HEALTH AND DISEASE IN TWO VILLAGES IN SOUTH-EASTERN LESOTHO: A SOCIAL ANTHROPOLOGICAL PERSPECTIVE

by

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ABSTRACT

Macro morbidity and mortality data identify major disease and health trends for large populations. It is also well known that high infant mortality rates, high incidence of infectious fevers, as well as the variety of diseases commonly associated with malnutrition, are correlated with social conditions of poverty. However, these broad trends say little about peoples' experiences of health and disease in conditions of poverty at the grass roots level. This thesis addresses this issue by focussing on how people maintain health and cope with disease in two villages in south-eastern Lesotho.

It is primarily a descriptive study of the social dimensions of health and disease-coping strategies in a situation of underdevelopment, where the essential resources pertaining to health, viz food, income, shelter, clean water and sanitation are inadequate, largely as a result of the historical and on-going political and economic processes beyond the control of the local people.

The thesis illustrates that in response to poverty, scarce resources are redistributed via a number of social relationships, in order to provide health for a wide range of individuals. Thus, there is no clear correlation between material differentiation of households and better access to health. Material differentiation does play some role in recognition of disease and choice of therapy. This is best illustrated by the fact that extreme poverty limits the individual's choice of therapy, and frequently prevents them from adopting the sick role.

In contradiction to earlier notions that the 'system of explanation' is the primary factor which determines the individual's utilisation of 'Western' or 'traditional' medical systems, there are numerous other factors which play a role in recognition of disease and choice of therapy, such as cost and availability in a geographic area. Moreover, against a quantitative baseline of the villagers' perceptions of their disease experience, incidences of invocation of the supernatural (such as 'witchcraft') are rare. This suggests that medical anthropology's interest in incidences of supernatural explanation have tended to underplay the extent to which people are able to comprehend and utilise natural explanation.

The focus of this study - the relationships between health and disease and natural and supernatural explanation - moves away from the singular disease emphasis of medical anthropology. It is suggested that by viewing disease as 'conflict', many of the problems associated with this approach can be overcome and the interrelationship between health and disease re-established.

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I have given the villages pseudonyms. 'Ngoe ('one' in Sesotho) is the village where the field work commenced and Peli ('two' in Sesotho) the village where I completed the second phase. I have also not referred to anyone by name. This is in deference to the wishes of some of the people who wished to remain anonymous and, because it is the first responsibility of the anthropologist to protect the people with whom he or she works.

I am grateful to Dr Maruping of the Lesotho Ministry of Health for permission to carry out this study and to Dr Sam Smith, Dr Marta Smith, Matron Ranue and the staff of the Machabeng hospital for a happy working experience. Thanks to Barbara and Jens Bjerre and to Ann and Billy Kok for their kind hospitality during my stay in the Qacha's Nek area.

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METSOALLE E RATEHANG

Liteboho ho lona kaofela ka kamohelo e mofuthu nakong ea ketelo ea ka Lesotho ka Tsitoe 1982, le ka Hlakubele 1983, le ka Phuptjane 1983. Ke rata le ho le lebohele tsebelisano 'moho le thuso ea lona lipatlisisong tsa ka, eo ke neng nkeke ka qeta mosebetsi ona haeba ke ne ke sa e fumana. Sepheo sa lengolo lena ke ho le phetela hakhutsoanyane ka mosebetsi oa ka o ngotsoeng bukeng ena.

Ha kea bitsa metse eo ke sebelitseng ho eona ka mabitso a eona a 'nete. Seo ke se entseng ke sena: motse oo ke qalileng lipatlisiso tsa ka bo ona ke o reile 'Ngoe, eare motse oo ke qetileng lipatlisiso ke le ho ona ka o rea Peli. Le bathong ke ntse ke entse joale-ha ho batho bao ke ba bitsang ka mabitso a bona a 'nete. Hona ke moetlo oa Lefapha la Social Anthropology junifesithing ea Cape Town hore mabitso a batho ba thusitseng moithuti ea etsang lapitlisiso, a sireletsoe. Kahoo, mang kapa mang ea balang buka ena, ha a na ho tseba ka ho qeta hore libaka le batho ba hlahang bukeng ena ke bomang.

