurse at Scott).*

Mme Tsitsa, a nurse at Mokhotlong hospital also reflected on this understanding of the healthy individual,

> *"A sick person complains about the sickness, himself or herself. Even a child will explain that he or she's not feeling well. A healthy person is up and about, is happy and wants to function. Being in a state of wellness makes a person happy, both physically and mentally because a person can be healthy physically but mentally not well.*
> *Q: What would you tell me if I'm not mentally well?*
> *MT: A healthy and harmonious relationship, if they participate in recreations with their peer groups"*
> *(Mme Tsitsa, nurse at Mokhotlong).*

It is clear from both of these nurses that for them, health of an individual is intricately linked with their inner health (both mental and spiritual) and with their social health. This type of definition tends towards a public health definition of health as being not simply free of physical ailments, but includes a sense of well being.

5.1.2. Relationality as key to health

What is evident from the quotes above is that relationships and the social are seen as integral to health. This is a point that came up time and again in the interviews. Health is about having people in one's life and about being in right relationships with those people. It is expressed across the board of healthcare providers. Relationships are seen to contribute to healing as Mme Tsitsa states,

> *MT: A healthy and harmonious relationship, if they participate in recreations with their peer groups" (Mme Tsitsa, nurse at Mokhotlong).*

For Mme Tsitsa, participating in right relationships is key to dealing with mental health issues. This was reinforced in an informal, unrecorded interview I had with the sister of the children's ward who indicated that when a child comes into the ward having been abused, the first thing the nurses do is encourage him/her to play with the other children and the first signal they have of the child beginning to heal is when s/he begins to play with the other children. It was also reinforced in the focus group discussion. I used the self reporting health tool to assess how

healthy nurses felt in relation to particular pictures I had placed on a graph. One of the comments on one of the pictures named “very healthy” was that the woman did not look healthy at all. The reason for this is that the picture had been interpreted as a woman travelling in a foreign country. The separation from her family was seen as detracting from her health.

Relationality is seen as a major part of the job of a nurse or nurse assistant and as an integral tool for healing. The nurse assistants at both Paray Hospital and Scott Hospital expressed this when they indicated that often people simply need someone to talk with – to be in relationship with someone.

> *I like to talk to patients so that I can help. In other words counseling. It’s what I like. Because I have so many problems, so people are talking to me. That’s why when someone is sick, I think of that home and maybe somebody has got problems at home and that’s why they are here - many of the patients. (Mme Mabakoena, nurse assistant at Scott).*

> *MN: We treat them according to their problems. Sometimes they just want to talk.*
> *L: So do you think that if somebody wants to talk that talking to them makes them better?*
> *MN: Yes, it’s true.*
> *L: why is that?*
> *MN: I really don’t know but it’s true because even I myself, if I have a problem and I talk to the next person, I get healed. (Mme Nthomeng, nurse assistant at Scott HC).*

> *Often the people come here just to talk, even if they bring their children for injection then the mothers want to sit and talk to us. They want to tell us their problems. Listening is my job. (Mme Makalaele, nurse assistant at Paray).*

I suggest that although the social element of healing is reflected in the psycho-social environmental model of health, it is expressed far more deliberately amongst the healthcare providers and is given far more centrality than in the public health discourse of health. This may have to do with the understanding of

connectedness that is dominant in an African perspective expressed in Sesotho as “motho ke motho ka batho” or “I am because you are”. It reflects an ultimate respect for other people and as such a need to care for others as if they were ones family. Interestingly enough however, this aspect of healing is often expressed in relation to faith or religion and attributed as such.

> *LG: Do you think your faith brings something to your nursing?*
> *MM: I think so because if you nurse somebody. If you have this humility in yourselves, thinking that well if this person is sick today, tomorrow it might be myself. What do I do to this somebody, would I like it if somebody does it to me? If somebody is sick, think of it as somebody that you love; your mother, your father etc being in another institution being treated like you are treating this somebody. That is one of the things that was inspiring me; that you should do something better for others. Usually when I go out, I greet people (the patients) outside, because I feel they have come to us for help. They should see that we greet them and accept them. But if you just pass without greeting them, they get afraid and cannot even ask questions or ask for help. When people are sick, anything that you say may irritate them. Small things irritate sick people really. I feel mad when I see a patient being ill treated, even poor people are ill-treated. (Mme Makoa, nurse assistant at Scott HC).*

This relational aspect of healing is reflected in how the hospitals and health centres are set up and it was something that struck me (as an individual influenced by Western biomedical clinical settings) from the start. The health centres, while being very sparse and small buildings, were also very warm and inviting. In every health centre I visited there was a fire burning in the fireplace and the people that came congregated around that fire to chat amongst one another. In addition, there was a pot of pap on the fire from which any of the people in the building could eat. This was provided at no cost and in a very casual fashion as if the health centre was someone’s home at which food was being provided. Often the nurse assistants, despite being busy, would sit for a while with the people in the centre and chat. As far as I could observe, many of the people sitting in the centre were there for the warmth and the comfort rather

than needing to consult with a doctor or needing any physical ailments addressed. Although the health centres don't compare to the pristine, polished private hospitals normally associated with healing, they really do project a sense of comfort and healing that no private hospital could ever do.

It is clear therefore that relationality is deemed a very important element of health and of the healing process for the healthcare providers.

5.1.3. The physical aspects of health

Although health is understood in a particularly holistic way by the healthcare providers there is also a strong recognition of the physical aspects of health. In fact, for the nurse assistants in particular, health of an individual is often exclusively defined as being related to physical symptoms. I suggest that this may be because the nurse assistants have must come out of training and have been exposed to the biomedical model in their training and may be expected to express health in this way. This was particularly the case at Scott Hospital where the location of the interviews – the boardroom – may have affected the answers that the nurse assistants gave. However, interviews at Paray showed the same trends amongst the nurse assistants. As such it is clear that the physical element of health is seen as being of great importance for the nurse assistants and the technicians. The physical element of health is expressed for them as the importance of identifying symptoms through testing to see if the person is ill.

> *A patient will always be complaining of this and that, that's when we'll be checking the temperatures and pulse, and the doctors are always there to help with medical prescriptions for them to take at home. (Mme Mokaloba, nurse assistant at Scott HC).*

> *L: And when somebody comes here, how do you know that they are sick?*
> *MN: Just everything, temperature, blood pressure. (Mme Nthomeng, nurse assistant at Scott HC).*

Sometimes you can't cos some patients you can tell if they are sick. But other patients doesn't look like they are sick. But after that, you can do tests like BP. If it's high, then he's sick, if it's low, then he's sick. But sometimes you cannot know they have high blood, unless you check it. (Mme Mokati, nurse assistant at Paray).

The lab technicians express this aspect of health using biomedical language – health is the absence of disease and one needs to identify what the disease is to address the problem.

NN: Free of sickness or illness.
LG: When you are here at Scott, how would you identify somebody who is healthy and somebody who is sick?
NN: They (sick people) normally come to us. These people normally come to the hospital when they feel that they are sick and then of course doctors will take over to diagnose and examine them and eventually prescribe medication according to the diagnosis and examinations. (Ntate Namole, pharmacy technician at Scott)

I think presentation of the patient, even if I'm just walking down the road now. I can not really be sure the kind of disease the patient is having but the kind of movement, or when you are greeting the patient the response, maybe the person has upper respiratory problems, persistent coughing, those things which you can suspect this patient is really sick. (Ntate Mokati, lab technician at Mokhotlong)

By doing a physical examinations and one also identify people by seeing or those who represent certain symptoms that you kind of associate with particular diseases or conditions. You also go further to diagnose using machinery like X-ray for different problems. Sometimes, through using some drugs, like I know there is this drug they call (bacterium?). What it does is it diagnoses ulcers in the eye. You just put some drops in the eye and look for a certain colour and if it appears you know you have ulcers and if it does not appear you have (ulcers?) in the eye. Those are the different methods to diagnose illness. (Ntate Matlonyane, pharmacy technician at Scott)

The dominance of the biomedical model for the technicians probably has to do with the fact that they are trained in predominantly biomedical subjects such as pathology and there is no need for them to be exposed to the public health model. This is further reinforced by the fact that the type of work the technicians are involved in does not involve direct exposure to the daily lives of patients, with all of the social and individual issues that come with that. Rather, their days are spent working with biological samples or chemicals. They are thus not exposed to the other aspects of health including the social aspects and the emotional aspect of health.

Interestingly, the physical aspect of health hardly comes up in the nurses responses. I suggest that this is because they are far more influenced by the public health discourse, particularly due to their involvement with the health centres where much of the work is around health education and in their training of village health workers and traditional healers. In addition, due to their seniority, they are more likely to express their own understandings of health rather than the expected understanding of health which the nurse assistants may be trying to convey.

5.1.4. The socio-economic aspects of health

It is well recognised by the respondents that socio-economic factors influence health significantly. The socio-economic aspect of health at an individual level was seen as very important for the nurse assistants. This is not to say that it is not important for the nurses or technicians – it is simply that they express this element of health at a broader level. The nurse assistants however directly related to the social-economic aspects of health and as such brought it up in the discussion of the healthy individual. Access to resources, a good income, money to pay school fees and feed children, access to water and a good house and clothing as well as adequate healthcare were all seen as extremely important elements for health. This was expressed most in the focus groups rather than in

the interviews. I conducted a health self-reporting exercise as explained in the methodology chapter in which the participants had to place a line to symbolise how healthy they felt in relation to the pictures on the graph. The question that followed this exercise was "Why do you say this?" It was at this point that the socio-economic aspect of health came across strongly. The nurse assistants' graph looked like this:

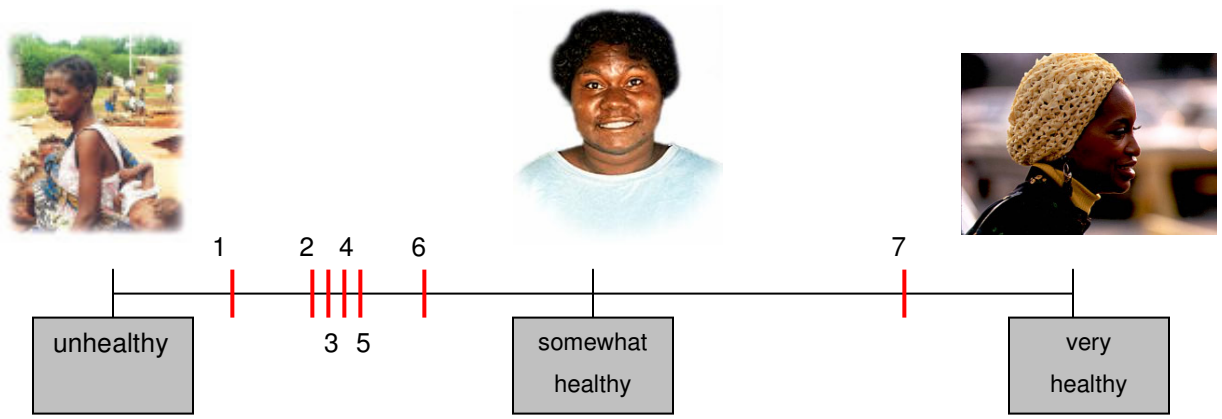

Figure 15: Self reporting health tool as completed by the nurse assistants

The red lines indicate where the nurse assistants identified themselves in terms of health. Number 7 was the only male nurse assistant in the focus group and he plotted himself as closest to very healthy because he had three wives. This traditional standing was thus obviously important to him. Number 1 was the oldest nurse assistant in the group and she plotted herself closest to unhealthy because she had a chronic illness. The other five nurse assistants plotted themselves on the unhealthy side of the line. This was interesting as the majority of the nurses plotted themselves closer to very healthy. When I asked why they saw themselves as unhealthy the conversation turned to their inability to meet their needs and the needs of their families. Some of the quotes from the focus group to this effect follow.

> *How can I be healthy when I can't pay school fees, I can't buy a new uniform for my child?*

I'm not healthy because they don't pay us enough here. There is not enough to live. Not enough for food, for school fees, for uniform.

I am looking after my mother in law. She is sick, she has chronic illness. I can't afford to pay for the doctor and my children's fees. There is not enough money. We are poor so we are unhealthy.

It is clear therefore that the environment in which one finds oneself and the stressors that are associated with that environment are seen as being very important for health from the nurse assistant's perspective. I attribute the dominance of this understanding of health at an individual level amongst the nurse assistants to the fact they are paid far less than the nurses and technicians and thus feel the impacts of not having access to resources to a far greater degree than the nurses or technicians.

5.1.5. Spiritual aspects of health

As has been explained before, Christianity has a long history in relation to healthcare in Lesotho and still plays a significant role in healthcare provision. This is at a tangible level however – through the provision of hospitals and equipment. It is interesting to note however that spirituality and faith are seen as important for health at an intangible level too. This is expressed at an individual level in relation to the health of the healthcare providers themselves. However, as will be illustrated it is given more emphasis in relation to health generally when the respondents were asked to think about healthy families and healthy communities. At the individual level, one nurse assistant immediately suggested the centrality of spirituality to health when she stated in response to my question of "What is a healthy person?"

Answer: There is nobody who is healthy, everybody is sick.
Lauren: Why?

Answer: We are born sick, no one is perfect except God.
(Mme Ekzenia, nurse assistant at Paray).

This illustrates the centrality of the Christian discourse of health for this nurse assistant in particular. This was also expressed in the PIRHANA workshop held in Masite at which three respondents named immorality as a threat to bophelo. However, it is expressed far more broadly for most other healthcare providers. For the nurses in particular, the teachings of the Bible influence their understandings of health as well as the health behaviour of seekers. This is of particular importance when dealing with HIV and AIDS, and alcoholism or drug abuse. The following quotes illustrate this.

When you actually read into the religion in the Bible, you find that Jesus Christ was just interested in the people, that he naturally applied things, advised people to go and wash themselves and they will get cured. There are a lot of things one can get from the Bible that teaches you that religion and health are one and the same thing. It also teaches that people do wrong by taking alcohol. So that is why health and the Bible work well together. Also people have to be responsible for their lives, so that they don't get sick. Jesus Christ told his disciples to go out and make people aware. (Mme Lerotholi, nurse at Scott).

One of the things that one can think of now of late is that we ourselves have never considered that God can do something for us. If we really had followed the Ten Commandments initially from the Bible. Under the commandments one of the things that we should avoid is pre-marital sex and get married to only one person. I think if initially we had been following the Bible we would not be having this disaster and epidemic of HIV/AIDS. We have been making it worse. So I think because we have never involved God to assist us in this, our plans will never help. We failed to obey those rules so the plans that we are making I don't think they are working. We are saying that by 2000 everyone will be well, but we never said God, can you guide us and show us how. We make policies but will every body be ok like that. (Mme Tsita, nurse at Mokhotlong).

What this illustrates is that for the nurses, religious living is equivalent to healthy living. Christian teachings are seen to be effective health teachings too and that if we were to follow these teachings we would be more likely to live healthier lives and to combat infectious diseases such as HIV and AIDS. This was also expressed to some extent by the nurse assistants as religion also plays an integral role in how they understand health and disease.

For the nurse assistants however, their expression of faith in relation to health has far more to do with their own support mechanisms. Religion gives them a sense of calling in their work and this gives them strength to continue with the work. Religion therefore is expressed as a far more personal aspect of health than for the nurses and is seen for them as an integral element of the work they do in healing.

> *I think if someone is battling to stand on their own, we need to pray. (Mme Ekzenia, nurse assistant at Paray).*
>
> *We have to pray to him and believe that he can do anything. Every morning and every evening we pray with the patients. (Mme Pitso, nurse at Scott).*
>
> *Yes, it was a calling 'cos sometimes it is hard, but if it is a calling you can cope. (Mme Ralenkoane, nurse at Scott HC).*
>
> *In the New Testament where Jesus talks about healing, I think that made me love nursing. (Mme Mokati, nurse assistant at Paray).*

For the technicians, understandings of the healthy person are limited to the biomedical view and the importance of faith is only mentioned in the discussions around healthy families and communities.

5.1.6. Other understandings of health.

What has been presented above are the dominant understandings of health that were raised in the interviews and focus groups with regard to the healthy individual. However, there were some other understandings that also came up that were particularly interesting and needed to be discussed.

Perhaps the most interesting is the link between age or seniority and health and between waistlines and health – something which challenges the Western understanding of health as being associated with youthfulness and the perfect figure. This came up in the focus group discussion.

As has been discussed previously, I used the self-reporting health tool to begin the focus groups. I arranged three pictures of women and identified them as being very healthy, somewhat healthy and unhealthy (as shown below).

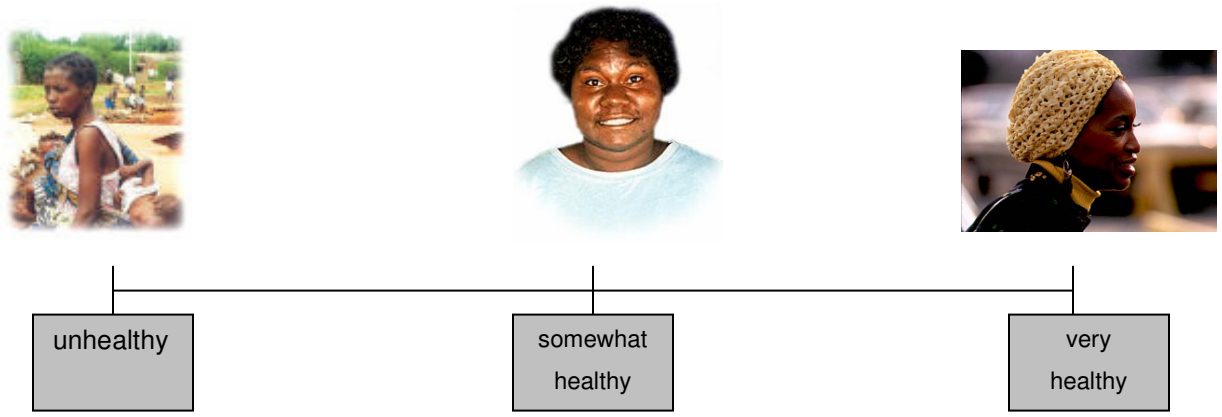

Figure 16: Self reporting health tool as presented to nurses

The first thing that the nurses did was rearrange my pictures so that the tool looked as it does in the picture below.

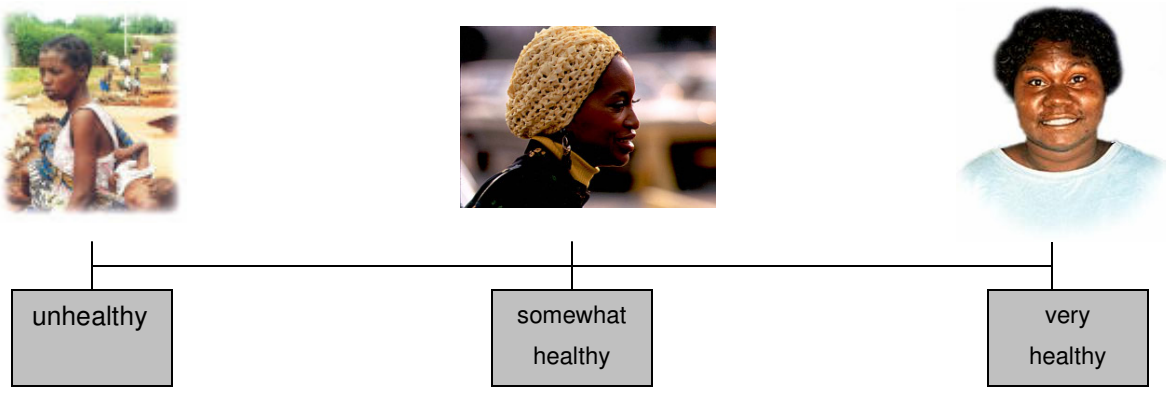

Figure 17: Self reporting health tool as reaaranged by nurses

When I asked them to explain why they had changed the order they explained that they agreed that the first women was unhealthy, as she looked poor and like she was unable to feed her children. The woman with the hat on was seen as less healthy than the woman with the blue shirt on because she was still young and seemed to be alone. To them she looked like a tourist and had left her country. On the other hand the woman with the blue shirt on was seen as healthier because she was fat and was older. She was thus seen to be a mother and had a family that was well cared for.

From this discussion it is clear that two things are of importance when talking about health for the nurses. Age and evidence of eating well are seen as important contributing factors to health in the view of the nurses. Interestingly from a Western perspective, youth is seen as healthy. Thus the focus on young models and actresses and the growth in the gym and cosmetic surgery industries. In addition, a slim figure is seen as healthy as dieting and gyming are advocated. In contrast, from a Basotho perspective, health increases with age and the more well fed one looks, the healthier they are seen to be. This reinforces the work of Germond & Molapo (2006) that suggests that in a Basotho understanding of bophelo a person's status in the community increases with age and after death as one enters the realm of the ancestors. In addition, as one

moves through the rites of passage of life one gains more family in the form of children and grandchildren. As such one's bophelo increases the older one gets.

It is clear then that when the healthcare providers were asked to consider a healthy person a number of understandings of health emerged including the physical aspects of health, a holistic understanding of health, the socio-economic aspects of health and the spiritual aspects of health. It is clear that one of the major considerations for healthcare providers is the importance of relationality for health. This is in opposition to the biomedical picture, which sees health and illness from an individual perspective and treats it as such. In order to understand health at a broader level it is important to consider the healthcare providers' notions of the healthy family.

5.2. Understanding of the healthy family

As has been discussed, Germond and Molapo (2006) in their work on the understandings of Bophelo state that in the Sesotho conception of bopehlo, health or bophelo is very much affected by socio-spatial arrangements as they relate to the individual, family, village, community and nation. Thus, although an individual may be healthy, s/he can never be truly healthy if s/he is living in an unhealthy family or village. The health of the individual impacts on wider social arrangements such as the lelapa or family and in turn the lelapa impacts on the health of the individual. It is for this reason that it is important to understand what a healthy family is for Basotho healthcare providers.

5.2.1. Relationality

One of the most important aspects of health when in comes to the family for Basotho healthcare providers is once again relationality. As has been discussed, at an individual level, Basotho healthcare providers saw relationality as an immensely important aspect of health. At the level of family it is no different. From the nurse assistants' point of view the importance of relationality within the

family relates to how the family cooperates or works together. Thus, it is about inner harmony in the family. Trust, love, mutual respect and cooperation thus contribute to the bophelo of a family and by implication to the health of the individual.

> *Being happy in the family; no abuse to the mother and children. When we are all happy in the family and can talk freely. (Mme Mabakoena, nurse at Scott).*

> *I can say that a healthy family is one where, if there is a lot of work to do, everyone does their work without being pushed. Everybody is active. (Mme Ekzenia, nurse assistant at Paray).*

> *Love. Love is important. (Mme Nthomeng, nurse assistant at Scott HC).*

In contrast, the nurses' emphasis when it comes to relationality and the family is on how well the family relates to the community around them. This indicates once again the inter-relationships of the socio-spatial arrangements when it comes to health. For Mme Ramatla harmony within the family is as important as the role that the family plays within the community. What she says below indicates very clearly the interconnectedness that is so much a part of the healthcare providers' understanding of health.

> *"a family that is relating well with the community, and there is harmony within the family. The family must be able to meet its needs" (Mme Ramatla, nurse at Scott).*

It is clear therefore that relationality is a major theme that comes up time and again in discussions of health for Basotho healthcare providers. However, what is more dominant in the discussions of health at a family level is the environmental or socio-economic aspects of health.

5.2.2. Environmental and socio-economic aspects of health

For all of the healthcare providers there is a very strong recognition of the importance of socio-economic factors when it comes to health. This probably comes partly from the emphasis on primary health care and preventative medicine in Lesotho but also has to do with their own experiences as they manage the demands on their money in their own families as well as when they see the effects of lack of access to resources amongst their patients.

A big emphasis for the nurses when considering health is that of the environmental aspect. For these nurses, a person or family cannot be healthy if the environment in which they live is unhealthy and if they are unable to provide for themselves. When I asked Mme Malebeoana , "What is a healthy family?" she reflected this perception as she answered,

> *MM: It is the one with children, up to four because of there are more than four it is not possible to provide them with the necessary things they want like food and school fees.*
> *LG: What things do you look at to say this is a healthy home?*
> *MM: There is clothing, clean water, sanitation…*
>
> *Mme Matsutsu had a similar view of the family. Her perception of the healthy family is reflected in her answer to the question, "what is a healthy family?"*
> *"A healthy family is the one that can be able to eat a well-balanced diet that can be able to seek medical care where possible and be able to pay for that. The family that will be able to pay for the children's school fees, clothing etc. And also have an acceptable house." (Mme Matsutsu, nurse at Scott).*

There is thus a very clear consideration of the fact that where there is poverty, and where people are unable to meet their basic needs, there cannot be full health.

The nurse assistants held a very similar view of health but expressed it more personally, probably because, as has been indicated before, they experience the effects of poverty and lack of access to resources more acutely than either the technicians or the nurses. For them, it was expressed as preventative healthcare

which may stem from their recent training in which the importance of hygiene and good nutrition would have been emphasized.

> *The hygiene has to be good; they have to eat healthy food; and when they feel like they are sick, they have to go to the hospital so that they can get help. (Mme Pitso, nurse at Scott)*

> *It's a family, which is always together, clean, with proper meals. (Mme Makalaele, nurse assistant at Paray).*

It is clear therefore that a major component of the healthcare providers' understanding of health is the socio-economic aspects of health.

5.2.3. Holisitc understanding of health

Although the holisitic understanding of health was something that the nurses discussed when asked about the healthy individual, it is picked up on by the nurse assistants when it comes to discussing the healthy family.

Mme Mokhutsoane expresses the holistic view of health when she says that a healthy family is

> *a family that eats well, has a balanced diet and is well spiritually, physically and emotionally. (Mme Mokhutsoane, nurse at Scott).*

This is also something that was picked up on predominantly by the technicians. As has been stated previously, the technicians' understanding of health at an individual level was limited to the biomedical understanding. However, when they were asked about healthy families it was clear that the holistic understanding of health played a major role. This is indicated most clearly in Ntate Namole's statement which reflects the bophelo type of thinking about health.

> *A healthy family is the family that is stable in all aspects of life, financially, socially, spiritually, and physically. Physically I mean they are ok, they are not sick, healthy conditions. And also politically and academically. If people are not educated, that*

family isn't really healthy. Not only physically healthy but other aspects of life. (Ntate Namole, pharmacy technician at Scott).

There is therefore evidence of thinking holistically about health but this is emphasized far more by the nurses in their understanding of the healthy individual.

5.2.4. Physical health

Discussions on the physical aspects of health were still evidenced, particularly by the nurse assistants. The question about a healthy family was intended to encourage the interviewees to think of their home and thus how they would define health outside of the work place. The expectation was that even if they were thinking biomedically about health in the workplace, if they were encouraged to think of health outside of the workplace they might think more broadly about health.

Interestingly enough however, when it came to the nurse assistants, the biomedical definition of health extended to the home. This indicates that the biomedical understanding of health is so dominant for the nurse assistants that it influences every aspect of their lives.

Thus in terms of family life for the nurse assistants in particular, a healthy family is seen as one that is physically well, that is free of disease and illness. One determines this by doing tests at home. This understanding is clearly reflected in one particular quote although it was a common theme in many interviews.

Q: And like with your child, and your husband, in your family, what are the things you look at to say we are a healthy family?
A: Everything. You can't just know how the body is working by just looking. You must do tests. He may be sick but not so sick.
Q: When you are at home, do you take these examinations to say we are a healthy family, or how do you know you have a healthy family?

> *A: I don't do the tests, I just listen to my family and then I can know if I must bring them here to the doctor, because we don't have the things at home for tests. (Mme Mokati, nurse assistant at Paray).*

It is clear that the physical aspects of health therefore still play a major role for the nurse assistants. Interestingly however this was not something that was mentioned by either nurses in discussions of the family.

5.2.5. The role of spirituality

The role of religion in the health of the family was picked up on by the nurse assistants and the technicians very clearly. Without any prompting religion was mentioned as integral to the health of the family. The nurses however did not mention religion in relation to the health of the family at all. For them religion plays an important role at a community level.

The nurse assistants once again expressed the role of religion as it pertains to their own lives and their views of the ideal family and it is linked with the relationality of families in that spirituality assists in bringing love and caring for one another. Spirituality therefore is important as it is about doing things together and supporting one another.

> *Like you go to church, and everyday you go to Bible study in the evening with my mother, father, sisters and brothers. (Mme Makalaele, nurse assistant at Paray).*

The technicians also see the importance of religion but express it more at a general or philosophical level rather than at a personal level. Religion for Ntate Matlonyane is about the practice of religious principles as they lead to good living and this contributes to a more peaceful and respectful environment for all. This illustrates once again the interconnectivity of socio-spatial arrangement of bophelo that is so much a part of the healthcare providers' understandings of health.

> *I would say a healthy family is a family that subscribes to religious principles, believes in God, prays, and communicates with the almighty. It lives within a very conducive environment free of fighting, seeking peace and common understanding, practises freedom of speech and respect. (Ntante, Matlanyane, pharmacy technician at Scott)*

At a familial level the dominant understandings of health are that of the socio-economic and environmental aspects of health, the importance of relationality and interconnectivity, the physical definition of health and the role of the spiritual in health. It is clear that at a familial level there is even more evidence of an increasingly broad definition of health. However, it is at the village or community level where discussions about health indicate particularly broad understandings of health and which take us back to the bophelo understanding of health.

5.3. Understanding of the healthy village

The discussion on the healthy village brought to light some very interesting understandings of health that the providers hold. These discussions push the boundaries of our typical understandings of health and illustrate how broad the conception of health is for Basotho healthcare providers. It links back to the discussion that Germond and Molapo (2006) have about bophelo which illustrates that in its broadest conception bophelo refers to "life in all its fullness" and thus takes into account such diverse elements of life as physical life and the means to sustain it, good relationships, the land, the role of politics and the importance of play as well as the role of religion and tradition. In the following section I go through each of these understandings to illustrate the diverse understandings of health that the healthcare providers hold.

5.3.1. Socio-economic aspects of health

Socio-economic aspects of health have been mentioned at all levels of the discussions around health and it is obviously a key component of the

healthworlds of Basotho healthcare providers, predominantly because health care in developing nations is focused on primary healthcare and public health, which addresses issues of access to livelihoods, access to resources and services and a healthy environment. This point came up most clearly however in the discussions around the healthy village, both in the interviews and the focus groups.

In the interviews with the nurses this point was brought up clearly – a healthy community has access to the means to meet their needs.

> *A healthy community is the one that has clean water, enough food supply, and the community earn average income. There is infrastructure such as schools, post offices, hospitals etc. (Mme Matsutsu, nurse at Scott).*
>
> *It is not easy to say a Mosotho is healthy in the village because we are poor. Because you will find that even though they are taught about good nutrition it is not possible for them to eat well. (Mme Shale, nurse at Scott).*

This was reinforced in the focus group discussion where key services were circled on the map of Morija. In the focus group I presented a map of Morija with the central features such as schools, shops and churches on it and asked the nurses to circle what they saw as important to the health of the community and to add in anything I had left out. The map is shown on the following page.

From this exercise the focus on the need for the community to sustain itself and meet its basic needs was seen as contributing to the health of the village. For example, the lights leading up to Scott Hospital, representing access to electricity, were added onto the map. The shops and egg circle were also circled and it was explained that these were seen as important as they represented the ability of the community to feed itself. Thus all features of the village that were seen to contribute to access to resources that would enable the community to sustain itself were circled. This was also why the printing works were circled. The

Morija Printing Works is seen as contributing to the health of the village because it provides jobs for so many villagers. The Post Office was also circled in this regard. This was interesting, as it had come up earlier in Molapo's work[16] when a health seeker told him that Morija was a healthy village because it had a post office. It seems that a large part of the importance that is attached to the post office with regard to health is linked with remittances. Most families have at least one member who is a migrant worker in South Africa, and the post office provides a contact point for the receiving of money which is sent from a loved one working on the mines in South Africa.

Education was also seen as integral to the healthy functioning of Morija and this relates to the future prospects for their children. A good education is likely to lead to a good job. All the schools and the theological seminary were circled. Education is thus seen as important for the health of the community.

The library and book depot were seen as integral to the health of the community. Not only did they bring money in, in the form of business and tourism, for the nurses they also housed the collective memory of Morija and more broadly of Lesotho. Memory and the link with the people that came before was thus seen as very important to health.

[16] The data from the research conducted by Sepetla Molapo in this regard was never written up.



Figure 18: Map of Morija as marked by the nurses

This emphasis on the socio-economic factors was also expressed by the nurse assistants who define a healthy community as one that knows how to prevent diseases and one which is able to meet its needs. This understanding can be linked with the preventative healthcare understanding of health. For the nurse assistants, if a community can meet its needs, knows about hygiene and sanitation and has access to basic services, it is a healthy community. Another aspect of this definition is access to livelihood strategies and the activity of the people in the community, especially children. This is illustrated by the following quotes.

> *A healthy community like this one in Morija. If you ask anybody here about clean water, they'll tell you. Like boiling water if you draw it from an unprotected well, or take children for immunizations. People here know a lot about health. (Mme Mokaloba, nurse assistant at Scott HC).*
>
> *It is a healthy community. They have to maintain their hygiene and get healthy food; they got to have toilets, so that they can*

maintain a healthy life. (Mme Makalaele, nurse assistant at Paray).

They have all the things they need. And if they have enough food to eat, clean water, good sanitation, good environmental health. (Mme Mokhutsoane, nurse at Scott).

This understanding of health was backed up the focus group data. I conducted the same exercise as with the nurses and asked the nurse assistants to indicate the important elements for health in the community. This showed that basic services such as access to education and healthcare were essential for the health of the community. They also circled the post office, egg circle and shops indicating that these were important for the community to sustain itself. They added electricity, water and food to the map as other essential elements for the health of Morija. However, there was also a recognition that because these services were not offered for free they sometimes subtracted from the health of the people who had to worry about finding the resources to pay for services.



Figure 19: Map of Morija as marked by the nurse assistants

The other notable point in the focus group discussion was the debate that I have termed the urban/ rural debate. For some of the nurse assistants the fact that Morija was a relatively developed village and was close to Maseru was important for its health. The urban element for them was important as it meant access to resources and jobs and amenities that would otherwise not be accessible. This was a dominant viewpoint. However, the other viewpoint that was put across very strongly by two of the participants was that urbanisation and 'development' was actually detrimental to the health of the village. This was so because it brought with it crime and distrust and competition among people. The discussion was centred on whether or not the police station was healthy for the community or not. Those that opposed urbanisation believed that the police station simply showed that there was crime in the village where once there hadn't been any crime. In their mind they had a utopian vision of what life might have been like in the past and wanted to return to that. Overall however, there was a like for the pleasures that urbanisation and development offered. Thus the road to Maseru was circled as important for the health of the community. These modern values were also reflected in the fact that nurse assistants did not turn the pictures on the graph around as the nurses had done. For them being young and slim represented health more so than being older and fatter.

It is clear that the socio-economic aspects of health are prevalent for both the nurses and nurse assistants. Interestingly, it was also only when talking about the community that there was any evidence that the technicians in any way considered the socio-economic aspects of health. But there was a clear comprehension of this element of health. In particular, what is important is the ability of the community to care for its members, physically and environmentally. The technicians, when speaking about this element of health show a very clear understanding of the role of preventative health care in contributing to the health of a community.

It is a community, which is aware of all things that would pose as health hazards. It is also a community, which say after infections or whatever problems it may have information of where to go to seek medical services. It is a community, which focuses, or concentrates on preventative measures rather that curative measures. Preventing whatever risk, danger, sickness, and disease before it can occur. If I have to make another example from HIV/AIDS, what we are trying to educate the communities here on is trying to focus/direct all efforts on preventing the disease. Lets abstain, let's use condoms. The curative, the seeking of medication, and counselling are secondary, but the primary should be preventative. So I think a healthy community is one that directs its efforts at preventing the diseases. (Ntate Namole, pharmacy technician at Scott)

If I go out of my village, to another village seeking food, that means my village is not healthy. But if I am hungry and I know I can get bread from this house that means we can provide for ourselves. (Ntate Matlonyane, pharmacy technician at Scott)

Let's not talk about Mokhotlong particularly, let's just … a village, if I consider it healthy, it must have facilities. Toilets, there will be no littering. People shouldn't depend on other people. For instance, we are making our own food, whatever that we need. (Ntate Namole, pharmacy technician at Scott)

It is clear therefore that at the level of the village, the respondents' thinking about health is dominated by the socio-economic elements of health. However, relationality also has a major role to play.

5.3.2. Relational aspect of health

The relational aspect of health comes up once again in the discussion on the healthy community. It is expressed in various ways ranging from the importance of support amongst members of communities to a sense of responsibility and cooperation being necessary for health. It also includes the role of politics in maintaining cooperation within a country and controlling conflict and makes reference to the importance of social activity and rest. Thus relationships are not confined to neighbourly relationships but include broader social relationships that

impact on the community. This once again raises the issue of interconnectivity when it comes to health – that is, what is happening at the level of the nation impacts on the health of the community in the same way that the health of the family impacts on the health of the community.

The first level at which the relationality aspect of health is expressed is at the level of mutual support and caring form one another. This is seen as integral to good functioning in the community and indicates the importance of being in right relations with ones neighbour.

The nurses' understanding of a healthy community is a very holistic one. They referred to the need for harmony between people in the community at both familial and community levels. This links back with the focus on good social relations that was discussed in the understanding of a healthy individual. Harmony and peace are seen as necessary elements of health.

The other aspect of the healthy community that is dominant for the nurse assistants is the social understanding of health. For the nurse assistants the ability for members of a community to depend on one another is important for the health of the community. For the nurses, this aspect was far more dominant in their understanding of health, and there was also an emphasis on justice and harmony in a general sense. For the nurse assistants, the social understanding of health is understood at a far more personal level. It is about knowing who you can depend on for advice and support. It also has a spiritual dimension to it. There is an understanding that much of this support is spiritual or religious in nature.

> *It's a community, which works together, share problems, support each other, advise each other. (Mme Mabakoena, nurse at Scott).*

This understanding of the healthy community was also reflected on by the technicians who agreed that a health community is one where there is mutual support, particularly when others are suffering.

> *A healthy community, like I said with the family, and also, the community that is healthy, I think is a community where people can join hands together, people who can support each other in the sense that the practice here in Lesotho like when someone has passed away, we join hands and we buy something for the family. "(Ntate Namole, pharmacy technician at Scott)*

Support and care is one association with health that is made by the healthcare providers. However, their understanding of the healthy community also takes into account the importance of principles of justice and good politics as well as right relations and respect within the community. It seems to invoke ideas about morality that are seen as essential for the health of a community. This was particularly the case with the nurses.

> *Communities are involved in different political parties, different church denominations, but when they are working as a community, they should not discriminate against each other and say this one is this and this one is that. They should work as one and even political institutions shouldn't discriminate each other, we should all be united and live together, see to it that there is progress on the activities. The community that forms the church starts within the family. The community should feel well, understand each other and also move towards going to church. I think it should have the same understanding of things and work towards achieving one thing, also to avoid conflicts (political). (Mme Pitso, nurse at Scott).*

Conflict and discrimination as well as lack of respect therefore contribute to a community being unhealthy. They are what Germond & Molapo (2006) term threats to bophelo. This was reinforced in the focus groups in which the chief was seen as important for the nurses as he maintained correct relations within the community and provided a referee in disputes.

Although this understanding of health was more dominant amongst the nurses, the nurse assistants and technicians also picked up on the importance of morality and right relations for the health of the community.

> *It is important for the community to love faithfully and to avoid things like to steal, to robber, to rape. (Mme Mokaloba, nurse assistant at Scott HC).*

For the technicians, thinking about health began to reflect a far more utopian element when we began to speak about the health of the community. Thus, their definitions of health moved from the physical or biomedical understanding to an understanding of health similar to that of the nurses. Health came to mean the community living in harmony and unity with one another, a place where peace prevails.