Ke le bolelletse here ke tlile ho tla ithuta ho lona-mekhoa eo ka eona le khonang ho thibela mafu tlasa moema a bophelo a boima. Bukeng ena ke lekile ho ngola seo ke ithutileng sona. Ka ona mokhoa oo, ke lekile ho ngola lethonyana ka histori ea Basotho ho tloha selemong sa 1869. Ke nako eno, joalo ka ha le tseba, Moshoeshoe I o ile a kopa Engelane ho sireletsa naha ea hae maburung le mangesemaneng a neng a batla ho ikhapela eona. Ka mor a mono Engelane e ile ea busa Lesotho ho fihlela le fumana boipuso ka 1966. Empa Engelane e ne e sa buse Leshtho ka hlokomelo haholo lilemong tse qalang tsa puso ea Engelane Lesotho. Ho ne ho sa hlokomeloe litsela, metsi le matloana a ho ithusa, haholo mahae. Le Afrika Boroa ha e a ka ea thusa haholo karolong tsena. Ke ka hoo ho se nang tsela tse ntle, metsi a hloekileng le matloana, haholoholo lithabeng koana.

Karolong ea pele ea puso ea Engelane, Basotho e ne e le balemi ba hloahloa, hoo ba ileng ba tsoanela ho lefa lekhetho bakeng sa poone ea Lesotho e neng e romeloa libakeng tse ka mathoko. Lekhetho lena le ne le lefisoa balemi ba Lesotho ho sireletsa balemi ba tekatekang ba Freistata le Transefala. Empa ka hanyane naha ea 'na ea nyenyefala, 'me banna ba ea sebetsa merafong ho fumana chelete ea ho lefa lekhetho le ho hlokomela malapa a bona. Nakong ena banna ba bangata ba sebetsa merafong, empa likonteraka le tsona li ea li ntse li fokotseha.

Tlasamaemo ana a boima a bophelo, moo ho se nang metsi a hloekileng, matloana, masimo le mesebetsi batho ba ntse ba leka ka matla ho phela. Ho 'na ho bonahala eka batho ba thusana ka tlamahano ea lelapa, boahisani le metsoalle. Ka tsela ena batho ba bangata ba fumaneloa lijo le matlo.

Ke bontsitse hape mosebetsing oa ka hore le na le kutloisiso e tebileng ka mafu le mahloko. Dingaka le ba thusanang le bona ha ba eso ele ntlha ena hloko. Ke boletse hore le mpolelletse hore letsollo ke lefu le atileng haholo 'me le lumela hore tsebeliso ea metsi a hloekileng ke khato ea bohlokoa bakeng sa ho thibela a mang a mafu a teng.

Le nthutile haholo ka khothalo, bophelo le batho-ke leboha ho feta kamoo mantsoe a khonang ho bolela. Ke mpa ke tsepa hore batho ba bang ba ka balang buka ena, le bona ba tla ithuta ho bona.

ACKNOWLEDGMENT TO THE VILLAGERS

Grateful thanks to all of you for your kind hospitality during my visit to Lesotho between December 1982 and March, 1983, and again in July 1983. I would also like to thank you for your co-operation and help with my research, without which the study would never have been completed. This letter is to tell you briefly about my study.

I have not called the villages where I worked by their real names. Instead, I have called them simply 'Ngoe, where I started my field work and Peli, the village where I completed the fieldwork. I have also not referred to any of the people by name. This is because it is the custom of the University of Cape Town Anthropology Department to protect the identity of the people with whom he or she works. Thus, anyone who reads this book - I am obliged to send a copy to the National University of Lesotho, Roma, and to Dr Maruping of the Ministry of Health - will not know exactly where and whom the study is about.

I told you I came to learn from you - how you prevent and cope with disease in difficult circumstances. In this book I have attempted to write down what I have learnt. At the same time, I have also tried to document a fragment of the history of the Basotho people which I trace to 1869. Then, as you know Moshoeshoe I appealed to Britain to save his country from land-hungry Boer and British settlers. Thereafter Britain ruled Basutoland, as it was called then, until Independence in 1966. But Britain tended to neglect Basutoland, especially during the early part of her rule. She paid little attention to roads, water systems and sanitation, especially in the rural areas. And South African industry has also done little in these areas. Hence, the general lack of good roads, clean water systems and

sanitation, especially in the mountain areas.

During the first part of British rule, the Basotho were outstanding farmers, to the extent that an import tax was placed on maize from Basutoland by the Orange Free State and the Transvaal, to protect the less efficient white farmers. But gradually land became scarce and men went to work on the mines to get cash to pay tax and to keep their families. Now, most men are employed on the mines, but contracts are also becoming scarce.

But in these very difficult circumstances, where clean water, sanitation, land and jobs are scarce, the people are very resourceful. It seems to me that via the bonds of family, neighbourhood and friends, people help each other. In this way they ensure food and shelter for as many people as possible.

I have also pointed out in my study that you all have a very sound and common-sense view of disease. Doctors and other medical people are not always aware of this. I also said that you told me that diarrhoea was your most prevalent disease and you consider the implementation of clean water systems an important way of combating some of your disease problems.

You taught me so much about courage, life and people - I am more grateful than I will ever be able to say. I only hope that others who may read this book will also learn from all of you.

Chapter One: INTRODUCTION TO THE THESIS

> ... the contemporary challenge to the anthropologist who seeks to understand what is happening in the black rural areas of South Africa lies precisely in the possibility and necessity of integrating the experience of individual families with an appreciation of trends at the macro level (Murray,1980:3)

Introduction

The rise of medical anthropology - the anthropological study of health and disease - has increasingly veered towards disease orientated studies (as some recent bibliographies indicate - see, for example, Feirman, 1978). As Janzen (1981) has pointed out, this has resulted in an emphasis on the more unusual disease episodes where supernatural explanations are invoked while health and naturally caused disease, or ordinary everyday ailments are consistently underplayed. More recent studies which focus on both types of ailments point to the statistical rarity of disease episodes where supernatural explanations are invoked (see, for example, Frankel,1981).

The emphasis on the rarer and more spectacular disease episodes tends to exaggerate differences between so-called 'Western' and 'primitive' societies, while similarities are systematically under-emphasised or ignored. This emphasis on differences has significant implications for health-care practice (see Note 1).

In South Africa where the policy of apartheid is partly legitimated in terms of distinct cultural differences between people (see, for example, Multinational Development in South Africa, 1974; Official Yearbook of South Africa,1977), an emphasis on the unusual disease episodes where supernatural

explanation is invoked, is seen to signify different perceptions of disease causation of medical practitioners (see Note 2), and in particular black patients (see, for example, Jansen, 1982:11-16). Areas of shared understanding of disease and its causation are seen to be minimal and 'traditional' beliefs a stumbling block to reduction of disease and improvements in levels of health.

There is clearly a need to broaden the research focus of medical anthropology, both to reveal certain broad similarities between what are assumed to be different medical systems, as well as to improve the practical provision of health care. Areas of shared understanding are useful starting points for better communication between doctor and patient. But more important a move away from the more unusual (albeit spectacular) disease episodes will hopefully serve to focus attention on the more pressing everyday problems which characterise the black populations in Southern Africa today.

With these ends in view this study endeavours to widen the research interests of medical anthropology by including the areas that have been underplayed. First, this thesis addresses the debate concerning the relative importance of the health-disease dimension of the medical domain (Janzen, 1981:185). This leads on to (as will be argued) the problematic distinction drawn between natural and supernatural explanations of disease episodes. The second, less explicit theme, concerns the attempt to relate observed social (and medical) processes at the local level to the broader macro disease patterns and historical and contemporary political and economic process.

The macro mortality and disease data play an important role in the study. They identify the broad health-disease trends for a country or region as a whole (see, for example, Bourne and Dick, 1979:58), but there is also an urgent need for

qualitative grassroots studies which examine popular perceptions and responses to these areas of social life in order to complement macro data (Irwig,1981:21). It is this aim which constitutes the main thrust of the thesis.