> *Ja, You have to belong somewhere because when you belong somewhere you take responsibilities. You know you are directed, every family has its own constitutions, its own principles, s every person has to go by certain rules, certain principles, like when I'm working here, I have to follow hospital principles. (Ntate Namole, pharmacy technician at Scott)*

> *Also, some roads. A community that has a vision for the community, also for the country, and a school also. A community that is able to take their children to school, also to church, that is what I would consider a community as really being healthy. Also it is very active, and can raise funds. (Ntate Mokati, lab technician at Mokhotlong).*

From this it becomes clear that the church plays a role in keeping the community healthy. Words like "love faithfully" as well as Mme Pitso's comments that the community should "move towards going to church" illustrate that the church is understood as reinforcing health in the community. It is likely that this is because the church is seen as teaching morality and providing a place where a sense of community is encouraged. Ntate Namole reinforces this perspective when he says,

Like I said before, there are these organizations in the community where every month money is contributed and then when someone has passed away in the community, we can help them. A community that is united. There is that saying, I don't know if it from the bible "where there is unity, God brings blessings." Spiritually healthy, every person believes in something. We are different denominations. Some are Christians, Some Muslims, others Bahai faith. All those kind of things. Then if almost every person believes or belongs somewhere, and almost every person knows there is God, even the Muslims or Bahai, they have prophets but God is still there. In this case I don't really want to take the side. But I believe that every person has to attend church, whatever church, but people have to belong somewhere, they must have God in their mind. Someone who doesn't even know or care that God exists, that person is not really spiritually healthy. No matter how successful a person can be, if you don't have family, you don't have relatives, not really healthy. (Ntate Namole, pharmacy technician at Scott)

The role of the church in bringing unity to a community is evident. Social rest and social activity is also seen as playing an important role in encouraging togetherness in the community and is thus seen as being very important for health. This is clear in comments from nurses as well as nurse assistants.

A healthy community is a community that is able to make its own plans to keep itself. For it to be also a healthy community, it should meet all the needs that it requires to satisfy each household involved in the community activities. So from the activities that are going on, the benefits should met all the household needs half way according to the economic needs of the people. The community should be able to meet their health needs and others like water, food and social rest also. The community is always involved in activities that they are supposed to participate in, like the political and church activities. (Mme Pitso, nurse at Scott).

I think if there would be work to employ many of the people and infrastructures. If the ground for sports and everything concerning the sports and people know about it and people here are using the horse or by foot for transport. If there could be transport and the roads because people must get up to walk

early in the morning and it's cold. And schools, education. (Mme Mokati, nurse assistant at Paray).

This is supported by the focus group data. In both the focus groups the sports fields were circled as being important contributing factors to the health of Morija. It is thus clear that social rest and activity contributes to the health of the community. This is perhaps related to the fact that physical activity is healthy for the individual, but it also contributes to togetherness within the community. Both of these aspects would be taken into consideration.

Overall therefore, a sense of harmony is seen as integral to the healthy community. Good politics and a sense of justice contribute to this, as does a sense of morality and responsibility. So too does social rest and activity as does the church in the sense that it teaches morality and community living. But the church also has a more active role to play in the health of the community.

5.3.3. The role of the church

As has already been stated, the church is perceived to play a passive role in the sense that it contributes to teachings around morality and encourages a sense of community. However, the nurses and nurse assistants are clear that the church also has an active role to play in health promotion. In the first instance this is expressed in an understanding of the role faith plays in their work. Thus, their work is attributed to a sense of call which in turn gives them the strength to continue their work and also contribute to the healing of patients. A nurse who I had an informal conversation with spoke of how she finds that the prayers at the beginning and end of every shift give the patients hope. She believed that prayer was an integral part of the holistic healthcare approach that Scott advocates. Another nurse I spoke to informally pointed out that the LEC church has a special service dedicated to nurses and that she finds this church service to be inspirational to her. Mme Mme Lerotholi, nurse at Scott also reflects on the way that faith contributes to her work.

> *I think that there is a link because if I am a Christian and working in a hospital, one has the feeling that they have to spiritually help people. You are able to treat the patients as people, holistically. (Mme Lerotholi, nurse at Scott interview).*

This has already been given more attention previously. But another aspect of this is that church hospitals are perceived by the nurses to be superior hospitals in that their practices are rooted in faith and they begin each shift with prayer. This was expressed by Mme Shale who stated,

> *This is a church institution and I think that so many things are done differently from the government. Here you have to start with a prayer before you continue with work. We have Morning Prayer service for the staff first then for the patients. That I think spiritually contributes something with healing. (Mme Shale, nurse at Scott).*

Our research in fact found that this was not particular to the church hospitals but was in fact practiced at the government hospitals too. Nevertheless, faith is seen to be integral in contributing to the strength of the healthcare providers and the healing of their patients. This must be recognised and could be seen as an intangible religious health asset. This was also a point that the technicians picked up on.

The technicians were perhaps the most explicit about the role of religion in health. For the nurse assistants, their reflections had been largely based on their own experiences. The nurses however had a far more abstract notion of the role of religion in health. The technicians recognize the role of religion broadly as creating harmony and unity, but also speak very strongly of the practice of religion in their daily lives and its importance. Thus religion is not simply about a call, in fact this did not come up at all. Rather, it has broader personal health effect. They also recognise the role that the church plays in practical interventions for health.

In relation to health, churches do spiritual counselling, also prayers for the patients and some churches also give donations to the patients, some of them buy blankets. Because if a person is admitted and they don't have a blanket ad they are cold, then at the end of the day, the treatment has failed. Sometimes they even buy food for the patients because there is that relationship between drugs and food. So at the end of the day they are really supportive, especially for this issue of HIV/AIDS. Some of the people even go to the wards and bath the patients. (Ntate Matlonyane, pharmacy technician at Scott)

This is where they relate to you, what God and Christianity expects out of you. What is it that it can offer you relief to live positively, what is it that it can offer you to live happily even when positive but still being productive. They quote text from the Bible and use that as guideline/yardsticks. They explain what it is saying to you and. As far as I am concerned, people from spiritual counselling often come out with a very positive outlook to life. And most of them live openly with the disease, they don't hide, they no longer fear about their stigma. They even talk about, they counsel and give each other advice. (Ntate Mokati, lab technician at Mokhotlong)

The point I am driving at is if you happen to be rich spiritually, that is like healing yourself for whatever kind of sickness, spiritual counselling brings healing as well as praying and communicating with God. God is for ever there to provide for whatever needs we have got. He is the provider regardless of whatever sickness you have. (Ntate Namole, pharmacy technician at Scott)

But the church is also seen to play a more tangible or active role in healthcare promotion within the community. This ranges from teachings on health that are given at services to the authority that the church carries.

The church is a place of education where the congregation can be taught about such disease as TB as well as good healthcare practices. Often the nurses will be allowed to use the congregation as an audience for their messages of health education, or simply to advertise education events.

When they preach, when they get to address the communities, they actually mention that (health). During health day activities, like anti-smoking days and immunization days, health workers request the church to teach about this day. In this particular institution, a day in November is actually set aside for health celebration. So on that day, everything that is related to health is taught in the church. Even the contributions that are collected are collected that day are given to health. (Mme Ramatla, nurse at Scott).

If we have something here in the hospital that we need the community to know about, we can go through the church and it is then that most of the people would know that there is something taking place here in the hospital. The church also plays a great part in the health system. (Mme Matsutsu, nurse at Scott).

Sometimes the minister is going there on Sundays and talking about TB or HIV and AIDS. Sometimes they organise workshops to talk about health issues. (Mme Nthomeng, nurse assistant at Scott HC).

The church also tends to give the nurses some authority. When a gathering that focuses on health education is being organised the nurses have to get permission from the chief. They find that the fact that they are from an LEC run hospital or a member of the LEC gives them some authority or influence with the chiefs.

Yes, I organise events where we teach the children about health, about avoiding drugs and alcohol. When we have these events we must ask the chief for permission. If I say I am from LEC then they listen to me. (Mme Pitso, nurse at Scott).

It is clear then that the church has both a tangible and intangible role to play in the health of community. This is an area that could be further researched. An aspect of health in the community that was less explicitly mentioned but nevertheless seen as important was the role of tradition.

5.3.4. The importance of Sesotho traditional forms

Given the fraught history that Sesotho traditions have had with Christianity in Lesotho, it was expected that the role of tradition and traditional healers would not be perceived as playing an important role in health for the healthcare providers. At face value this certainly seemed to be the case. Often, nurse assistants and technicians were quite dismissive of the role of traditional healers in health as was expressed by Ntate Matlanyane who states,

> *No, I believe in holistic medicine and there has never been a time when I felt western medicine was failing. I have never believed at any point that I would find traditional doctors services outwardly provided at hospitals. Besides I think it would rather be insane to see a doctor or a health professional / expert going for services to a traditional doctor, to me it does not make sense.*

However, upon further analysis it became clear that tradition was viewed as being integral to the healthy functioning of the community.

In the discussions around the role of tradition in health the traditional healer was viewed with some condescension. That is, they were seen as important where people could not access Western medicine and that they were in need of training from Western professionals. Thus, Western medicine was favoured and seen as the first choice, with traditional medicine playing a role in filling the gaps.

> *Well traditional healers play a pivotal role in the health of our African society, especially for communities where modern health services are not easily accessible especially in the rural and mountainous areas. They play a very important role. However I believe that modern medicine and traditional medicine should collaborate somehow. I think they should work in harmony because they (traditional healers) are practising things which they do not observe but which we feel they have to observe. Like sterilisation processes, because we are quite aware of high mortality rate of people in their initiation schools due to infection.*

Traditional healers are not sterilising their equipment and apparatus. Basically there are some procedures that they are not observing currently which we believe they have to observe and appreciate. That is why I believe we should match services. Otherwise I strongly advocate for the role they play, especially where the government is unable to provide services. They kind of compliment those services the government is supposed to provide in those areas. (Ntate Matlonyane, pharmacy technician at Scott)

We are actually collaborating with them and of late, we are even conducting trainings with them. Initially, we used to have regular meetings with them and we are conducting trainings related to health issues. Because sometimes when somebody gets sick, they usually think they are bewitched, so the first person they contact will be the traditional healer. When a traditional healer has patients with acute classic pulses, where the patient gets attacked and couldn't live, we present him with that patient. If a child has got polio and suddenly cannot walk, anybody in our community as a Mosotho will think the child has been bewitched. They would not think of going to the hospital, but will seek help from the traditional healers. Since this country has been one of those marked as having cases of polio, there are some procedures that are to be used or have to be administered for such cases and diseases. So if we fail to treat such a child within a period of 14 days, we will have failed, and polio is a virus and one of those diseases that can cause paralysis. So we have to be informed of such cases before the patient goes to the traditional healer. Therefore during our trainings we make them aware of such things which they can't handle, and ask them to involve us. We do not stop people from using traditional healers but we want us to network, so that they can refer patients/people to us, even if the patient wants to follow the medicine of the traditional healer. Like in a case of somebody who was supposed to be admitted with positive TB sputum, she said her traditional healer had told her to go and slaughter a goat and then return to him before she can be admitted. We advised her to get her treatment first, then go and slaughter the goat. That is how we work with them. We train the people and make them aware of things and actions that are hazardous to them, like using sharp objects like razorblades, needles, knifes to avoid getting infected, when used by people who are infected with HIV. That is what we highlight in our meetings. We therefore work in collaboration with the traditional healers. We as Africans, when somebody gets sick, we do not think first of

western medicine, we think of what our doctors can do first. (Mme Ramatla, nurse at Scott)

It is clear from these discussions that traditional healers are seen as important for health in the community and that traditional explanations of health are deeply ingrained within the community. This is reflected when Mme Ramatla states, “If a child has got polio and suddenly cannot walk, anybody in our community as a Mosotho will think the child has been bewitched.” Thus, even for nurses who are biomedically trained, traditional views of health are deep seated. This is the case despite the clear sense of apprehension that is expressed, particularly regarding the need for training of traditional healers.

This data was backed up by the focus group with the nurses in which the nurses pointed out on the traditional aspects of the community. In deciding what was important for the health of a community the nurses circled the traditional healer, the cemetery as well as the chief’s homestead. When asked about these elements they agreed that many people in the community depend on the traditional healer and are healed by the traditional healer. She was thus seen as a necessary part of the community. The graves were circled and mention was made of needing to honour the ancestors. The place of the ancestors in the community was highly valued. This was surprising as in the interviews the nurses seemed to dismiss traditional practices as important for health. Finally, the chief’s house was seen as important due to his guidance and his role in ensuring justice and harmony in the community. Thus rather than circle point to or mention parliament in Maseru as important for justice, this responsibility was seen as the chief’s.

The role of tradition was expressed far more by the nurses than either the nurse assistants or the technicians. In the case of the nurse assistants this may be due to the fact that they felt the need to be seen to be saying the right thing, particularly as many of them were interviewed in the boardroom.

However, this indifference with regard to the traditional healers was also reflected in the focus group discussion, which suggests that it is a deep seated attitude rather than stemming form a need to say the right thing. The nurse assistants did not recognise the traditional elements as important on the map exercise. They did not circle the traditional healer, or the chief's house. For them the traditional healer was detrimental to health in the community as s/he prescribed the wrong things and told people that she could cure AIDS. The nurse assistants thus harbour the same disregard for traditional healers that is evident from the biomedical perspective. They did circle the cemetery as important for health; however, this did not have anything to do with the ancestors as it did for the nurses. Rather, the cemetery represented the correct or hygienic methods of dealing with a dead body.

Nevertheless, as will be shown later, it is clear that tradition is deep seated for the Basotho healthcare providers, even where there is disdain for traditional healers and this needs to be taken into account.

5.3.5. The physical aspects of health

One other element that did come up in the discussions, particularly with the technicians and nurse assistants was the physical aspects of a healthy community. That is, there was still recognition of the importance of the physical aspects of health in the understanding of the healthy community. Rather than this being expressed in biomedical terms however, it was expressed more in preventative healthcare terms and the discussions revolved around the need for communities to be aware of diseases and protect themselves against those diseases through vaccinations and positive health behaviour.

> *And also in relation to health, that is aware of certain diseases. Let me make an example. This is why we are always encouraging people to inject for flu vaccine. The community must be aware of typhoid, those kind of diseases that can*

happen in the community. I think that's a very good community. (Ntate Namole, pharmacy technician at Scott)

Although this was a minor point, it is interesting that it was still mentioned at a point in the interview when I was encouraging the respondents to think more broadly about health. This indicates that this understanding of health is relatively deep seated.

5.4. Conclusion

What this chapter has done is to present the understandings of health that the healthcare providers hold. The key research question for this dissertation was "How do Basotho healthcare providers understand health?" This chapter has provided that answer. It is clear that there are diverse understandings of health ranging from relational aspects of health to socio-economic aspects of health. The themes that have arisen out of the findings are important to point out as they will be used in the following chapter as I analyse how these understandings relate to the dominant discourses as expressed in the literature. It is clear that there are many different influences on how health is understood in Lesotho and many associations that are made. What is required therefore is to work towards a comprehensive analysis of how all of these ideas about health sit together. An analysis of the dominant discourses and how they influence the healthworld will provide the framework in which to understand this and this is what the following chapter aims to do.

6. DOMINANT DISCOURSES OF HEALTH AS EXPRESSED IN LESOTHO

The previous chapter presented how healthcare providers understand health. In so doing, various themes around relationality, holism and physical aspects of health amongst others became apparent. This chapter analyses these themes in relation to the dominant discourses as expressed in the literature. As such, this is an analytical section of the dissertation that attempts to understand the perceptions of healthcare providers and how particular dominant discourses of health play themselves out in a particular setting and in turn impact on these perceptions.

The chapter presents the key literature pertaining to each of the dominant discourses (biomedical, public health, Christian and traditional) and goes on to analyse how these discourse find expression (i.e. are shown to influence) in the understandings of health presented in the previous chapter. It illustrates how health discourses have come to play the role they do in healthcare in Lesotho broadly, as well as more particularly in the understandings of health of the healthcare providers. In essence, this chapter is a discourse analysis of health in Lesotho. I begin the chapter by introducing the key elements of each discourse as they are discussed in the literature. I then go on to conduct a discourse analysis of each of the four dominant discourses apparent in Lesotho, illustrating what influence they have on the healthcare providers. I conclude by making the case for a broader study of lay perceptions of health that includes understanding discourses, particularly cultural and religious discourses that are often overlooked or silenced.

6.1. Dominant Discourses of Health

6.1.1. The Biomedical Discourse

With the rise of modernity and its focus on science and rationality, came the rise of a biomedical understanding of health – that is one rooted in scientific discovery and rational explanation as opposed to the medical practices that had included balancing the humors of the body and frontal lobotomies to treat headaches. While modern medicine has provided breakthroughs in the treatment and eradication of major diseases and has all in all provided for a healthier society with extended longevity, the scientific backlash against all premodern ideas has meant that the values underlying the strange and often very damaging practices have also been wiped out. In Africa in particular, this has meant that biomedicine, through the colonial project, has aimed at silencing traditional practices of healing.

6.1.1.1. Outlining the biomedical discourse of health

The biomedical model has for a long time been dominant in defining, explaining and reinforcing health. According to Curtis & Taket (1995: 53), "the world view that has shaped modern Western science and technology, including Western medical science, commonly referred to as the mechanistic or Cartesian paradigm, emerged in the sixteenth century." Thus for the past 500 years, our thinking about health has come to be increasingly dominated by the biomedical discourse. Although the biomedical discourse is dynamic and diverse, there are some assumptions and commonalities that allow us to look at biomedicine as a specific discourse or model of health.

The key to understanding the biomedical model is to realise that it has its roots in the Cartesian paradigm which detaches parts of a whole to study each separately. As Curtis & Taket put it, the biomedical model takes a "'reductionist approach' to the body. This is reflected in the treatment of the body purely as a physical entity – a 'machine' that can be taken apart, studied and repaired.

Disease is thus seen as “temporary or permanent impairment in the functioning of any single component, or of the relationships between the components making up the individual” (Polgar, 1968 in Curtis & Taket, 1995: 26). Health is thus seen as the absence of this impairment that is the absence of disease.

Curtis & Taket (1995) suggest that there are four assumptions that inform the biomedical model. The first is that disease is understood as a deviation from “normal biological functioning” (1995:27). This in turn suggests that there is a level of normal functioning. However, deciding what that definition of normal is is a matter of power relations and can certainly be questioned. Foucault questions what is defined as normal in his work on the rise of the mental institution. Despite the second assumption of the biomedical model - that of the objectivity of science and medicine - decisions around normality are in essence subjective and are the product of power relations. Biomedicine has used this assumption quite effectively to silence other discourses. For instance, traditional healers that may commune with the ancestors, would from a biomedical perspective be defined as mad. In this way the biomedical discourse works to de-legitimate the traditional discourse of health.

The third assumption of the biomedical discourse is the ‘doctrine of specific aetiology” (1995: 27). That is, the idea that any disease is caused by one or a specific pathogen – germ or virus and that once that pathogen is located it can be treated. Thus the idea that there are other contributing factors to diseases falls outside of the discourse of biomedicine. Finally, biomedicine rests on the assumption of the generic disease. That is that any disease, caused by the same pathogen, will have similar outward appearances i.e. symptoms and processes and as such can be treated in the same way.

I would add that stemming out of these four assumptions are a number of other characteristics of biomedicine. Stemming from the understanding that disease is a physical entity caused by a specific pathogen, is the practice of treating the

individual patient. When one sees the doctor, one goes alone. Consultations are one on one and do not generally involve the family. Even when family members come along for support the primary focus of the consultation is the individual patient. This is as opposed to more traditional discourses that see disease as a social entity requiring treatment of the whole family involved. Finally, as has been touched on previously there is an element of power relations involved in biomedicine. Biomedical knowledge is seen as specialist knowledge and is thus the domain of those having been professionally trained (Gilbert *et al.* 2003). In many respects, other knowledges are sidelined in favour of the scientific approach. Thus, the patient is seen as the passive recipient and the doctor as the all powerful agent of healing.

This is another way that the biomedical model works to de-legitmate or silence other discourses of healing. By claiming that only professionally (read Western) trained doctors are qualified to deal with health issues, those that have had years of cultural training and apprenticeships or those with a gift of healing are no longer seen as professionals. Rather they are relegated to the realm of superstition (as in the colonial era) or more recently to the realm of alternative or complimentary or alternative healing. Healers with gifts and training that fall outside of the Western training model are thus sidelined and no longer deemed legitimate. In addition the biomedical model rests on a particular body of knowledge - that of science – and this knowledge is once again claimed to be legitimate. The scientific body of knowledge is also only accessible to a few people, in particular those who excelled in Western schooling and can go on to be trained in Western medical universities. Due to the fact that science and rationality is celebrated in modern society, biomedicine, which is rooted in science, gains dominance over other discourses rooted in other bodies of knowledge such as spirituality or theology. These bodies of knowledge are relegated to the realm of superstition and since claims cannot be proven they are seen as illegitimate from a biomedical perspective. The biomedical discourse has come to be dominant in almost all parts of the world, primarily because it has

emerged alongside modernity and has been the face of the modernizing project in the health sector. Thus through colonialism, international decision making and local policy making, the biomedical model has been reinforced as the dominant model of healthcare. This is no less the case in Lesotho.