Such mortality and disease profiles also play an important role in the operationalisation of the study especially insofar as they provide departure points for the investigation of health, which is a difficult area to circumscribe. They also provide a reference point whereby anthropological findings can be made referable to biomedicine (see Note 1) - a matter of some importance to which Frankel has recently called attention (1981:8) especially if anthropological findings are to inform health-care practice.

Research for this thesis was done in two villages near Qacha's Nek in south-eastern Lesotho. The situation encountered there in many respects epitomises the health profiles and medical problems found elsewhere in black rural areas of Southern Africa. However, the Qacha's Nek area attracted particular attention because a large modern hospital was opened there in 1982. This focusses renewed attention on some of the popular misconceptions regarding the health needs of underdeveloped areas.

Theoretical Considerations

'Health' and 'disease' are the 'A and non-A' of the larger medical definitional category (Janzen,1981:185). It is in this complementary sense 'viz health as absence of disease and disease as lack of health' that these familiar notions are most commonly seen (Temkin,1973:395). The notion of a close interrelationship is found in numerous explorations of the concepts (see, for example, Engel,1953; Lewis,1953; Engelhardt, 1975). For instance, 'disease' may be the 'unnatural' and

'health' the 'natural' (Temkin, 1973:398) or 'health' the 'functional' and 'disease' the 'dysfunctional' (Boorse,1977). The terminology may vary but clearly in a definitional sense health and disease are best and most frequently viewed in terms of each other. Together they comprise the single medical domain which suggests, from a definitional standpoint, that a medical study should endeavour to include both health and disease.

But, as pointed out, studies in medical anthropology not only emphasise disease, but also tend to focus on the more unusual episodes where supernatural explanation is invoked and ordinary ailments or incidents of natural causation are underplayed (Frankel, 1981:109). Yet, 'natural' and 'supernatural' like 'up' and 'down' and 'in' and 'out' imply an opposition such that each is best understood in terms of each other (King, 1975:13), which is similar to the relationship between health and disease

To start the discussion on what is understood by the terms natural and supernatural with respect to disease, the following broad statement can be made. 'Natural' causation refers to those diseases which have a 'nature' - ie, they have a recognised cause and a regular and predictable course. 'Supernatural' refers to those which are perceived to be inexplicable by natural laws and are apparently 'irrational', 'abnormal' or 'extraordinary' (Evans-Pritchard, 1976(1937): 30-31; King, 1975:13-15). However, the terms are more complex than such a simple definition implies. What is deemed natural or supernatural can vary over time and place and between

individuals in various situations - which may have a bearing on a researcher's selection of interest areas for investigation.

Sperber has argued that anthropologists have consciously and unconsciously tended to select and focus attention on beliefs and behaviours which they consider to be abnormal or supernatural. What 'interests concerns and delights .... (is) .... all activity whose rationale escapes' the observer (Sperber, 1979:3-4).

Similar criteria may play a role in directing choice of disease episodes for medical anthropological investigation. Some scholars would not include ordinary ailments or those without a 'socially significant' (ie. supernatural) cause worthy to be included in a 'chapter on medicine' (Glick, 1967:35). Moreover, disease episodes which include supernatural explanation also entail the use of a variety of therapeutic avenues (see, for example, case studies analysed in Janzen, 1978). Thus, in addition to appearing more obvious (because the researcher perceives them to be different), such disease episodes will also appear more important because of the lengthy therapeutic process usually involved.

It has also been suggested that an emphasis on episodes of supernatural explanation is linked to a misinterpretation of Evans-Pritchard's classic study of the Azande (see Gillies, 1976:358; Janzen, 1981:188-189). Evans-Pritchard was concerned to illustrate the rationality behind the Azandes' belief in witchcraft as a means of explaining apparently extraordinary events (see, for example, 1976(1937): 63-83).

Hunter makes a similar point regarding natural causation. The common cold is a relatively familiar event, especially in winter (as we know from our own experience), and does not

prompt higher level explanation among the Pondo. However, if the afflicted individual develops pneumonia and dies, the situation becomes unusual and supernatural explanation ('witchcraft' for example) may be invoked (Hunter, 1969: (1936):273).