6.1.1.2. The expression of the biomedical model in Lesotho

The biomedical model has certainly influenced health in a profound way in Lesotho. As has been previously discussed, missionaries and mission doctors brought the biomedical model to Lesotho in the early 19th century. This had a major impact on traditional healing methods and began to challenge what had been the dominant health discourse in Lesotho. Although no official figures exist in Lesotho to determine the percentage of healthcare that is offered by the biomedical framework, Helman contends that Western scientific medicine provides only a small proportion of health care in most countries of the world. "Medical manpower is often a scarce resource, with most health care taking place in the popular or folk sectors" (2001: 58).

Despite this fact, biomedicine still influences thinking around health in a profound way at both a national and individual level. This is clearly illustrated in some of the perceptions that healthcare providers at Scott Hospital as well as at Paray Hospital and Mokhotlong Hospital hold.

It is clear that Scott Hospital is a biomedical setting. All nurses, technicians and doctors are biomedically trained and the equipment used is for identification of symptoms and treatment of specific illnesses. This includes the use of chemical drugs for treatment. It is thus not surprising that the biomedical discourse is quite dominant within the Scott setting. However, this is true predominantly for the nurse assistants and technicians.

Interestingly, although the nurses do point out that health is physical as well as mental, social and spiritual; apart from this reference to the physical the nurses mention nothing that could be said to draw on the biomedical discourse of health. And yet they are the most likely to have had extended training that draws on the biomedical model. It is not clear why there is almost no mention of the biomedical model at all. I suggest later that the realities of working in healthcare in Lesotho mean that the public health discourse comes to have far more dominance for the nurses.

Nevertheless, the biomedical discourse still has a lot of sway at Scott Hospital, particularly with the nurse assistants who were so influenced by it that it was often difficult to get them to think about health in any other way other than through the biomedical lense. They expressed their understanding of the healthy person as someone who was not sick. A sick person could be identified by looking for certain symptoms. Mme Makolaba and Mme Mokati expressed this most clearly.

A patient will always be complaining of this and that, that's when we'll be checking the temperatures and pulse, and the doctors are always there to help with medical prescriptions for them to take at home. (Mme Mokaloba, nurse assistant at Scott HC).

Sometimes you can't cos some patients you can tell if they are sick. But other patients doesn't look like they are sick. But after that, you can do tests like BP. If it's high, then he's sick, if it's low, then he's sick. But sometimes you cannot know they have high blood, unless you check it. (Mme Mokati, nurse assistant at Paray).

The biomedical view is also particularly influential for the technicians. Although they do recognise other aspects of health, their intensive biomedical training was

evident in many of the answers they gave with regards to defining a healthy person. Ntate Matlonyane expresses this when he states,

By doing a physical examinations and one also identify people by seeing or those who represent certain symptoms that you kind of associate with particular diseases or conditions. You also go further to diagnose using machinery like X-ray for different problems. Sometimes, through using some drugs, like I know there is this drug they call (bacterium?). What it does is it diagnoses ulcers in the eye. You just put some drops in the eye and look for a certain colour and if it appears you know you have ulcers and if it does not appear you have (ulcers?) in the eye. Those are the different methods to diagnose illness. (Ntate Matlonyane, pharmacy technician at Scott)

So it is clear that the biomedical discourse of health plays a strong role in the understandings of health that the nurse assistants and technicians hold. But the question remains as to how it is expressed in comparison with the actual biomedical discourse as outlined in the literature review. As has been stated, the biomedical model rests on four assumptions as outlined by Curtis & Taket (1995). This first is that of the mind, soul, body split. That is that biomedicine is concerned with dealing with the body and does not take into account the mind, soul or the exterior influences. The second is that of specific aetiology, the third is the role that power plays in biomedicine – that the professional has power through knowledge and finally the assumption of generic diseases. How the biomedical approach is articulated by the nurse assistants and technicians reveals that the discourse has influenced them quite strongly but that there are some clear cut differences in the expression of it as well.

Where the discourse has impacted on them is through the doctrine of specific aetiology and related to that on the assumption of generic disease. This is expressed by the respondents in their ideas that an unhealthy individual needs to be identified by looking at particular symptoms identified through tests such as

temperature, blood pressure and pulse. Illness afflicts the body and needs to be assessed in this manner. For the technicians in particular, once the symptoms have been identified the illness can be named and the correct medication prescribed for its healing. It is clear that if the symptoms are similar the disease is the same as is the treatment. The biomedical model has a very clear impact on the understandings of health that the nurse assistants and technicians and this is carried through into their understanding of the healthy family as ill health would be identified in the same way within the family. This was expressed by Mme Mokati.

> *Q: And like with your child, and your husband, in your family, what are the things you look at to say we are a healthy family?*
> *A: Everything. You can't just know how the body is working by just looking. You must do tests. He may be sick but not so sick.*
> *Q: When you are at home, do you take these examinations to say we are a healthy family, or how do you know you have a healthy family?*
> *A: I don't do the tests, I just listen to my family and then I can know if I must bring them here to the doctor, because we don't have the things at home for tests. (Mme Mokat, nurse assistant at Paray).*

Health is therefore seen as a physical entity – affecting bodies. This view is quite dominant for the technicians and nurse assistants.

Where their understanding does differ from the dominant discourse is in the assumption of the mind/body split. Although their focus when describing health and ill health was on the physical elements, there is also a clear recognition that health is not just physical but that it has spiritual, social and mental elements. This understanding of health could be attributed to any one of the other three major discourses and this will be discussed later.

The final way in which the nurse assistants' view is different is that of power. Whereas the dominant discourse of biomedicine rests on the assumption of the power of the professional, this does not come across at all amongst the nurse assistants. In fact, the nurse assistants come across as doubting their own

knowledge and the power that is associated with that knowledge. There are three explanations for this, all of which I think contribute to this attitude. The first is the fact that they felt intimidated by the interview process and the race dynamics contributed to this as did the place of many of the interviews. This would have affected how they came across in the interview. The second element is that the majority of the nurse assistants were newly qualified and as such did have some doubts about their knowledge. The final explanation is backed up by another observation. The nurse assistants typically expressed their desire to help, to sit with patients, to counsel patients, and this was certainly the case when the nurse assistants were observed in their tasks. They seemed to practice an enormous amount of empathy that is often absent from surgeons and doctors in a Western clinical setting. This suggests that in fact they are quite influenced by the Christian or traditional discourse of health which would encourage this sense of empathy in healing. It is thus clear that although the biomedical discourse does influence the nurse assistants and technicians quite considerably, there are some noticeable points at which other discourses seem to be playing a more significant role in their understandings of health.

It is clear that the biomedical discourse of health is one discourse that is strongly supported nationally in Lesotho. Extending healthcare to all for instance involves ensuring that all people have access to hospitals or Health Centres (MOHSW, 2005). This demonstrates that the Ministry values access to a biomedical setting over access to traditional healers. In addition, nurses and nurse assistants are trained in many biomedical subjects including physiology, biology and anatomy (Makara interview, Ted Germond interview). The training programmes along with the hospital settings thus perpetuate the biomedical model. This dominance plays out at Scott where it is clear that, at least overtly, there is a disregard for traditional forms of healing – seen as superstitious. One pharmacy technician stated the case quite clearly when he said,

No, I believe in holistic medicine and there has never been a time when I felt western medicine was failing. I have never believed at any point that I would find traditional doctors services outwardly provided at hospitals. Besides I think it would rather be insane to see a doctor or a health professional / expert going for services to a traditional doctor, to me it does not make sense. (Ntate Matlanyane, pharmacy technician at Scott)

It is not only the technicians that feel this way. The nurses also see traditional healers as being problematic. Although there is recognition for the role that they play in the community, they are seen by the nurses as in need of proper (i.e. Western/ biomedical) training. This illustrates the way that biomedicine aims at relegating other forms of healing (the traditional discourse in particular) to that of complimentary or alternative. Although the nurses speak of collaboration, their ideas around collaborating with traditional healers generally refer to the fact that traditional healers need to refer cases to a hospital and that traditional healers need to be trained. For the healthcare providers, it is alright for people to see traditional healers and perform the tasks that s/he sets out for healing (as this may be the expected course of action in a community), however, the patient should also be following a biomedical doctor's orders in order to really treat the problem. Mme Matsutsu's statement about traditional healers below illustrates very clearly how traditional healing is silenced and suppressed in favour of the dominant discourse.[17]

> *However I believe that modern medicine and traditional medicine should collaborate somehow. I think they should work in harmony because they (traditional healers) are practising things which they do not observe but which we feel they have to observe. Like sterilisation processes, because we are quite aware of high mortality rate of people in their initiation schools due to infection. Traditional healers are not sterilising their equipment and apparatus. Basically there are some procedures*

[17] This is not to say that there are real concerns with regards to practices by some traditional healers and their effects on HIV"AIDS. However, the way these are articulated and exaggerated illustrate the way in which the dominant discourse works to silence or de-legitimate other discourses.

> *that they are not observing currently which we believe they have to observe and appreciate. That is why I believe we should match services. Otherwise I strongly advocate for the role they play, especially where the government is unable to provide services. They kind of compliment those services the government is supposed to provide in those areas. (Mme Matsutsu, nurse at Scott).*

It is clear therefore that at least at the level of thinking about traditional healers, traditional forms of healing are frowned upon. Interestingly, this comes at a time when globally there is a trend towards critiquing biomedicine and encouraging the use of alternative forms of healing.

6.1.1.3. The Deconstruction of the Dominance of Biomedicine

Globally, biomedical discourses of health are currently being challenged and increasingly, biomedicine has had to shift in order to incorporate the demands of the 21st century – demands that include a more holistic approach to medicine. Social thinking about health has done much to contribute to this shift.

Social thinking about health began, according to Armstrong (2000: 24) with an "almost total acceptance of the biomedical model." The functioning of this new field was to support the model with such subject matter as how to best influence patient behaviour. In its second phase, social thinking about health begins to establish itself as a field outside of the model, yet still fails to significantly challenge the model. It is only in its third and fourth phase where social thinking begins to actively challenge the biomedical model, engaging with issues such as the power of doctors and the view of the patient as passive as well as more broadly with the emergence of biomedicine and locating it as culturally and historically specific. This paved the way for more diverse thinking about health and illness.

It is in this place in the history of social thinking about health and illness that the subject of social epidemiology or social determination of health and disease arises and the field of public health begins to gain popularity.

Increasingly the biomedical discourse of health has come to be replaced in dominance by the Public Health discourse of health. Since the WHO's Alma Ata Declaration in 1979, public health has come to very influential, most particularly in developing nations where limited resources require early intervention and prevention.

6.1.2. The Public Health discourse

The psychosocial environmental model has been increasingly attaining dominance over the past 30 years as sociologists and other behavioural scientists have challenged the ways in which biomedicine has developed and pointed out that disease has multiple causes (Gilbert, Selikow & Walker, 1996). While biomedicine sees the causes of disease as being the pathogen, the psycho-social environmental model points out that the causes of disease and the causes of health are multiple and range from the pathogen, to the environment in which an individual lives, their social standing and their psychological condition amongst other factors. Thus social epidemiology has a broad base that must be recognised. Further, all of these factors interact in different ways to result in either health or illness.

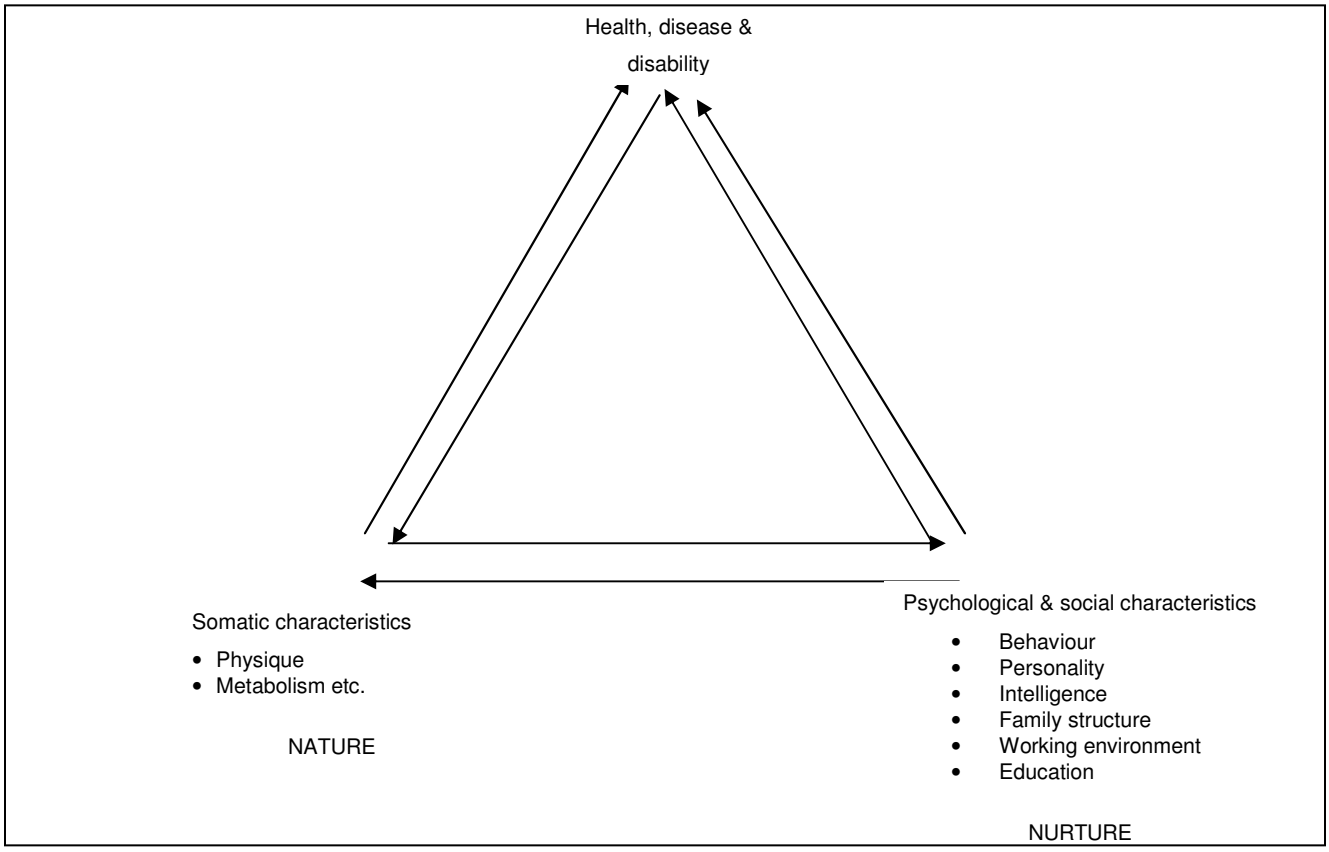

Figure 20: The psycho social environmental model of health[18]

The field of public health has emerged and expanded with the recognition of this model. Public health experts have successfully managed to redefine health in many ways by challenging the biomedical definition of health as absence of disease. Rather, the generally accepted definition of health is the World Health Organisation definition which reads, "health is a state of complete physical, mental and social well being and not merely an absence of disease or infirmity" (WHO, 1988 in Curtis & Taket, 1995: 30). This definition takes us from a narrow to a much broader view of health and in turn, it forces us to consider the various

[18] Source: Gilbert, Selikow & Walker (1996) adapted from Kark, S.L., Epidemiology & Community Medicine, Appleton-Century-Crofts, New York, 1974, p. 22.

factors that impact upon health or well-being. One of the reasons that public health has come to gain popularity is because of its link with development. Health has always gone hand in hand with development in the sense that part of the modernizing and colonising project was to introduce biomedical hospitals and employ biomedical doctors in areas that had depended upon traditional forms of healing. However, the shift from the modernisation project of development to the assets based approach to development (which takes elements other than economic growth seriously) has meant that access to quality healthcare is now a measure of development and is taken more seriously by development practitioners. Where money and technical training is limited, public health becomes the most viable option. Preventative and primary healthcare and health education come to take precedence over inpatient medical treatment of disease. Nurses and village healthcare workers are in far greater supply than doctors and as such health systems must depend on them. In addition, the work of these healthcare workers is not simply about health from a biomedical sense but incorporates elements of broader development objectives including sanitation, access to clean water and a safe environment as well as livelihoods. Health therefore comes to play an increasingly significant role in development.

6.1.2.1. Social determinants of health

The field of social epidemiology or social determinants of health broadly deals with the social factors that impact on health ranging from class to race and gender.

Bartley is one of the key researchers in the field of Social Determinants of Health. In his book “Health Inequality: An Introduction to Theories, Concepts and Methods” (2004) he argues that interest in the field began with the recognition that certain race groups were more susceptible to certain diseases than other race groups. According to Wilkinson (1996) this research continues. Many researchers (Himsworth, 1984; Kelleher et al. 1990) have tried to establish that

there are certain genetic differences between classes and races that determine health. However, Bartley then sets out to establish categories such as race, ethnicity and gender as simply mediating factors of disease. The real causes are thus not the race or gender of the individual but the social and political effects on the lives of the individuals, which is ultimately determined by their race, ethnicity or gender. So, rather than trying to establish biological causes to explain the differences, researchers should be looking at such elements as socio-economic status, the conditions under which the individual lives, education, social roles, and access to health resources as simply some of the explanatory factors for disease.

In Marmot's work with Wilkinson on Social Determinants of Health (1999), they state that the field of social determinants has reached a stage at which there is enough evidence to prove five statements:

- That "differences in health between population groups are due to characteristics of society, not to differences in health care" (Dixon, 2000: 1) and the differences in health care are conversely due to characteristics of that society. This understanding of health encourages us to think beyond individual health behavior to the broader social forces that affect people's lives and by implication their health. He is encouraging us to think about the political economy of health.

- That people's health is correlative with the environment in which they live (Dixon, 2000).

- That health is linked with socio-economic status across the spectrum and is thus more complex than simply stating that poor people have poor health.

- That something can be done about what he terms the "health gradient." The health gradient theory states that it is not simply a case of poverty causing ill

health. Rather at every level of the socio-economic gradient, health disparities also exist. Thus even at the top end of the scale, the differences in health of a middle manager and a top executive are distinctive. That is "increments of additional social advantage, even at the highest levels,…, appear to confer additional health advantage" (Mechanic, 2000: 271).

- That social position determines health rather than the other way around.

Marmot is clearly concerned with the complexity of the field of social determinants and wants to move away from the simple dissertation that poverty causes ill health. In his article "Social determinants of health inequalities," (2005), he makes the case for a more nuanced analysis of the causes of inequality that lead to poor health.

> *"It is not difficult to understand how poverty in the form of material deprivation – dirty water, poor nutrition – allied to lack of quality medical care can account for the tragically foreshortened lives of people in Sierra Leone. Such understanding is insufficient in two important ways. First, if fails to properly take into account that relief of such material deprivation is not simply a technical matter of providing clean water of better medical care. Who gets these resources is socially determines. Second, and related, international policies have not been pursued as if they had people's basic needs in mind" (2005: 1101).*

For him a better understanding of social determinants would allow public health professionals to have a more clearly defined path of action.

The field of social determinants research has yielded five different theories about how social determinants impact on health. The first is the material explanation, which states that an individual's income determines their diet, the quality of their housing and their working conditions. These all impact on the health of the person. The second is the cultural/behavioural, which states that the differences in beliefs or norms of an individual determine their health behaviour. Thus, in some cultures drinking and smoking would be discouraged leading to less risk of

heart and lung disease. In South Africa, cultural explanations of promiscuity that put people at risk of AIDS would fall into this category. Thirdly, the psychosocial approach states that "status, control, social support at work or at home, balance between effort and reward influence health through their impact on body functions" (Bartley, 2004: 16). The life course approach states that individuals' health is determined at a young age and that events at birth and in childhood affect health throughout the individual's life. Thus, a person's access to adequate food in the early stages of their life will influence their immune system and general strength for the rest of their lives. Finally, the political economy explanation is perhaps the most radical. In this explanation, "political processes and distribution of power affect provision of services, quality of physical environment and social relationships" (Bartley, 2004: 16). Theorists working in this field may simply point out the disparities or may be more uncompromising by suggesting that this is an active decision by those in power and thus blame can be laid at their door. Farmer (2003) tends towards this position. In order to understand this field more clearly it is necessary to comment on some of the literature, using Bartley's categories.

a. Material

Wilkinson, along with Bartley and Marmot, has also been involved in the key social determinants text Social Determinants of Health – The Solid Facts (2003). This text is written on the assumption that there no longer needs to be disagreement about whether or not socio-economic status has an effect on health. For these authors, "material disadvantage combines with the effects of insecurity, anxiety and lack of social integration to affect the health of those at progressively lower levels of socio-economic status" (in Dixon, 2000: 87). The book is based on internationally comparative data from the World Development Report and the WHO Global Burden of Disease Study.

The case for material disadvantage seems to be clear cut. Where an individual does not have adequate housing, heating, food and water they are far more likely to become infected with disease and be quote in an illness cycle. There is at least some merit in President Thabo Mbeki's statement that poverty causes AIDS. It is certainly true that the poverty stricken or the worst hit in terms of their lack of resources to control the disease and as such the speed with which the HI Virus causes AIDS.

The case of AIDS illustrates the fact that it is not simply about lack of material resources. It points to the case for structural poverty and the fact that the poor are so susceptible to contributing factors such as social conditions and health system failures. For instance, a young girl wanting to get a good education may be required to sleep with the 'sugar daddy' that agrees to pay for her schooling. Her material deprivation and therefore her susceptibility to the social power relations at play have a direct impact on the likeliness of her contracting the virus. The same can be applied to whole communities. Patrick Bond (2000) outlines how lack of access to sanitation and the impacts of state decisions around privatization impact directly on the outbreak of a cholera epidemic that affects large poverty stricken communities.

Issues of material deprivation and structural poverty often impact more on women than on men and the field of gender inequality and its link to health is well established.

One of the key researchers in the field dealing with gender is Krieger (2003). She points out that both sex and gender may have an affect on health, depending what the health problem is. For instance, women are more likely to be infected with HIV upon first exposure due to sex related factors i.e. a larger surface area for exposure. However, women are also more likely to be exposed to the virus due to gender i.e. with less power in a relationship; they are more likely to be forced into having sex (my own examples). Thus, for Krieger, any studies around

gender and epidemiology should take an empirical and case-by-case, rather than philosophical approach.

Moss (2002) has also looked at the field of gender and health. For her, research into this field needs to take note of the relationship between socio-economic determinants of health and gender equity. Researchers too often look at the micro-level issues that women face i.e. how the family, household and community affect her health, but don't often look at the geopolitical context that women find themselves in. Moss (2002) suggests that it is essential to understand that the multivariate levels of social life all impact on a women's health and thus on her family's health. Research in this field therefore needs to look at the political forces that maintain her domination, the cultural and demographic landscape, that is the factors that influence behaviour, as well as at the individual level where women face particular issues in the household. It is interesting that Moss (2002) points out the role of culture in influencing behaviour. However, outside of pointing that out she does not spend much time discussing the importance of factors such as culture.

Finally, Denton (1999) looks at two hypotheses around gendered health. She analyses the behavioural determinants approach, which states that certain types of behaviour (smoking, drinking, sedentary lifestyle) impact significantly on health and that differences in behaviour between men and women explain gendered health. However, she challenges this hypodissertation and through her research (1999) illustrates that in fact social structural explanations of health are more important in explaining gendered health. Thus structural inequality needs to be addressed. In another paper (2003), she discusses the two further hypotheses that aim to explain gender differences in health. The first (differential exposure) suggests that due to structural inequalities, women are differentially exposed to diseases than men and are thus likely to suffer from different types of illnesses than men. The second hypodissertation (differential vulnerability) suggests that the explanation for gender differences in health is directly related to how women

and men react to disease i.e. their vulnerability to them. Denton (2003) suggests that in fact there is interplay between the two explanations. Men and women are exposed to different disease due to structural factors; however, they also react differently to them. Denton looks at how men and women react to life crises and work stressors to analyse differing reactions.

Unfortunately, very little is written about the burden of disease on women as the carer and homemaker. While she may not be ill herself, inevitably the care of ill children, husbands and other relatives lands on her. Furthermore, the feminisation of poverty is not given much attention, particularly as much of the literature regarding gender and health stems out of Europe and America. Despite recognition that female education can be a vitally important strategy in increasing health levels in poorer nations (Mechanic, 2002), the link between gender and health in these nations is under-researched.

Understanding that material deprivation has a major impact on the health of individuals is not difficult but what is interesting is that changes in health are not simply linked to poverty and wealth. Rather, as Marmot (2004) has found, changes in health occur at every level of the social ladder. Thus, there is also a change in health between middle managers and top manager, and between top managers and directors. The more wealth one has, in general, the more health one has too. Bartley terms this trend the health gradient and it has been touched on before.

The material aspect of social epidemiology is most certainly reflected in the respondents' understandings of health although it must be said that this is not at a technical level but rather at a lived or experienced level. As Marmot (2005) points out, "It is not difficult to understand how poverty in the form of material deprivation – dirty water, poor nutrition – allied to lack of quality medical care can account for the tragically foreshortened lives of people in Sierra Leone." This is certainly recognised by the respondents. The nurses, nurse assistants and

technicians all point to the need for families and communities to be able to meet their basic needs, to have access to healthcare, access to clean water and sanitation and healthy food for health to be maintained. In addition, the nurse assistants in particular express concern over their inability to meet those needs. Morija is seen as a healthy village because of its access to resources that assist its people to meet those needs. At all levels of the discussions around health the material aspects of health came up, as they did in the focus group meetings. It is clear that this is a lived concern – in their own lives and in the lives of their patients and it reflected in the joining together of the areas of health and social welfare into one Ministry within the government. This is also why part of the work of the nurses at Scott is to go into communities and assist in planting of vegetables and crops, and ensuring that good sanitation practices are in place. Mme Shale outlines some of the work that Scott does in attempting to deal with the material causes of ill health.

> *We also have projects, which care for HIV orphans. We have one called the Vulnerable Orphaned Adolescents Project within which we teach the orphans how to sew. They are supplied with sewing machines and materials. The expectation is that after completing the training, they will be able to generate income for their families and other orphans. Some are already taking care of other orphans. (Shale interview)*

A key element of social epidemiology is the material aspect and this is perhaps one of the most dominant explanations of health amongst healthcare providers in Lesotho. However, behavioural explanations also influence their understanding of health.

b. Cultural/ Behavioural

This field looks at how individual behaviour contributes towards their health. On a basic level it looks at the correlations between smoking and ill health, or between overeating and heart disease and points to behaviour modification as one of the aspects of dealing with the disease. The focus is thus on the patient to be an

active agent in his/her healing. On the other hand, it also shifts blame for ill health to the individual.

Lay health behaviour is a broad field that will be looked at in a little more detail, particularly in relation to cultural explanations of health. However, at this point it is important to point out some of the issues that come to light in terms of behavioural aspects of health. One of the major areas of interest is the difference in health seeking behaviour between men and women. Denton (2003) points out that the way that men and women react to certain stressors in their lives may go some way to explaining the differences in health between men and women. Thus the commonly held notion that "women get sick and men die" (Annandale, 1998: 123) may have some truth to it. However as Annandale states this statement "increasingly belies the complexity of the relationship between gender and health status" (Ibid.). As such a more comprehensive and nuanced approach to the connection between gender and health is necessary.

Stemming from this call, much research has been conducted into how femininity and more particular masculinity contributes to health. Cleaver (2002) calls for gender studies to include discussions on men and the issues that they are facing in the globalised world. Gender in relation to policy documents and development thinking all too often focus on women to the neglect of men. This is an important call as masculinity is facing a crisis of change as economic change occurs. Without going into all the intricacies and problems associated with defining masculinity and femininity, Thomas, in Cleaver (2002) suggests that poverty and economic change are having "demasculinizing" effects. This in turn may impact on the health of men as well as women.

Riska (2002) looks at types of masculinities and how they impact on health behaviour. In her study she looks at the Type A man (as named by Friedman and Rosenam in their study of stress and heart disease) and contrasts it to the hardy man – the man with "control, commitment and a sense that change is a personal

challenge" (Kobasa, 1979 in Riska, 2002: 351). The Men's Health type masculinity perhaps best represents this category. Outside of the fact that these masculinities are social constructs, Riska points out that how a man defines himself, that is, how he interprets his masculinity, impacts on his health behaviour. Hardy men are more likely to take active control of their health than the Type A men, who probably proved the adage, "women get sick and men die." While this piece is written from an American perspective, it is clear that understanding how men and women perceive of themselves is incredibly important in being able to determine health behaviour.

From an African perspective this is perhaps even more integral as HIV and AIDS continue to spread. Ideas of particular types of masculinities and femininities have a huge role to play in relationships, and in particular in sexual relationships. Work needs to be done in the public health sector to attempt to change perceptions of what 'being a man' means if any impact is to be made on levels of condom use. Harrison, O' Sullivan et al. (2006) have looked at masculinity and its impact not only on condom use, but also on number of partners and attitudes within relationships about gender roles. Castro-Vasquez (2000) pointed this out in his study of Mexican teenagers, which indicated that decisions around condom use and sexual practices had far more to do with sexual reputations – that is reputations of a certain type of masculinity – than with rational decision making.

Interestingly, there may be a role to play for traditional cultural understandings of masculinity. Too often, cultural constructs of masculinity are passed off as being part of the cause of the problem of the spread of sexually transmitted diseases, the suggestion being that cultural traditions of polygamy contribute to attitudes of it being alright to have more than one sexual partner. Cultural conceptions of male dominance over women is also frowned upon in the modern era. There may be some truth to these arguments but the flip side must also be considered. Sorrell & Rafaelli suggest that in fact focusing on attaining "culturally recognized markers of masculinity" (2005: 585) may be one way of addressing the spread of

HIV and AIDS. This finding is corroborated with anecdotal evidence in Lesotho that suggests that the church did much to abolish traditional rites of passage such as initiation rituals at which proper sexual practices were taught. However, the church did nothing to fill this void, preferring to be silent on the matter of sex. As such, teenagers and young adults are confronted with a silence on the matter from the people and organizations that should provide guidance. The call from LoveLife tries to address this issue in its campaign aimed at parents, which encourages parents to "Love them enough to talk about sex" (LoveLife, 2006). Perhaps the same call should be made to religious organizations and to cultural leaders.

Studies around gender and health behaviour illustrate that behavioural aspects of health do need to be understood in a more nuanced way. Marmot (2004) makes the case for socialisation as a mechanism for explaining social inequalities in health. However, rather than suggesting that unhealthy behaviour is a learned response, Mormot & Singh-Manoux suggest that socialisation is the concept that can link previously mutually exclusive explanations for social determinants of health. He thus suggests that social class and gender and the norms and values attached to these categories, teach us certain behaviours. Thus, "health related and psychosocial behaviours are never truly 'voluntary'; they are a product of, and embedded in, the structures of society" (2004: 1).

The healthcare providers pick up on this quite clearly. Much of the nurses and nurse assistants' work revolves around behaviour change. In this sense, their work is strongly located in the Public Health discourse which aims at influencing behaviour for better health outcomes. The nurses and nurse assistants reflected on the importance of this work in the interviews. Behavioural aspects of health are expressed in terms of what individuals, families and communities should be doing to maintain their health. The lessons range from the need for good sanitation to the need for social activity and good family planning. They are

expressed as preventative measures rather than as laying the blame at people's feet. Mme Tsitsa prescribes how best to run a healthy family,

> *It is the one with children, up to four because of there are more than four it is not possible to provide them with the necessary things they want like food ad school fees. (Tsitsa interview)*

Their work, particularly in family planning therefore has an influence on their understandings of health. It is clear though that although the behavioural approach does play a role in their understandings of health, the material far outweighs this which gives a sense of the political economy argument which will be expanded on later. There is a sense in which, although there are certain things that can be done to prevent ill health, these are limited in an environment in which material deprivation leads to ill health anyway.

Although I had interviewed technicians to understand whether or not there were gender and differences in the understandings of health, contrary to my expectations and contrary to the literature which suggests that men and women understand health quite differently, I did not find any evidence of this in this research. There are no doubt gender difference in understandings of health that have to do with socialisation. However, the literature that has looked at this has done so from a particularly Western perspective. At Scott hospital as well as at Paray Hospital and Mokhotlong Hospital, gender differences were not evident. There were certainly differences in understandings of health, particularly regarding the influence of biomedicine for the technicians. However, I explain this as an occupational difference related to their training rather than as a gender difference. Further research could perhaps assess gender differences more closely and in comparison to the literature that has been covered in this dissertation.

Religion also has a major role to play in influencing identity and particularly gender identity as well as gender roles through socialisation. As Goldman &

Isaacson suggest “gender doctrine involves patterned definitions of femininity and masculinity embedded in every religion's overall doctrine. It delimits gender differences, the nature of deity(ies), the division of labor, interpersonal bonds, sexuality, and procreation” (1999: 411). An understanding of the healthworld will go a long way in addressing this aspect of health behaviour.

What must be stated is that although the field of understanding lay health behaviour and attempting to change behaviour has resulted in many studies and programmes, overall health behaviour is exceedingly difficult to influence and change. Despite education programmes around HIV and AIDS, sexual promiscuity is still rife. I suggest that one way to better research health behaviour, and thus be able to influence health behaviour, is through the type of research that I have conducted – assets-based research. The reason for this is that assets-based research reveals the underlying discourses that motivate health behaviour and enables us to understand that while a particular action may make sense from a biomedical or Public Health perspective, it may not make sense from a cultural or religious perspective. Changing health behaviour requires that messages are targeted in such way as to be acceptable despite the differing explanations of health that individuals hold together.

The concept of the healthworld challenges how we have thought about people’s choices of where they go to seek health. Kleinman (1979 in Helman, 2001) suggests that there are three sectors that people go to when seeking health. “Each sector has its own ways of explaining and treating ill health, defining who is the healer and who is the patient, and specifying how healer and patient should interact in their therapeutic encounter” (Helman, 2001: 51). He outlines the popular, professional and folk sectors.

The popular sector

This sector refers to “lay, non-professional, non-specialist” healthcare providers. It is in this sector that ill health is first identified and attempts (successful or not)

made to alleviate the illness. This is also the sector in which healthcare is provided without any financial transaction. It is the sector in which friends and family aid with health maintenance and treatment of disease. When a person consults their mother or grandmother for health advice, or self-medicates, they are operating within the popular sector. Kleinman includes care that is provided through relationships of kinship, but also includes organizations such as support groups or faith-based organisations (FBO's) in this sector. It is important to note that the popular sector is playing an increasing role in healthcare particularly in light of the HIV.AIDS pandemic where hospitals are overburdened and cannot care adqualtely for patients. In these situations, families and in particular non-profit organisations such as CBO's, FBO's and NGO's come to play an increasing role. As such they need to be studies further.

The professional sector

"This comprises the organized, legally sanctioned healing professions, such as modern Western scientific medicine, also known as allopathy or biomedicine" (Helman, 2001: 58). Professional healthcare takes place within doctors' rooms and hospitals by qualified and registered health practitioners such as doctors, nurses, physiotherapists and dentists. It almost always involves a financial exchange whether that is through payments by the patient, medical aid companies or through government spending. It is in this sector that power relations are so evident. As Helman states, "they (health practitioners) have the power to question and examine their patients, prescribe powerful and sometimes dangerous treatments or medication, and deprive certain people of their freedom and confine them to hospitals if they are diagnosed as psychotic or infectious" (2001: 59). Kleinman has a relatively narrow view of the professional sector and it is not clear whether he would include social workers, occupational therapists and the like in this sector. What is clear is that traditional healers are relegated to the folk sector.

Folk sector

This sector involves those people that are specialists in healing but are not "part of the official medical system" (ibid. p.53). These are generally cultural or traditional healers, homeopaths, chiropractors and the like. They are not medical professionals in the sense described above. Rather they are trained through apprenticeships, or through spiritual guidance. They not only practice health in the healing of disease sense, but seek to maintain overall health including the health of the family and community in relation to the ancestors. The Basotho 'folk' sector is discussed further later. This sector would also include members of the community that have been specially trained to provide education on health, and sometimes even the treatment of diseases or the provision of inoculations. The grouping of all forms of 'folk' healing into one sector does not do justice to the multiplicity that exists within this sector and the use of the term 'folk' is somewhat patronizing especially in light of the fact that in South Africa in particular there is a high professionalisation of traditional healers and in Lesotho traditional healers are professionally organised. Simply looking at the Basotho traditional health discourse reveals that it is a dynamic discourse with multiple players and understandings.

Kleinman (in Helman, 2001) suggests that each sector has a set of meanings that are attached to health. My discussion on healthworlds will challenge this claim as I suggest that within each sector multiple discourses of health, each with its own set of meanings, exist. Kleinman further suggests that when an individual is seeking health s/he will choose which sector to go to depending on the symptoms and may move between the sectors should s/he not find the solution. Thus a picture of Kleinman's conception would look like that in figure 18 below.

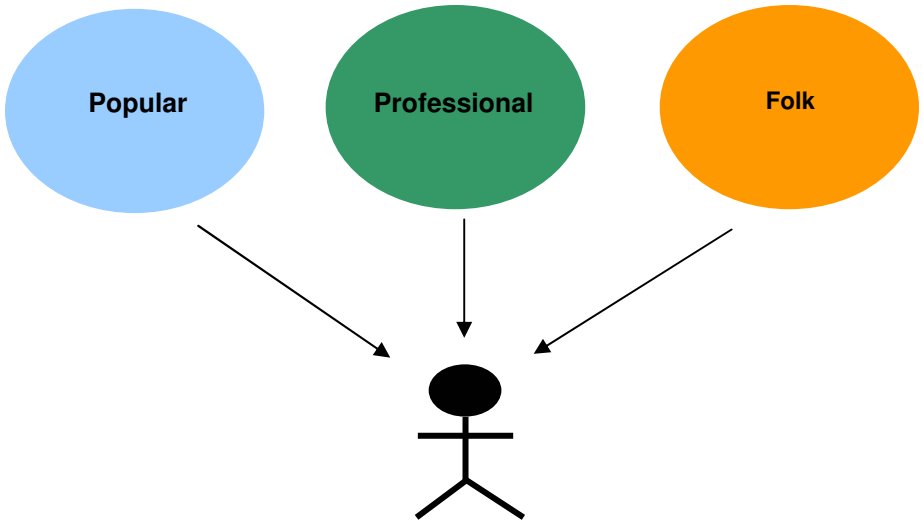

Figure 21: Kleinman's model of health behaviour

This model suggests that the individual has agency in so far as s/he can choose which sector to go to. However, there is no analysis of how s/he reaches that decision apart from the idea that if one doesn't work they will go to the next. In fact, decisions about where one seeks health are very much linked to the individual's healthworld. This model does not seek to address the particular discourses of health at play and how they influence an individual when s/he takes any health action.

But health is not affected only by the behavioural choices that people make. The circumstances in which they find themselves also contribute substantially, not simply through lack of material wealth, but through the psychological and social stressors that are linked with that.

c. Psycho-social

The psychosocial approach states that "status, control, social support at work or at home, balance between effort, and reward influence health through their impact on body functions" (Bartley, 2004: 16). This is a key area of research, and is a particular focus of the World Health Organisation's publication The Solid Facts. The basic premise of this argument is that stress increases the less control an individual has over the circumstances of his/her life. "Continuing

anxiety, insecurity, low self-esteem, social isolation and lack of control over work and home life, have powerful effects on health" (WHO, 2003). According to this research, this risk increases the lower down the hierarchy an individual is in industrialised nations. However, having conducted research with people affected daily by poverty, it is clear that these stressors are significant for the majority of the population in Lesotho – a non-industrialised and underdeveloped nation. This contributes significantly to disease as well as to a lack of health in the general sense.

This points to the role of social capital in promoting and maintaining health as well as in supporting those with terminal diseases. The link between social capital and health is well researched. Woolcock and Szreter (2002) point out that there are three ways of understanding the link between health and social capital. The first is the social support view, which documents the role that social networks play in general well being but more interestingly, in the prevention of certain diseases. The second approach argues that increasing inequality has led to a reduction in mutual trust between citizens and heightened anxiety and stress levels with its associated diseases. Finally, understanding the role social capital plays assists in introducing community based public health strategies. However, the corollary of this is the possibility that meaningful intervention is set aside as empty promises of community networks and social support are made (2002: 1).

The effects of social capital on sexual behaviour and on vulnerability to HIV and AIDS has opened up an interesting avenue of research. Leserman, Perkins and Evans (2002: 1514) conducted a study on HIV positive patients and found that "satisfaction with one's social support networks and participation in the AIDS community were related to more healthy coping strategies." Similarly Gregson et al. (2004: 2119) found that social capital impacts on health behaviour quite significantly. "Participation in local community groups is often positively associated with successful avoidance of HIV, which, in turn, is positively associated with psychosocial determinants of safer behaviour." It is clear that

social capital has a major role to play in prevention of diseases and in managing of diseases. The church plays a significant role in this regard, particularly in developing nations (Garner, 2000). This was recognized by the WHO who approached ARHAP to conduct research that would map out formal and informal religious organizations that might assist in the provision of ARV's and the support of people on ARV's for greater adherence to the ARV programme. The results of this research are currently being written into an official WHO report.