Thus, the invocation of witchcraft as a cause of misfortune (or illness) only occurs where natural causation is deemed inadequate. At the same time, however, witchcraft explanations do not preclude a significant awareness of natural causation (see, for example, Hunter, 1969 (1936): 272; also Ashton, 1952:300-301 with specific reference to the Basotho).

We also need to remember the research interests of these scholars. They were concerned to point out the 'rationality' behind the belief in witchcraft and how explanations of misfortune worked for society as a whole. In other words, they were not looking at disease as such but as a broader category of general misfortune. While disease was viewed simply as one element of misfortune for the earlier scholars, disease associated with misfortune, to the exclusion of other ailments, became the central concern of a number of subsequent medical studies (Lewis, 1976). Consequently, the focus of medical anthropology has tended to be narrow and important areas of investigation are largely under-researched.

Studies which focus on quantifiable disease data point out that invocation of the supernatural is rare (Gillies, 1976; Warren, 1979; Frankel, 1981:109). By focussing on the supernatural, generalisations are being made which are based on investigations of only a limited aspect of medical behaviour. This often leads to emphasising differences in disease perceptions and neglecting areas of common understanding.

A narrow approach to the investigation of disease also tends to underplay changes in medical behaviour and perceptions that emerge through experience over time (Frankel,1981:89). Furthermore, as pointed out earlier, disease episodes which involve higher level explanation frequently entail the use of a number of healing options. Yet, it is often only the better-off members of a community who can afford a number of consultations (see, for example, Segar,1982:55). Poverty may prevent an individual adopting the sick role if this means an inability to continue work (Stiano,1981:329). Therefore, by focussing narrowly on the more unusual disease episodes, the responses of other, for instance the poorer members of a community, may be ignored.

Where the emphasis tends to be on explanation as a determinant in choice of healer (see, for example, Janzen,1978), other factors such as cost (Westcott,1979:283), availability in a geographic area, and perceptions of quality and effectiveness of service are not taken into account (Last,1981:392). These are all factors which are most likely to highlight the more commonsense aspects associated with choice and selection of the available therapeutic options.

Clearly there is a need to broaden the research focus of medical anthropology to include those areas that have been underplayed. The perception of disease causation in both ordinary and unusual episodes needs to be examined, as well as factors determining the therapeutic responses of all members of a community. Such an approach provides useful quantifiable data (see, for example, Lewis,1975; Frankel,1981), and also recognises factors such as income, cost, and availability of healing resources in a geographical area, which are all significant when investigating disease profiles, legitimation of disease and choice of therapy.

The general views of health and disease discussed earlier imply that health (normality) is the context in which disease (abnormality) occurs. They also point out that disease (in the context of health) is recognised as deviation from normality, which is commonly a 'biologically measurable norm' (Mishler, 1981:11). But the exact point of deviation may be difficult to identify (Engel,1977:130). The more obvious upper and lower limits of deviation may be identifiable but this leaves large 'grey' areas where distinctions between normality and abnormality are less easily distinguished.

Lewis refers to the interrelationship between health and disease as 'merely uplands and lowlands in a continuously graded and terraced country' (1953:110). The 'peaks' of the 'uplands' may be identifiable as marked deviation from 'normality', but the various levels of deviation on the 'slopes' are less distinguishable and the point at which 'normality' merges into 'abnormality' is difficult to recognise.

The solution appears to lie in taking cognisance of both dimensions (ie disease and health) without dichotomising the two or rigidly defining either. In a sense, therefore, they merely constitute poles of a continuum with the one necessarily referring to the other.

The health dimension of the medical domain has received minimal attention thus far in medical anthropology (Janzen,1981). Ngubane's ethnography of health (1977) is perhaps an exception. But she tends to focus on utopian beliefs about an ideal state of health. Apart from the difficulties of defining ideal and its ambiguities (see Dubos,1977:32 and Engelhardt,1975:124), she gives little attention to the practical day-to-day issues of nutrition, lack of clean water, inadequate sanitation and generalised poverty which plague the vast majority of Southern Africa's rural population.