The psycho-social approach is reflected very clearly in the understandings of health that the nurses hold although more on the social side than the psychological side. The social element plays a fundamental role in their understanding of health. However, it is expressed quite differently to how the social element is expressed in the epidemiology literature. The social epidemiology literature is written from a first world, British and American perspective. As such the focus of the work is on the role that social support plays in healing, as well as how stress at work impacts on health. As Bartley (2004: 16) states, "status, control, social support at work or at home, balance between effort and reward influence health through their impact on body functions." Once again, social factors are seen to impact on the "body functions" that is the physical elements of health. The social factors for the respondents are understood far more broadly than the official discourse line. I suggest that this illustrates the influence of the Public Health but it also indicates that the respondents are equally influenced by the traditional discourse of health which advocates for a far more social understanding of health than the Western conception of Public Health allows.

In the previous chapter I have called this aspect of health the relational aspect of health. It was expressed clearly many times across the board. In this instance healthy relations, whether they contribute to the better functioning of the physical body or not, are seen as contributing to health. In the same way, conflict, even if it is not directly affecting the physical body, is still seen as a major threat to

health. Germond & Molapo (2006) illustrate this in their Bophelo paper which indicates that conflict, unjust laws and witchcraft amongst other things are seen as threats to bophelo. Basotho understandings of the social are therefore far more extensive than the social epidemiology literature allows. I would suggest that this has to do once again with the traditional discourse of health which does not separate out the social from the individual but sees them all as being related. If this is the case, then right relations would naturally be seen as integrally important to health, regardless of the physical impacts. This is what seems to be the case at Scott Hospital. This is also reflected in the Klieniek ea Mathatha. Although it is termed the hospital of troubles, a psychologist does not counsel there. Rather it is an available nurse who just listens to the troubles – it is a hospital where you can come and off load to others and get support, as opposed to a clinical psychologist's rooms. The relational aspect of healing is a strong element of their understanding of health and could be used to extend current theories around social epidemiology to include African perspectives in particular.

Although social support plays a significant role in health, often the health of an individual is determined at a much earlier stage.

d. Life course

The life course approach states that individuals' health is determined at a young age and that events at birth and in childhood affect health throughout the individual's life. Thus, a person's access to adequate food in the early stages of their life will influence their immune system and general strength for the rest of their lives. As Wilkinson, Bartley & Marmot state,

Observational research and intervention studies show that the foundations of adult health are laid in early childhood and before birth. Slow growth and poor emotional support raise the lifetime risk of poor physical health and reduce physical, cognitive and emotional functioning in adulthood. Poor early experience

and slow growth become embedded in biology during the processes of development, and form the basis of the individual's biological and human capital, which affects health throughout life. (2003: 14).

This argument not only stands for the nutritional aspect. Children learn behaviour from their parents and are affected by their parent's own health behavior. Thus education for parents around healthy lifestyles should be beneficial to children. Emotional support at a young age is also linked with positive health later in life.

The life course approach is understood implicitly but is never mentioned in the interviews. There is a clear understanding of the need to feed and clothe the child and have family planning so that good education can be afforded in order to give children a better chance at a job. But this is the extent of this understanding. The life course approach however is not linked to physical health for the respondents. There is no indication that the health of a child will affect its health throughout its life. Thus, the life course approach seems to play a very limited role.

It is important however not to get caught up in explanations of disease that absolve the greater global community. The political economy approach deals with this aspect of health.

e. Political Economy explanation

Another area of social determinants that Bartley (2004) points out is the increasing field of global social inequality and health. This is often a very quantitative or demographic field in which socio-economic conditions in a country are compared with life expectancy within the country. More recently work is focusing on the effects of discrimination either according to ethnicity, race or religion on health. This and looking at religion tied to ethnicity are the only areas

in which religion is actually addressed as a determinant of health. Religion is not given any more attention as a determinant than that.

The political economy understanding of health has come to gain recognition in the field of public health. In this approach, “political processes and distribution of power affect provision of services, quality of physical environment and social relationships” (Bartley, 2004: 16). Theorists working in this field may simply point out the disparities or may be more uncompromising by suggesting that this is an active decision by those in power and thus blame can be laid at their door. Farmer’s (2003) work, as has been discussed previously is significant within this field and contributes significantly to the rationale for this research. Mechanic (2000) also contributes to this literature in his study of the positive role that focused and deliberate attempts at making healthcare accessible for all can have for a community. He studies Kerala in India which has a higher Human development Index (HDI) than the Bronx in America primarily because of the India Communist Party’s insistence that all members of the community should be able to access healthcare. This drive has meant that the life expectancy in Kerala is surprisingly high, particularly considering its low GDP per capita. From this example. Mechanic illustrates that “healthcare for all” (WHO, 1979) is truly an attainable goal. Thus, for Mechanic (2000), any reasons that accompany a lack of access to crucial treatments and to basic healthcare should not be excused. Rather aspects of power must be taken into consideration when analysing who has access to healthcare and to whom it is denied.

Wilkinson (1996) adopts a critical view of the field of social determinants of health. For him the resultant theories that have been established over the years have only served to “absolve the social structure of responsibility” (1996: 63). For him there has been far too much willingness in the field to assign blame for ill health on genetic factors, individual behavioural choices or social mobility. He suggests that there still needs to be a real recognition of the socio-economic factors that impact on health, and thus, a need to redress the inequalities that

cause "'excess' – or potentially preventable – mortality in society" (1996: 59). In fact for Wilkinson, "the amount of inequality itself in states, regions or nations is associated with increased mortality and poorer health" (in Mechanic, 2000: 271). Wilkinson, like Farmer therefore tends towards the more radical political economy approach.

There is an awareness of the political economy approach, particularly because of the situations the respondents find themselves in. This was not expressed explicitly but came across in how the respondents, particularly the nurse assistants related to me. There were many uncomfortable moments where it was pointed out that as a white South African living in Johannesburg, I had access to resources that they did not. There were thus often implicit or explicit requests for financial assistance either at an individual level, or at an organisation level. There was thus a keen awareness of the inequality that exists between Lesotho and South Africa, and in particular, between Morija and Johannesburg.

f. Primary Health Care

Stemming out of the increased understanding of the multiple causes of disease, the primary health care approach attempts to deal with health by maintaining it. That is, a preventative approach is followed as opposed to a curative approach. The preventative method not only seeks to prevent ill health but also aims at promoting good health through family planning programmes, community health education and environmental interventions.

The World Health Organisation's Alma Ata Conference of 1978 put the importance of primary health care on the international agenda as a tool to achieve "health for all by the year 2000." As Lush states, (in Weller, Aizenburg & Mercer, no date: 1), "in 1987, the Alma Ata Declaration made an international commitment to comprehensive primary health care as part of a broader political and economic development agenda."

The primary health care model is based on the idea of making health care accessible to all through the establishment of health centres. Under this strategy all people should be able to access first level care. Access to preventative healthcare would mean that limited resources would be better used as many diseases could be dealt with through prevention or early detection. Based on my observations, Lesotho is driven by this model. While this model may have been successful, it also needs to be taken into account that the realities of budget cuts and the general poverty facing developing nations has meant that the achievements may have been somewhat hampered.

The Public Health discourse is probably the most dominant discourse of health at Scott Hospital as well as at the other two hospitals, if not at all the hospitals in Lesotho. Across the board there is a clear conception of the Public Health discourse and the socio-psycho-environmental elements that contribute to health. However, as with the biomedical model there are some key differences as well. It is clear that the Public Health discourse, expressed through understandings of social epidemiology and the practices used to address these, is a very influential discourse for the respondents. This has to do predominantly with the nature of their lives and those of their patients as well as the predominance of the Alma Ata influenced policies in Lesotho.

Although the public health discourse encompasses many broad ideas about health and health strategies, including the traditional sector, it is important to focus more closely on the traditional discourse of health.

6.1.3. The Traditional Discourse

Before attempting to define the traditional discourse it must be acknowledged that practitioners working within this discourse have diverse ways of understanding the body, illness and healing. Thus it is difficult to generalize but

nevertheless necessary for the purposes of understanding what we mean by a traditional discourse. It is also important to remember that while there are differences within one particular cultural tradition of healing, there are also diverse ways of thinking about health and healing between cultures. Thus a Sesotho traditional understanding of health may be quite different from a Zulu understanding. As Green states, “it is always dangerous to make generalizations about the people and cultures of sub-Saharan Africa, yet it is necessary to engage in some of this for our purposes” (1994: 17).

In addition, as with all discourses, traditional healing has changed significantly over time. Thus despite the fact that some may claim that traditional healing is a pure remnant of the past, it has in fact been highly affected by Western or biomedical discourses of health, religion and by professionalisation such that traditional healers today are likely to incorporate elements of other discourses into their healing methods. This was the case with one healer we visited in Lesotho who was both a well known diviner in the area who communicated with the ancestors, and a devout and recognized Catholic woman, who incorporated prayers and hymns into her healing.

Nevertheless, traditional discourses of health are most definitely a distinct category of healing from biomedical discourses of health. The WHO defines traditional medicine as “comprising therapeutic practices that have been in existence, often for hundreds of years, before the development and spread of modern scientific medicine and are still in practice today (in Campbell, 1998: 2). Despite the differences within the traditional discourse there are some commonalities that can be recognized that distinguish traditional understandings of health.

The first is the dualistic view of the person. While biomedicine rests on the Cartesian separation of body, soul and mind, traditional healing cannot separate the body from the mind and soul. The soul and body are intricately linked and as

such they affect one another. The health of the soul will thus impact on the health of the body and vice versa. “Traditional African medicine and treatments address healing of both the body and the spirit” (Campbell, 1998:7). This was the reason why Molapo in his initial interviews with traditional healers battled to explain what the research aim of ARHAP was. In distinguishing between religion (concerning the soul) and health (concerning the body from a western perspective) he was inadvertently separating the soul and body. For a traditional healer in particular this was a conception that did not make any sense. There was no question for them on the link between religion and health as the soul and body were intertwined. The link between the soul or mind and the body is starting to be taken a little more seriously within Western medicine with increased interest in psychosomatic symptoms. This is of particular interest to psychologists. Having said this, the emphasis within the western discourse is still very much on the particular pathogen rather than the potential psychological cause. Linked to the health of the soul is the link with the ancestors and the role they play in the spiritual and therefore physical health of the individual.

Understanding the role of the ancestors in an individual’s health requires a shift of mindset. From a Western perspective (largely influenced by Christianity) the dead are dead and have no influence in day to day physical reality. The only recognition given to the dead is through memory – both practiced (as in a memorial service or funeral) and lived (as in day to day memories of family and friends that have died). In the African conception, dying is simply another phase of life. Like the rites of passage such as birth, initiation, marriage, child bearing and becoming an elder in the community, becoming an ancestor is simply another rite of passage that brings with it added honour and respect. As such, the ancestors are very much alive and involved in day to day life and must therefore be honoured and respected as such. Germond (2005: 4) puts it most clearly.

> *balimo (the ancestors) have all the normal physical and social needs of batho (people) – food, drink, clothing, and social interaction. Thus an ancestor can typically appear in a vision to*

> *a family member and say "Ke hlobotse" ("I am dressed in rags" – implying "I need a blanket"). The traditional Sesotho response to this is to slaughter a cow – the hide, of course, being the blanket (kobo). As one respondent, criticizing the theology of the church, said some Basotho had been adversely affected by the church teaching that "the dead are dead and only awaiting the resurrection."*

In this context the traditional healer fulfills the role of acting as an intermediary between the community and the ancestors and guides the community on how to honour and respect the ancestors, often through rituals. These rituals may include sacrifices but are more likely to revolve around the accepted rites of passage such as initiation and proper burial. In this sense, the healer plays the simultaneous role of priest in that he/she sees over the spiritual rituals of the community and communicates with the spiritual realm as well as interpreting for individuals the spiritual aspects of their afflictions and healing. As Maclean states, "The most respected traditional healers also perform a priestly function, interpreting for sick and anxious people the reasons for their state and pinpointing the spiritual and interpersonal influences which are believed to be influencing their health and well-being" (1986:9).

The healer's role in interpersonal influences brings me to the third aspect of traditional health discourses and that is the recognition of the role of the social in an individual's health. Western biomedicine focuses its health interventions on the sick individual and works with him/her for his/her healing. The role of the family and friends and even the broader community is not taken into consideration. The Public Health discourse increasingly looks at the role of the social on health and understands social epidemiology well. However, it does not look at interpersonal relationships and their effect on individual health in too much depth and this is really the realm of traditional medicine. Traditional healing is not so much interested in how stress impacts on an individual's well being as it is in focusing in on the state of interpersonal relationships as the root cause of ill health. The healer is thus not only the purveyor of medicine for the body but also

prescribes medicines that cure relationships ills. “Medicines do not simply deal with physical symptoms. They supply personal strength and power, they provide protection against the malevolence of gods and spirits and the enmity of close human rivals. They can also be used to influence the behaviour of others, to win a person’s affection or induce them to do a favour” (Maclean, 1986: 10). Even if the affliction is not linked with interpersonal relationships, the individual is still not seen alone. Rather the family is eeply involved in the diagnosis and healing of the illness. As Maclean puts it, “

The social context of healing is of the greatest significance – whole families are usually involved if one of their members becomes seriously such and a grouip of kinsmen may decide after long discussion, upon the best course of action and about which of a number of possible outside specialists to consult. They constitute, in Janzen’s term, the ‘therapy management team’” (1986: 12).

Not all healers are able to influence interpersonal relationships or commune with the ancestors. There are various types of healers each with their own unique methods of healing and their own gifts. The symptoms an individual experiences will influence his/her decision on which healer to visit. There are a variety of specialists to choose from and these will differ from culture to culture. Green (1994) has defined four types of healers in North Africa as shown in the table below. Some of these are similar to what Molapo found in Lesotho.

Class	Sub-class	Specialists within sub-class
Diviner-medium	Diviner-medium, shaman, priest, witch identifier	Oracle Spirit medium Ceremonial specialist
Herbalist	Herbalists	Childrens' disease specialist Bone setter Infertility or impotence specialist Traditional birth attendant
Religious faith healer	Christian faith healer ("Cherubim" "Zionist" "Jerico") Muslim faith healer ("Marabout" etc)	

Table 1: Taxonomy of Indigenous African Healers (Green, 1994:18)

For Green (1994), the key distinction is between traditional alternative practitioners (diviners and herbalists) and non-traditional alternative healers (religious faith healers). My only concern with this distinction is labeling these healers as alternative. From a Western perspective they may be so. However, from an African perspective, these healers are often the first port of call and are seen as the primary method of healing. The distinction between traditional and non-traditional is a helpful one and one that Molapo recognized in Lesotho too.

In Lesotho, there are five broad types of healers that exist (Germond, 2005: 6):

- **bongaka chitja** -- bophelo provision based on the dispensing of herbal medicines (closest to biomedical healthcare)
- **bongaka ba litaola** -- bophelo provision based on divination and medicines.
- **bongaka ba Mapostola** -- a Basotho form of Zionism in which mapostola establish their own communities ("churches") of bophelo practice. The call to become mopostola is always mediated through an experience of illness which broadly follows the pattern of a call to become Ngaka ea litaola.

- **bongaka ba Baporofeta** -- another form of Basotho Zionism. Establishing their own communities of bophelo practice is not intrinsic to Baprofeta, for they are generally located in an already existing religious community.
- **lethuela** -- bophelo practice based on the Nguni sangoma system.

In Green's distinction the first two categories and the fifth category would be traditional and the third and fourth would be non-traditional. As has already been stated however, these categories are not always so distinct. Diviners often incorporate Christian rituals and understandings into their healing methods. There is always an overlap between these categories.

The traditional discourse, despite being passed off as superstitious and backward and targeted by missionaries and colonists, has survived. Interestingly enough, although the healthcare providers fairly disdainful of traditional healers, the traditional discourse in fact plays a very important role in their understandings of health and may in fact be even more powerful than either the dominant biomedical or public health discourse.

As has been stated previously, the traditional discourse is at face value frowned upon amongst the respondents. This is expressed predominantly in what has been termed the discourse contestation. That is, there is a clear cut recognition of the role of the traditional discourse in Lesotho, but it is overtly expressed as being inferior in comparison to the Western view of health. Thus, as has been elaborated on previously, traditional healers are in need of training and should know when to refer patients to the hospital. There is no indication of ever referring cases to traditional healers although, according to Dr. Germond, this has happened and he himself in fact referred one or two cases (T. Germond interview).

Despite this seeming indifference or patronization of traditional healers, the traditional discourse does in fact have a profound impact on the understandings

of health that the respondents hold. This is expressed far more implicitly though and it was only upon analysing the data that this was picked up.

It became more explicit in the focus groups when the nurses circled the graves (referring to the ancestors), the chief and the traditional healer as being important for health. It was at this point that it became clear that while tradition is kept at an arms length within the Scott institution, it very much plays a role in the individual healthworlds of the nurses at least. The nurse assistants and technicians are less explicitly influenced by this discourse despite the nurses being far more educated in Western terms. This indicates that even where dominant discourses (usually 'modern' discourses) are taught, these are quite easily held together with the traditional views.

But even where traditional views were not expressed explicitly they still play a role. The extent to which the relational aspect of health (discussed above) comes up across all respondents is indicative of the influence of this discourse. It is clear that the relational aspect of health is expressed in a far more holistic and broad way than the Public Health discourse would allow. As such, this understanding cannot be attributed to the Public Health discourse alone. Rather it must stem from the traditional discourse which is far more aware of the interconnectivity of people with people, and of individuals with families and communities. It is thus clear that at this level, the traditional discourse is very powerful for the respondents.

The Public Health discourse also does not mention the role of the spiritual in health which the respondents were all very clear about. For the respondents, spirituality most certainly does impact on health. This therefore must come from either the Christian or the traditional discourse. I would suggest that although spirituality is expressed in Christian terms amongst the respondents, seeing the link between spirit and health in such a strong way is indicative of the power of

the traditional discourse which recognises the role of the spirit, particularly as it relates to the ancestors, in healing.

It is clear therefore that the traditional discourse is held together with the biomedical and Public Health discourses without any tension. All discourses have a role to play in contributing to the respondents' views of health. So too does the Christian discourse.

Interestingly enough, although the nurses are very influenced by the traditional model of health, overtly they suppress or silence the traditional model, particularly in their references to the traditional healers. I suggest that there are two explanations for this. The first is that the traditional model is still conceived of as being premodern. The nurses, all of whom are highly educated in the Western sense, would want to be seen as being modern. As such there is pressure on the nurses to at least overtly acknowledge but suppress the power that the traditional discourse has. The nurses must therefore be in line with the dominant understandings of health that both Scott Hospital and the MOHSW hold. For both of these institutions, traditional healers are recognised but are not seen as equal to biomedical or Public Health professionals. And yet, nurses, due to the fact that they have a fair amount of seniority at Scott Hospital, also have the power to influence policy at Scott. This begs the question then, if the traditional model does influence them why is it that they feel the pressure to conform, instead of attempting to shift policy at Scott. This leads to the second explanation which is that the traditional discourse of health is so much a part of their lives that they do not recognise the influence it has on their understanding of health. This is where discourse is so powerful.

As has been stated, discourses are at their most powerful when they operate in the realm of tacit knowledge – that is the realm of taken-for-granteds (Germond, 2003). Thus, although the Public Health discourse and the biomedical discourse of health are overtly promoted and are dominant in decision making and practice

of health in Lesotho, the traditional discourse could perhaps be said to be the most powerful in that is has the strongest foothold in the realm of tacit knowledge for the healthcare providers. Perhaps this is because of the way the traditional discourse is so intricately intertwined with the Sesotho culture as well as the Sesotho history. This is the strength that no other discourse of health could have in Lesotho and which will make it very difficult to do away with the traditional discourse. For this reason, health practitioners must recognise the importance of the traditional discourse and learn more about it.

All of this may seem strange from a western perspective and all too often, traditional medicine is passed off as silly, as superstitious and as backward. This is how discourses operate after all. However, the value of traditional medicine should not be overlooked. Not only does it play an extremely important role for people through direct healing, it also indirectly influences the healthworlds of even the most biomedically trained and must therefore be understood. As Makinde asserts, "that a peoples' belief, faith and religion have much to do with the acceptance of the efficacy or otherwise of any particular system of medicine does not need philosophical justification" (1988: 91). Understanding traditional medicine, its practitioners and how it impacts on people's belief systems around health will go a long way in effectively addressing, whether through biomedicine, traditional medicine or a combination, many of the pressing health issues in Africa.