Janzen, who has urged that a greater attention should be paid to the neglected area of health (1981), proposes an operationalisation of the concept (1982). In doing so he draws on an earlier definition and makes a clear distinction between the health and the medical system (1982:2). He sees the study of the medical system as essentially focussing on peoples' perceptions of disease, its explanation and treatment (1980:9). The health system refers to a separate domain which requires a different investigation (1982). It examines, amongst other things, methods of hygiene, nutrition, social interaction and organisation (1980:8). The areas for investigation Janzen focusses upon are useful and important. But, considering the interrelationship of health and disease, whether these should be separate investigations is questionable.

Leslie also make a distinction between the health and the medical system (1978:xii-xiii). Health systems analyse the adaptive and dysfunctional relationships between a human population and its parasites, its patterns of nutrition, fertility, mortality and so on. They are epidemiological and ecological studies about the interrelationships between species as they affect the normal functioning of human beings. They may use social categories, but are essentially based on the theories and perspectives of biomedicine (1978:xii).

Medical systems, on the other hand, are ethnomedical studies. Their boundaries are not those of biological species and ecological networks, but social ones of political and cultural exchange. They analyse acts of consultation between laymen and specialists and acts among laymen to cure, alleviate or otherwise cope with physical affliction (1978:xii-xiii).

There are similarities between Janzen and Leslie's notions of the health and medical systems. For both scholars the medical system is primarily an ethnomedical study. The health system concerns matters such as hygiene and nutrition,

and the adaptive and dysfunctional relationships between a human population and its environment. But most important, as Leslie states and Janzen clearly implies, health systems include the normal functioning of a human population as it interacts with its environment.

The distinctions Leslie and Janzen make with respect to the health and the medical system, reflect the two broad categories of studies - ethnomedical and epidemiological/ ecological - which Fabrega states comprise the interest area of medical anthropology (1971). But in recent times ecological/epidemiological studies have tended to fall within the domain of biomedicine, and ethnomedical studies comprise the major portion of medical anthropology. Epidemiological/ecological studies seldom address ethnomedical issues, and it is perhaps the failure of ethnomedical studies to address some ecological and epidemiological issues that has led to the underplaying of health or normal functioning. This study, by endeavouring to bridge the health-disease divide, albeit to a lesser extent, endeavours to bridge the epidemiological/ecological - ethnomedical divide.

Such an aim, to move away from the disease orientation of medical anthropology and bridge the health-disease divide, requires an alternative theoretical framework. Many current theoretical debates in medical anthropology concern the notion of the medical system which is largely disease orientated (see, for example, Press,1980). Basically, there are two views, the 'closed' and the 'open'. Scholars who favour the former have been referred to as the 'systemisers' and those who favour the latter as the 'contextualisers' (see Studies in Medical Systems, 1981: 217); Studies in the Modification of Medical Culture,1981: 351-352).

For the systemisers, disease-related beliefs and practices which include perceptions of affliction, therapies and practitioners' roles, are viewed as a discreet and autonomous domain. Their analyses aim towards a system of tightly-linked concepts, practices and social roles separate from and unmodified by historical, political and economic process (see, for example, Greenwood,1981).

Such an approach is criticised for its tendency to over-systemetise and critics point out that in the systemisers' concern with 'cultural classification' much of the 'individual perspective' is lost (see Last,1981; Feierman, Helman, and Mudimbe in Issues and Findings, 1981:433). In effect, commentators are saying that systemisers, via disease-related beliefs and practices, seek the cultural essence that will distinguish a particular social group. Culture is seen as a group and behaviour-determining characteristic rather than a mark of the general human condition. According to this view (which is not necessarily confined to medical anthropology), society is seen in a diversity of distinctly different cultures (Sharp and West,1982).

The view that culture is a mark of the general human condition, rather than a distinguishing and determinant characteristic of a group, is not necessarily new to anthropology. As early as 1889 Boas suggests that culture is the ability of the human individual to put meaning on the 'flux of experience' (Stocking,1968:159). In other words, culture is not a fixed unchanging determinant of behaviour, but the ability of the human individual through the experience of social life to impart meaning to a dynamic environment in order to interact meaningfully with it.