6.1.4. The Christian discourse

Similarly, religion plays a vital role in shaping people's perceptions of health. In fact all religions have some teachings on health both in the broader sense of the word as well as speaking to health care specifically. This dissertation focuses specifically on the religion of Christianity and in particular on more mainstream forms of Christianity as they are found in lestoho, as opposed to Pentecostal

Christianity or African Independent Christianity.[19] Nevertheless, all religions have some teachings about health ranging from rules around what is allowed to be eaten and what is forbidden (this may stem from the actual health effects but comes to take on a spiritual health connotation) e.g. kosher foods. Equally, religious discussions on morality and behaviour come to address health issues, particularly in relation to HIV and AIDS and other STD's. At the broadest level, all Christian teaching is about health in some sense for "the way people seek health is profoundly symptomatic of what they make of life and of what life is making of them. We cannot therefore separate our attitude to health from our attitude to life" (Jenkins in McGilvery, 1981: xii).[20]

Religion has historically had an ambiguous relationship with medicine. It has played a role in speaking out against medicine. "During the Middle Ages there seems to have been much more concern for the soul than for the body. No surgery was practiced because incision of the human body was regarded as sacrilege since man's body was created in the image of God" (McGilvery, 1981: 3). More recently, the religious right has spoken out against stem cell research and cloning. Thus religion, and particularly Christianity has played an antagonistic role with regard to biomedicine. Equally it has played an antagonistic role with regard to traditional healing particularly through the missionaries that discouraged and undermined traditional medicine and the role of the traditional healer.

And yet, Christianity has also played a complementary role to biomedicine. As has been outlined already, a major component of missionary work in Africa was to introduce biomedicine.

> *"So much is this the case that when medical science and resources developed greatly in the nineteenth century and when*

[19] Although there is no doubt that both Pentecostalism and African Independent Churches exist in Lesotho, the mainstream religions of Anglicanism, Catholicism and Evangelical are far more dominant and widespread.

[20] This illustrates some interesting correlations with the idea of *Bophelo* as articulated by Molapo and Germond (2006).

> *there was a great expansion of Christian missionary activity from Europe to Africa and Asia in the same century a very considerable componenet in that missionary acticity was medical mission which set up hospitals and set out to bring medical care to pipulations lining in primitive and disease-ridden conditions 'in the name of Christ'" (Jenkins in McGilvery, 1981: ix).*

Today, apart from the religious right which very actively speak out against medical developments, for the most part Christianity and particularly the mainstream forms deals with health at a spiritual level whilst leaving the doctors to do their work. Thus, rather than claiming that healing is possible through a religious laying on of hands or anointing, mainstream Christianity has confined itself to teachings on spiritual health and to understanding ill health at an individual level (pastoring) and ascribing healing.

Thus, the Christian discourse of health has two aspects to it in the mainstream formulation. The first is that ill health is a symptom of the human condition of sinfulness (Conradie, 2006). Thus we experience ill health, accidents and death because we are ultimately fallen beings. This does not mean to say that "you are sick because you sinned" but simply that ill health exists because sin or a separation from God exists. This doctrine of sin allows us to explain ill health on various levels. In some instances, ill health is a direct result of ill living – that is we may become ill due to our own behaviour. For example, cirrhosis of the liver can be attributed to a life of alcoholism. In other cases, ill health is a result of other people's sin such as in the case of a woman who contracts HIV after being raped. Other examples of ill health can be attributed to "the consequences of structural violence" (Conradie, 2006: 6) – that is the effects of inequality as it is meted out through colonialism, economic exploitation and the like.[21]

If this aspect of the Christian discourse is extended it means that full health is never attainable until we live in fullness with Christ.

[21] It is likely that Farmer would recognise this aspect of the doctrine of sin in relation to health.

> *"This is why you cannot, and indeed must not, define health. Like life it is an open and as yet undefinable, because as yet unfulfilled possibility. At least, this is what we can and must say if we see the God who is known to Christians in Jesus as the source, redeemer and fulfiller of life. Health is what we enjoy when we are on our way to that which God is preparing for us to enjoy and when we are collaborating with Him in that preparation. It is also what we shall enjoy when all is preapered and available in the fulfillment of the Kingdom. 'Health' is thus a value and a vision workd which has both to be brought constantly down to earth and to be related persistently to a promise, an aim and a jope which lies ahead and above us" (Jenkins, in McGilvery, 1981: xii).*[22]

What the Christian discourse adds to an understanding of health therefore is that is primarily concerned with the soul and that the physical aspects are symptoms of an eternal soul condition. Although this has some strong correlations with the traditional understanding of health, what distinguishes it is that the Christian discourse of health is not as concerned with the social aspects of health in the same way that the traditional understanding is. Similarly, the traditional understanding of health, while being concerned with the spirit (or soul) does not attribute ill health to sin but rather to a lack of right relations within society.

It must be remembered that the Christian discourse of health is not articulated so clearly as being connected to sin and salvation. This is largely due to the fact that it is unpopular to do so. In the era of modernity and the supposed secularization that goes hand in hand with the rise of modernity (Bruce, 2002) it becomes frowned upon to articulate understandings of health that are explicitly connected to Christianity. As such the expression of this discourse is somewhat watered down. Rather than an individual making claims about the causes of ill health, they will leave that to the biomedical doctor and rather support the patient through pastoral counseling and prayer. The role of the Christian discourse is therefore to perhaps suggest answers to questions such as "Why me?", to look after the family and to pray that healing by the hands of the doctors will take

[22] This has some startling correlations with the Bophelo discussion which might be investigated further.

place. In its expression the Christian discourse of health thus plays a particularly complimentary role. It is interesting to note however that this complimentary role does not extend to the traditional understanding of health.

This is perplexing considering how much it has in common with the traditional understanding of health. However, historically the Christian discourse has been introduced at a time when biomedicine was introduced and went hand in hand with the colonising project which after all entailed the "White man's burden" (Kipling) of civilizing the native. This of course included discouraging traditional cultures.

The Christian discourse of health plays an important role for the healthcare providers. Many times the nurses, nurse assistants and technicians articulate the important role that religion plays in their own work as well as more generally in the health of the community and the family. There are also some key differences between how they articulate it and the dominant discourse.

For instance, in the Christian discourse, sin is seen as a cause of ill health – we are ill because of the sin that exists within the world. Only one nurse assistant picked up on this understanding of health but overall, ill health was not associated with sin. Even when given the example of a person living with HIV and AIDS, there was no connection made to sinful behaviour that might have led to the illness. The extension of this point – that full health is never attainable until we are one with Christ, is also not articulated by the respondents. In fact the Utopian vision of health is hardly mentioned.[23] Thus it is clear that this element of the discourse does not seem to play a dominant role at all.

However, in terms of the role of Christianity in providing support and guidance to both the healthcare provider and the health seeker, this was well articulated by

[23] This is in contrast to Germond & Molapo's (2006) findings which suggest that the *bophelo* understanding of health is at least in part a Utopian vision.

all of the respondents. It is clear that for them their faith adds much to their work and is essential in the healing of their patients. In addition, faith is essential as it adds to the moral living and right relationships which are seen as being so essential for the health of the community.

6.2. Conclusion

What is clear from looking at these trends is that all four discourses are evident to some extent in the understandings of health that all the respondents hold. I have analysed them at a group level, but equally one could analyse them at the individual level to determine which discourse is more dominant and how one mitigates the other.

The discourses in Lesotho must be understood in their historical context. This context explains why all of the discourses are still evident in Lesotho today and is testament in particular to the resilience of the traditional discourse. Before missionaries arrived in Lesotho the traditional discourse of health was dominant. However, missionaries, for the purposes of entrenching their Christian teachings challenged many integral aspects of the traditional form. Thus the Christian discourse of health has been at odds with the traditional discourse since missionaries first began their teaching. And yet, healthcare providers today hold traditional explanations of health together with Christian explanations of health with ease. Missionaries also introduced biomedical healing and this discourse was entrenched through colonialism and the establishment of hospitals and the bringing in of European doctors. The modernizing project of colonialism went hand in hand with the modernisation of health and this included suppressing the power of the traditional healer. Dominant health policies today, whilst recognising the role of the traditional healer, still perpetuate the dominance of biomedicine and relegate traditional healing to the realm of complimentary of alternative (i.e. not quite legitimate enough o be mainstream) medicine. 1979 saw the Public Health discourse of health being promoted and this has had a major influence in

Lesotho, to the extend that Public Health has come to replace biomedicine as the dominant discourse of health at least in policy and practice. What is interesting though is that the traditional discourse still operates most powerfully in that it is part of the social and individual lives of the healthcare providers and thus operates at the most powerful level – tacitly.

This Chapter has shown how the biomedical and public health discourses, dominant in the published literature as well as in Western practices, have come to influence the perceptions of health that healthcare providers hold, and more broadly how they have come to affect healthcare in Lesotho. In addition it has demonstrated the role that Christianity is perceived to play in healing in Lesotho. Finally, it has shown how resilient the traditional discourse around health has been, primarily because it finds expression in the daily cultural and linguistic activities of the healthcare providers lives. What is clear is that at Scott hospital and in Lesotho generally, nurses, nurse assistants and technicians hold together very different understandings of health at one time. The next Chapter will introduce the concept of the healthworld as a means of explaining this.

7. ON HEALTHWORLDS

The previous chapter presented a discourse analysis of healthcare in Lesotho both historically and through scrutinizing the responses of healthcare providers at three hospitals in Lesotho. In so doing, what was revealed is that Lesotho's healthcare system presents four discourses that are at play and that all influence the understandings of health that the healthcare providers hold. These are the biomedical discourse, public health discourse, Christian discourse and traditional discourse of health. What was found is that although biomedicine and public health have come to play a dominant role in the policies of health at a national and health centre level, Christian and traditional discourses of health still play a key role. This presents an interesting dilemma with which to conduct further research. Despite an historical discourse contestation for dominance in the field of health, all discourses still have a major role to play at the level of individual perceptions of health. And because they influence understandings of health so directly, it is important to begin to understand them in order for healthcare practitioners to make an impact when it comes to messages around health behaviour.

What this Chapter does is introduce the concept of healthworld. It presents this concept only at this point as it is not the central argument of the dissertation, but should rather be seen as the point of departure for future research. A key finding that has been presented in the previous chapters is that healthcare providers are able to hold together a number of competing discourses about health at the same time and without the tensions that inevitably exist between dominant discourses. This is a first attempt at trying to explain this but warrants further research.

What is clear from the previous chapters is that discourses come to influence our perceptions of health in a variety of ways, ranging from national policies, training programmes, familial or community perceptions as well as through linguistic and

cultural means. Our understandings of health are also reinforced or rejected by our health experiences. Our understandings of health are therefore influenced in the same way that the Habermasian lifeworld is influenced. This thinking has led to the concept healthworlds being introduced into the ARHAP vocabulary.

This concept is still very much under development and although this thesis makes some contributions to its development it must be stated that it is a concept still in its infancy. It is also a concept that various researchers in the ARHA Programme are thinking about and testing.[24] What is a key contribution to the discussion on the concept of the healthworld is the recognition that it draws on health discourses that exist within the society[25] in which an individual lives. That is, in order to understand how people conceive of health (their healthworlds) it is very necessary to understand what discourses are at play in the society in which the individual or organisation is located. This is so as healthworlds are predominantly influenced by dominant discourses but also have an element of agency. Although multiple discourses around health exist in Lesotho, this thesis has focused particularly on the four major discourses discussed in the previous three chapters.

7.1. Why the healthworld?

Before considering what the healthworld is and what the healthworlds of Basotho healthcare providers look like, it is important to consider why the concept of healthworlds is so significant and why it should be considered a key concept, not only for the ARHA Programme but also for health practitioners, and development practitioners generally.

[24] For a more developed discussion on the concept of the Healthworld see Cochrane (2006) AAR Conference paper.
[25] Society is used here in its broadest sense as an individual will be influenced most by their immediate community but will also be influenced to a lesser degree by the greater global society.

As has been stated in the theoretical framework, this thesis, like the work of ARHAP, is located in the assets based approach to development and advocates giving a space for the voices of the so-called 'underdeveloped.' Much of this thesis has been spent advocating for a move away from economic, top-down approaches to development and to health interventions. I have illustrated how these approaches have perpetuated inequality and led to irrelevant development and health programmes.

I have also illustrated how health is a powerful indicator of general well being, particularly as it relates to socio-economic impacts on health or social epidemiology.

What this dissertation advocates therefore is looking at health in way that incorporates the views of those that the targets of development and health programmes to ensure that the programmes instituted are born from the ideas and capabilities of the local population and as such meet their needs. As Cochrane (2006: 3) states,

"health thus presents to us a powerful lens on the well-being of society. It is personal, relational, social and ecological in its foundations, and in its reach. If this is so, then the suffering of ill-health may be understood not only to be the result of biological invasions or malfunctions, but also directly related to the capability of persons and communities to build and maintain a state of good health – a capability linked to freedom, understood in the sense of Sen (1999) , as the condition of development, and to justice, understood in the sense of Ricoeur (1992) as living well together in just institutions."

Healthworlds thus provide us with a concept, a tool with which to approach new situations and to evaluate the capabilities and assets that groups, organisations and communities hold with regard to health. It also introduces a more comprehensive way of understanding health that incorporates and holds together the tensions that are otherwise set aside. It takes into account that this is a

project of structuration (Giddens). Healthworlds illustrate that structure and agency impact on one another and that because of this multiple competing discourses can be held together at one time.

7.2. What is a healthworld?

The term healthworlds is being debated because we have found it difficult to analyse exactly how people (both health providers and seekers) understand and practice health without a common concept to work with. As Germond and Cochrane state,

> *"understanding health in sub-Saharan Africa demands multiple approaches to understanding the complexity of the conditions and possibilities of health (we dare say this is true generally and not just in Africa). The social fields within which health and illness are conceived of and dealt with in Africa are complex beyond the view of any single view or discipline. These contexts are suffused with a bewildering array of symbolic worlds, and the behaviour of people and the actions they take are driven by equally compels sets of motivations. If we are to avoid wholesale condition of paralysis because of this complexity, the multiple approaches we need must be able to 'talk to' each other, which in turn suggests that they will be related within an overarching framework that will allow a meaningful coherence between approached. These two concerns taken together – complexity and coherence – prompt our proposal for the notion of 'healthworlds'" (2005: 2).*

The word healthworld would typically bring up a connection with the Habermasian concept of the lifeworld. However, as is stated by Germond and Cochrane (2005), this should not be the case as the healthworld, while drawing on this concept, also intends to critique and extend it. The healthworld should also not be seen as simply an element of the lifeworld; although there is no doubt that the lifeworld as Habermas conceived of it would contain conceptions of health. However, the healthworld should be seen as an independent concept. This is predominantly because of how health is defined. If health is defined in the dominant way that the WHO defines health as, "a state of complete physical, mental and social well-being and not merely the absence of disease of infirmity"

(WHO, 1988: 1) and if this definition is extended further in the Sesotho sense of bophelo then when we talk of health we are not simply talking about a visit to a doctor. Rather we are talking about lifestyle and ingrained socialisations and discourses that are continually at play. Cochrane (2006:7) states this clearly,

> *"It encompasses the body and relationality as a mark of the body in the context of all that defines and constrains the body socially, policitically, economicallt and environmentally. Health here is defined comprehensively, as in the Alma Ata Declaration, to refer to body, mind, spirit, realtionality, and its social and environmental conditions."When we talk of health in this broad sense, then we are invoking day to day life activities. As such, the healthworld is not simply about health. "Distinctively it incorporates the claim that it is not just a 'segment' of the lifeworld as, say, sport might be, but a regional orientation arising in the lifeworld and directed towards all of social reality" (Cochrane, 2006: 7)*

There are thus two main elements to the healthworld. The first is that which is closely linked with the Habermasian lifeworld and is the background hidden context that influences our daily actions. The second is that of agency.

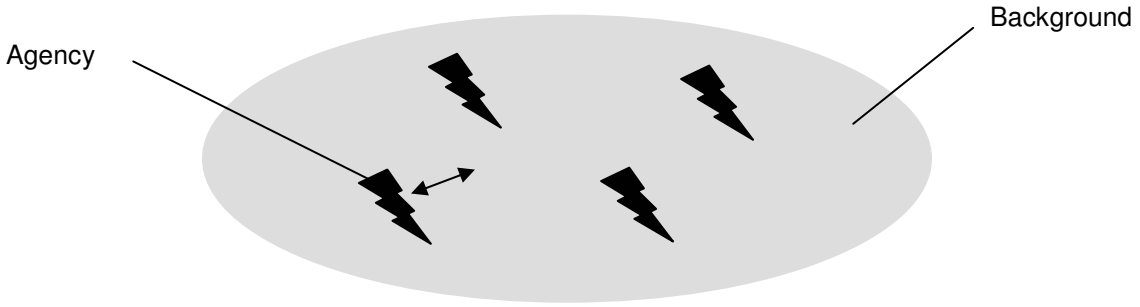

Figure 22: Elements of the healthworld

This figure illustrates that the healthworld consists of the background hidden contextual element (the grey shading) that can be aligned with what Habermas calls the lifeworld. The lifeworld is "a reservoir of taken-for-granteds, of unshaken convictions that participants in communication draw upon in the cooperative process of communication" (Habermas, 1988:124). In this case these taken for

granteds would apply to health. Thus the lifeworld, and in turn this element of the healthworld can be seen as "background convictions" (Ibid.) or what Germond terms tacit knowledge (ref). It is a web of "taken-for-granteds" that are hidden and that make up a reservoir from which we draw when going about our daily lives. It is possible that the lifeworld may be confused with the sociological concept of structure. I would suggest that the lifeworld is most certainly an element of structure. However, structure refers also to circumstances, institutions and our histories amongst other things. The lifeworld, while no doubt being influenced by these elements of structure, stands alone as it exists within our consciousness.[26]

I suggest that this "reservoir" or web from which we draw is highly influenced by dominant discourses. Like the lifeworld, discourses are also hidden and taken for granted and they permeate our consciousness without our knowledge, through the socialization that occurs throughout our lives. Foucault recognizes the way that discourses come to control us when he talks about subjectivity.

"What I would like to do, however, is to reveal a positive unconscious of knowledge: a level that eludes the consciousness of the scientist and yet is part of scientific discourse… Unknown to themselves they (naturalists, economists and grammarians) employed the same rules to define objects proper to their own study, to form their concepts, to build their theories. It is these rules of formation, which were never formulated in their own right, but are to be found only in widely differing theories, concepts and objects of study, that I have tried to reveal, by isolating, as their specific locus, a level that I have called, somewhat arbitrarily perhaps, archeological" (Foucault in Germond & Cochrane, 2005: 10).

As has already been discussed, the two major discourses that affect the healthworlds of Basotho healthcare providers at Scott are the biomedical discourse and public health or psycho-social environmental discourse of health.

[26] Consciousness here refers to our minds generally as opposed to the conscious part of the mind in the Freudian sense which is opposed to unconscious part of the mind. While a debate on this concept may be interesting, this thesis is by no means the place to introduce such a debate.

However, as has been alluded to, these are not the only discourses competing for a say in health in Morija or in Lesotho generally. The cultural and religious discourses around health are also very pervasive and will be given the description they deserve later.

The second element of the healthworld is the lightning bolt that is agency. Agency is also a sociological concept that refers to the individual's ability to act or make choices. Thus, agency in this sense refers to an individual's ability to make an impact (or choose not to make any impact) on his/her structure. The concept of agency that I am using here is slightly different although it most certainly does recognize and draw upon this explanation. In my conception of agency (one that I share with Germond & Cochrane (2005)) agency refers to the agent's ability to use its capabilities and assets. Thus it is about intentionality. In this it differs from the strict sociological sense of agency which suggests that even if a person acts unintentionally or does not act at all, s/he is still making an impact on his/her structure. However, in the healthworlds concept, agency is specifically about intentionality. It is about the agent actively making decisions and acting. So, while the lifeworld is characterized by being "always unproblematic" (Habermas, 1984: 70), the agency aspect is characterized by being always problematic in the sense that there are always problems or decisions that require thought and action presenting themselves. As Germond and Cochrane (2005) point out, capabilities are also attached to freedoms and unfreedoms as Sen would outline. Thus there are also constraints to agency that nevertheless do not negate agency.