The contextualisers or the protagonists of the open medical system, in their concern with historical, political and social process (see, for example, Comaroff,1981), favour

an 'open' view of culture. They also highlight the inter-relationship of disease-related beliefs and practices and other aspects of social life (see, for example, Janzen,1978). But their interest remains primarily within the realm of disease, especially the more easily recognised episodes which involve a lengthy therapeutic process.

However, the problem of trying to view disease as an integral part of the health process, rather than as merely the opposite of disease, still remains. In this regard, some of the insights from theorists who have written on the theme of conflict in society might prove useful.

Simmel recognised some similarity between conflict in society and disease within an organism by using a disease metaphor to illustrate how he viewed conflict:

> Conflict is a way of achieving some kind of unity .... This is roughly parallel to the fact that it is the most violent symptoms of a disease which represent the effort of the organism to free itself of the disturbances and damages caused by them (1908, in Levine, 1971:70).

At the time of Simmel's writing the organic analogy was a popular one in the social sciences and this might account for his choice of the disease metaphor. But the analogy between health and conflict is useful in that it serves to emphasise the extent to which disease can be viewed as an integral part of the process of searching for health. However, one must not fall into the trap of therefore assuming that health represents a state of normality or equilibrium, as some theorists were accused of assuming for society (Radcliffe-Brown,1952:7).

In fact, one should rather emphasise that disease, like conflict, is an integral part of normality and that normality does not necessarily constitute a state of equilibrium.

Plan of the Study

Health as a social normality in which disease episodes occur is not easy to circumscribe (Janzen, 1981:186; Lewis, 1981:214), and some writers argue that it is too vague a concept to constitute a useful research focus (Bibeau, 1981:431-432).

The World Health Organisation defines health in positive terms - more than merely the absence of disease. Health, for it, constitutes complete mental, physical and social wellbeing (see Polgar, 1972:330). The utopia implied in this definition has been criticised as both unrealistic (Dubos, 1977:32), vague and ambiguous (Engelhardt,1975:124).

Nevertheless, there have been some, although few, attempts to conceptualise and operationalise health. However, especially at the level of practice, a number of problems are posed. While Janzen (1980:8 and 1982) and Leslie (1978:xii), both focus on the practical issues associated with health-maintaining behaviour, they nevertheless see it as a separate type of investigation which tends to ignore the interrelationship of health and disease. Ngubane (1977), as mentioned earlier, focusses on utopian beliefs and avoids many of the practical issues which face Southern Africa's black rural populations. This is not to deny that people do have beliefs about an ideal state of wellbeing. But it is only by commencing with the everyday practicalities of maintaining health that such beliefs can be put into their proper perspective.

In adopting a practical approach to health, regional or national, mortality and disease profiles which are relatively easily accessible, provide useful guidelines. Such statistical

information refers to the 'unhealthy' aspects of a community (Bourne and Dick, 1979:57). But in the sense that disease and health are closely interrelated and commonly seen in terms of each other, it is from the unhealthy that epidemiologists infer broadly about the 'health status' of a social group (Bourne and Dick, 1979:58). Moreover, at the same time as mortality and disease profiles inform about the health status of a community, they also indicate characteristics of the social conditions which may serve as departure points for the study of everyday health as the 'modus vivendi' (Dubos, 1977:32).

Lesotho, where this study is carried out, has a high infant mortality rate, low life expectancy (see Tables 1.1 and 1.2) and the commonest reported diseases are:

> diseases like typhoid and gastro-enteritis are endemic. The most prevalent diseases are these plus venereal diseases, measles, mumps, whooping cough, and tuberculosis. Chronic malnutrition is widespread (Lesotho Third Five Year Development Plan, 1980-1985: 327 - see Notes 3 and 4),

It is well known that this combination suggests social conditions of poverty and under-development: a lack of adequate clean water, sanitation, food, shelter and income (see, for example, Savage,1979; Kirsch, 1979). Because food, shelter, clean water, sanitation and income are universally recognised as primary determinants of health (see, for example, Morris,1979:20), I focus on these dimensions of life in the two villages to create the context of health or social normality.