The final aspect of the healthworld is the interplay between the lifeworld and agency as is indicated by arrow 1. A lifeworld is not static. It must always change to incorporate the new realities that the agent has faced in order to ensure that these can form part of the background knowledge from which the individual can draw in the future. Thus while the lifeworld continually influences our agency, our agency in turn continually influences our lifeworld.

Another diagram of the healthworld might look like that in figure 11. As has been stated previously, healthworlds are influenced by dominant discourses that exist within a society. Thus an individual might be influenced by the homeopathic discourse of health as well as the biomedical approach. Thus, for colds and flu s/he would visit the homeopath, but for something more serious, s/he may face the decision of having to choose between the homeopath and the medical doctor. Any agent's healthworld will be affected by multiple competing discourses of health. Very rarely will an agent be influenced by just one discourse. Rather they will draw on elements of discourses to form the healthworld. The healthworld will also be influenced by social pressures and will be either confirmed or challenged by problems that require agency.

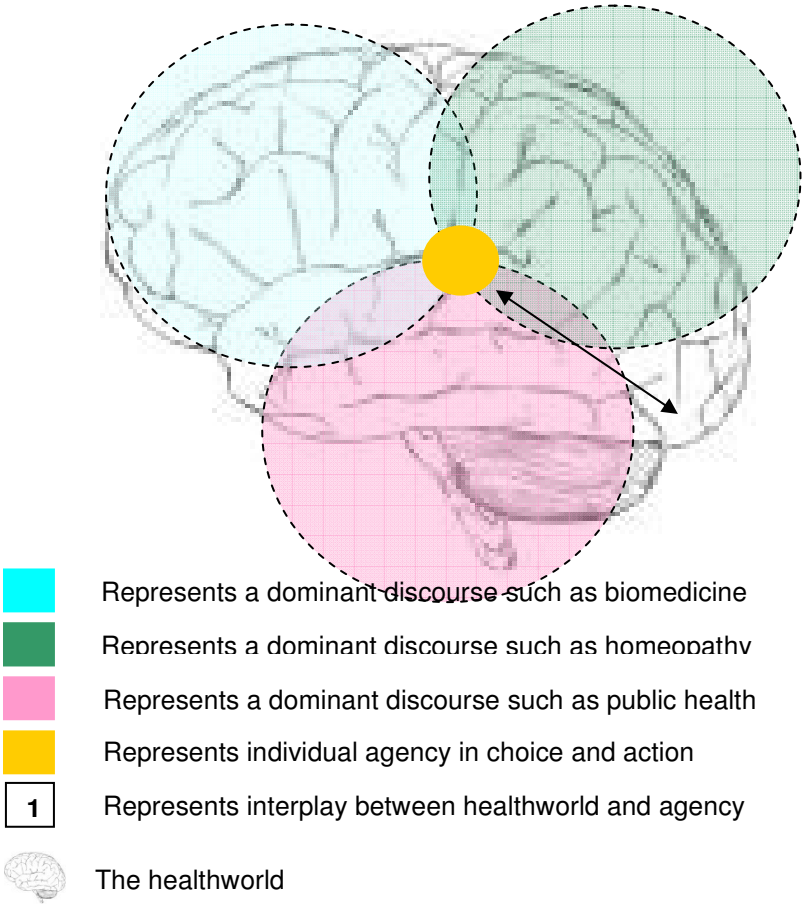

Figure 23: Discourses and the elements of the healthworld

If the biomedical discourse is dominant within an individual's healthworld, they are not likely to choose to visit a traditional healer as was stated by a pharmacy technician at Scott Hospital.

> *No, I believe in medicine and there has never been a time when I felt western medicine was failing. I have never believed at any point that I would find traditional doctors services outwardly provided at hospitals. Besides I think it would rather be insane to see a doctor or a health professional / expert going for services to a traditional doctor, to me it does not make sense (Ntate Matlanyane, pharmacy technician at Scott).*

It must be remembered however, that although an individual may reject the idea of traditional healers, this does not mean that they reject traditional understandings of health, particularly where those have to do with the link between health and relationality, and this is because of the ingrained cultural and linguistic transmission of the discourse.

7.3. Healthworlds at Scott

Having discussed the concept of the healthworld and looked at the four discourses that I have seen as being dominant in Lesotho, what remains to be done is actually analyse what the healthworlds of the healthcare providers at Scott actually look like and what they are made up of. Once again I must point out that every individual has a healthworld that is unique to him/herself. However, as a group there are patterns that are evident. Thus there is a group mind that exists.[27] I will discuss each group – that of the nurses and nurse assistants as well as the technicians.

[27] While it is not within the scope of this paper to go into any detail on this issue, it must be stated that the field of group psychology is a burgeoning field of psychology that looks at how groups form a mind that is greater than that of the individuals within the group and encourages members to old beliefs or carry out actions that they wouldn't normally do when not part of the group. Hence the idea that the nurses at Scott Hospital have individual as well as a group healthworld is not a foreign idea.

7.3.1 Nurse Assistants

I interviewed twelve Nurse Assistants. The nurse assistants tend to be younger than the nurses and are often new to the field of healthcare provision. Although there are some older women who have chosen not to study further and remain as nurse assistants, the majority of the nurse assistants I came into contact with were young and had every intention of continuing their studies. As such, the nurse assistants, most of whom were only in their first or second year of working, would still be significantly influenced by their training which focused on biomedical and the preventative healthcare model (Germond interview).

The effect is that the biomedical model dominates their healthworld quite significantly. Even when trying to push them to think more broadly of health their answers definitely reflected a biomedical dominance.

The public health discourse also plays a significant role for the nurse assistants. However, their answers around public health were not in terms of public health applied to the communities they lived in. They were not able to abstract the benefits of public health or primary healthcare. The evidence of their recognition of the public health model came more from their own experiences as was evidenced in the focus group with the discussion around poverty and health discussed previously. Thus they do not see the broad implications of the public health model. Further, they don't verbalise an understanding of health that incorporates the social aspect. Their recognition of social health is limited to discussion on the importance of counseling as opposed to broad social health in its bophelo sense. I would suggest that this might be because the cultural discourse plays less of a role in their healthworlds than it does for the other practitioners. Having come so freshly from their training, they may ignore the importance of the cultural discourse or not recognise the role that it has to play in health. I would therefore suggest that the cultural discourse has little impact on their healthworld.

The role of religion is fairly significant for the nurse assistants but once again it is expressed at an experiential as opposed to an abstract level. Religion is discussed in terms of its role in their calling or how prayer makes them feel, rather than in its importance for the well being of the hospital or of a community.

In summary therefore, the nurse assistants' healthworld is dominated by the biomedical discourse with their experiences leading to the public health discourse playing secondary role. Religion also plays an important role on a personal level, while the cultural discourse is pushed away. An illustration of their healthworld is presented on pg. 234.

7.3.2 Nurses

The nurses tend to be a bit older than the nurse assistants and are by definition more educated. They are also in positions of authority at Scott and as such have some power to influence policy and the actions that Scott takes.

The nurses seem to have a far more holistic approach to health and healthcare. Although the biomedical model is evident, it most certainly does not dominate their understanding of health. Rather, the public health model dominates with discussions on community and social health being important. In addition, this is evidences in their actions as has been discussed. I suggest that the public health model is so dominant for the nurses firstly because of experience but also because the cultural discourse seems to play a strong role for them. When I say this I do not mean that the nurses embrace traditional healing methods, but that the understanding of health that the cultural discourse offers plays a significant role.

I would suggest that the role of agency for the nurses is more evident. The nurse assistants, being new to Scott seem to be far more influenced by its practices and teachings. The nurses on the other hand show fair divergences from what

Scott teaches. This is especially in relation to the lack of dominance of the biomedical discourse and the significant role that the cultural discourse plays. It seems that their experiences over their working lives have led to their healthworld changing and being dominated by other discourses.

Religion is also important but on a far more abstract level than for the nurse assistants. For the nurses, religion was about unity, and holding the community together rather than about their personal endeavours and the importance of prayer for healing. Religion therefore also plays a lesser, but important role.

The nurses' healthworld is therefore dominated by the cultural and public health discourses with religion playing a lesser role and biomedicine being evident but not as nearly as dominant as would have been expected. Their healthworld is presented on pg. 235.

7.3.3 Technicians

I interviewed two pharmacy technicians and one laboratory technician. All three were male and were in their mid-thirties with families. They all trained at the National University of Lesotho. Due to their training and their work, the dominant discourse for them is the biomedical discourse. The primary reason for this is that their work consists mainly of working in laboratories with samples or with medication. They rarely have contact with patients and are thus not directly exposed to the social and individual realities that the nurses and nurse assistants are. This is not to say that they are biomedical robots that have no other beliefs. However, it does mean that the biomedical discourse is definitely dominant. That said, they are articulate in recognising the role of the social in health and have the same kind of thinking as the nurses about it. That is they verbalise the notion of bophelo so well when talking about unity and harmony. I would suggest therefore that despite them being fairly derogatory about traditional healers, they are in fact fairly strongly influenced by the cultural discourse. The public health

model does not play such a significant role, probably because it really doesn't form part of their daily experience. Religion however is also seen as very important in the same way that the nurses articulate it. Thus, religion is important for unity and togetherness in the community – the health of the social. This is probably also because of the role that the cultural model plays. The lab technicians' healthworld is presented on pg. 235.

7.4. Illustrative comparisons of healthworlds

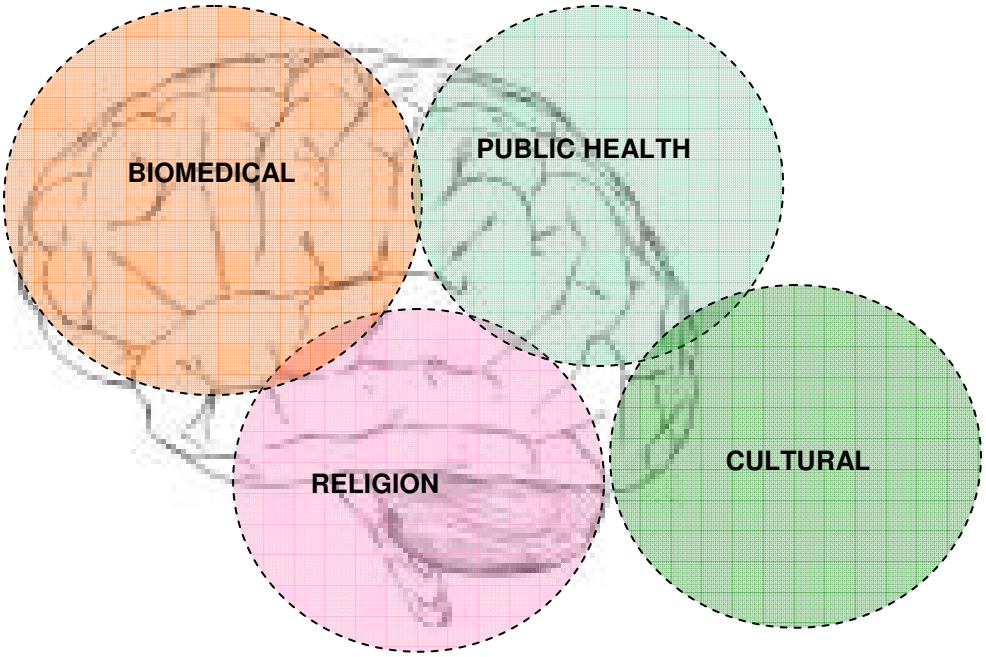

Figure 24: Healthworld of nurse assistants

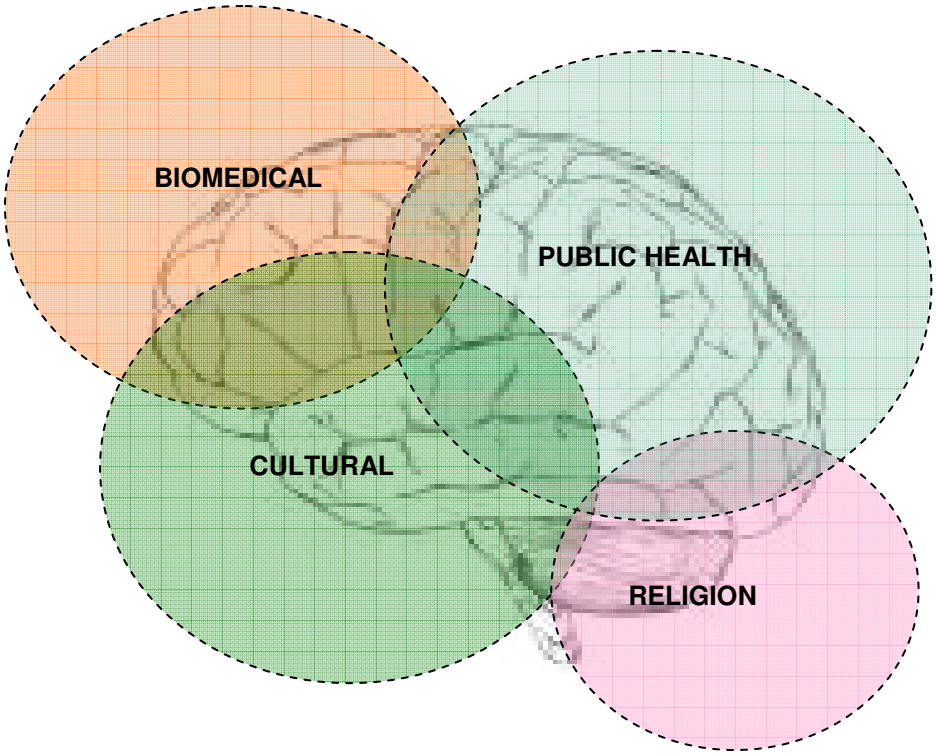

Figure 25: Healthworlds of nurses at Scott Hospital

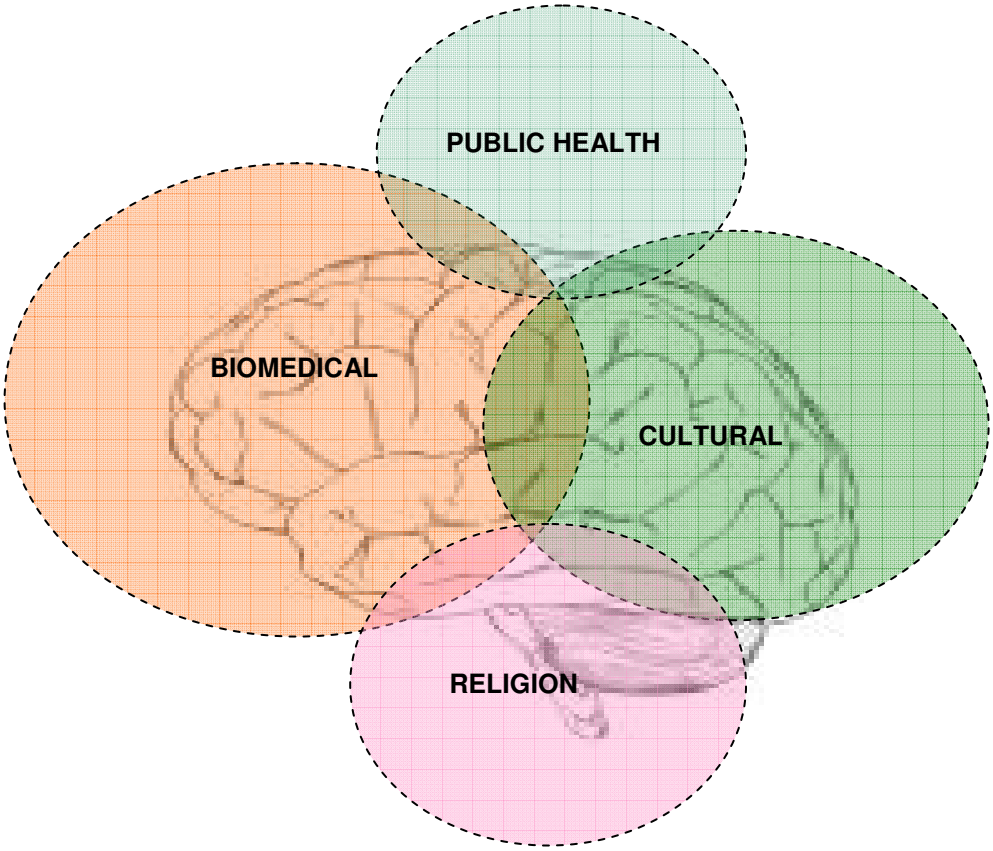

Figure 26: Healthworlds of technicians at Scott Hospital

7.5. Conclusion

As has been stated before, there are multiple discourses of health that exist not only within Lesotho, but more so globally. I have chosen a case study in which I identified four dominant discourses. However, if this study were to be extended the number of discourses around health would be immense. More and more these discourses are beginning to be taken seriously by those that study health. This is primarily because of the fact that each and every individual will find some value in discourses that may challenge the biomedical discourse, which has traditionally been seen as legitimate. This is not just the case for health seekers, but evidently for health practitioners as well. The concept of the healthworld forces us to consider people's agency in their health behaviour and to look beyond simple logic to deeper, underlying discourses that affect the health choices we make.

What this chapter has done is discuss the concept of the healthworld, analyse its importance for a greater understanding of health motivations and illustrate what the healthworlds at Scott look like. The most striking finding here is that all of these discourses, which are often perceived to be contradictory to one another, are held together and compliment each other within the healthworlds of individuals at Scott Hospital as elsewhere.

8. ON FUTURE RESEARCH

The aim of this thesis has been to understand the healthworlds of Basotho healthcare providers. By doing this, it has opened up a discussion about development. Health is an indicator of development as is illustrated in the United Nation's Human Development Index which takes life expectancy into account when calculating relative levels of development. But more so, access to healthcare and attitudes about health and healing speak to attitudes about development. As such, this thesis is primarily a work on development.

Chapter 3 has illustrated how development has impacted on health in Lesotho. In doing so, it has advocated the use of the assets-based approach in dealing with both health and development. By using the assets-based approach to development, this dissertation has shown that healthcare providers at Scott have particular understandings of health that can be seen as assets. One key asset is that they are able to hold competing discourses of health together in one healthworld. Although there are clearly power dynamics at play when it comes to discourses of health, the fact that healthcare providers (and this is no doubt the case for health seekers too) are able to hold these discourses together without tension means that healing mechanisms from each discourse are able to be used in caring for patients and in fact in caring for themselves. Taken a step further, this means that individuals are able to draw from at least four discourses of health when it comes to maintaining their health. This is a key asset that is often overlooked by health practitioners who insist that a particular discourse is the best way of dealing with health issues.

By implication then, this dissertation also contributes to the literature on health seeking behaviour and lay perceptions of health. The literature around health seeking behaviour thus far works from the premise that rational individuals will pursue rational actions to maintain their health. Rational is understood from a particularly Western perspective and is often equated with biomedicine. Other

healing mechanisms such as prayer or traditional healing are usually relegated to the realm of supplementary or alternative. What this research suggests is that in fact these discourses can be used simultaneously and can each be drawn upon to deal with ill health and maintain good health. Furthermore, these 'alternative' discourses are not simply supplementary but are central to the healthworlds for many healthcare providers.

When we as researchers begin to understand the centrality of all of these discourses we can also begin to think of health very differently – as something more than the absence of disease and even as something more than physical, mental, social and spiritual well being but rather as bophelo – life in all its fullness.

Having stated how this dissertation has contributed to the literature and the significance of the findings, it is also necessary to point out the gaps that it has left in order to inform paths for future research. A number of these gaps have been pointed out in the body of this work, but perhaps the key gap that should be addressed in future research is that of critical development theory. This dissertation has advocated the use of the assets based approach to health and development in Lesotho but has been rather uncritical of this approach. In fact, neither Sen nor Nussbaum capture the African reality in their works. From their perspectives, the assets based approach is a particularly individualistic project that does not sufficiently consider the community aspect of health that is so integral to health in Lesotho. Given that the concept of healthworlds draws on the Habermasian, critical realist concept of lifeworld, perhaps critical development theory could better be applied to the health and development situation in Lesotho as well as in other developing nations. What the critical development perspective offers is a recognition of the interplay between the individual and society. Rather than separating out structure and agency, critical development recognises the impact of both. It advocates research that deconstructs major development theories and provides a place for individual voice whilst not being relativist. This

research would contribute significantly to a discussion on critical development theory. However, there is no space in which to tackle that project in this dissertation. Rather these discussions will be left for further research.

It is hoped that this dissertation has given adequate voice to the healthcare providers of Lesotho and that their voices have shown a new direction in both health and development studies. Much work is necessary to fully understand the healthworlds of Basotho healthcare providers and how this impacts on their work. This dissertation is only one step in that direction.

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