Because this study adopts a practical approach to health (Dubos,1977:32), which implies social action, the focus

Table 1.1 Deaths per every 1000 infants born in a selected sample of the world's countries

Sweden	9	Malaysia	75
Iceland	11	Albania	87
South Africa (whites)	12	Botswana	97
United Kingdom	16	South Africa (average)	117
United States	17	Zaire	160
West Germany	21	Niger	200
Guyana	40	South Africa (rural blacks)	240
		Lesotho	106-130

Source: Perspective,1982:9

The figures for Lesotho have been added - Report on a Joint Mission to evaluate the Lesotho expanded immunisation Programme, 1982:11)

Table 1.2 Life expectancies at birth for a selected sample of the world's countries

Lesotho	50,9
Kenya	55,7
Malawi	49,1
Australia	71,2
Canada	73,1
Denmark	73,9
United Kingsom	72,2
United States	72,2

Source: Morris,1979:128-133

becomes more specifically peoples' strategies to maintain health and to cope with disease in two villages where the primary determinants of health are inadequate.

A micro village-based investigation will have little meaning unless examined in the context of historical and contemporary political and economic process. In this way we are informed about events leading up to the present, as well as some of the factors in the wider social context that villagers face in their efforts to survive using limited resources and to cope with disease. The village ethnography viewed within the context of macro social process constitutes the broad framework of this study.

Within this framework an historical chapter reviewing some of the political and economic processes which have contributed to the present national situation of a general inadequacy of clean water, sanitation, nutrition, shelter and income, lays the foundation for the ethnography. Thereafter, the reader is introduced to the villagers whose lives are the concern of this study. This section discusses the settlements and their local surrounds, and is largely data-based with tables compiled from a question schedule (see Appendix A). The tables show demographic profiles, household composition, material resources (such as land and livestock), and employment profiles. With the setting thus created, both at a national and local level, the ethnography follows.

Food, shelter, income, water and sanitation are the focal areas for the investigation of health which is examined at two levels. Water and sanitation (see Chapter five), which are matters of infrastructure, and largely beyond the financial scope and technical expertise of the average household, focus attention on some of the wider political and

economic factors affecting the health of a population. Food, shelter and income, over which the household has some control, are the focus for household health strategies in chapter three.

Food, shelter and income are interdependent at the household level. Agricultural yields are insufficient to feed an average household and the majority of sustenance requirements are purchased (see, for example, Wallman,1969:66-67). 'Building of the homestead' (see Spiegel, 1979:50-52), which is the notion of shelter adopted for this study, also requires considerable cash outlay. It is difficult to separate out the interdependence of income, food and shelter. But for the purpose of planning the study, as is discussed below, food is a measure of the day-to-day demands on the household budget and 'shelter' tends to reflect these over time.

However, it must first be pointed out that chapter three is not a study of food in the nutritional sense (ie what constitutes an adequate diet), nor an investigation of levels of nutrition in the country. Numerous studies of this nature have been undertaken (see, for example, Williams, 1971:32-33), and such studies tend simply to demonstrate and document the interrelationship and extent of the poverty, malnutrition and disease.

Daily food intake is a starting point for the investigation of household health strategies. Food is a basic and regular necessity for the maintenance of physical survival. Examining what constitutes the daily diet of the household; where the cash to buy food or work the fields comes from, and how food is distributed among members of the household, or in the community, gives us some indication of the social relationships between individuals and households. Such social relationships

are one of the primary interests of this investigation, being the broad health strategies that are frequently the most observable.

While food points to the more immediate day-to-day health strategies, the notion of shelter adopted in this study is intended to give greater time depth to the process of survival (and hence the maintenance of health). It is important to view shelter, not simply in terms of a roof over the head, but in a much broader sociological sense (see also Marais, 1972).

As Murray and Spiegel argue, the process of 'setting up house' (Murray,1976) or 'homestead building' (Spiegel,1979) is crucial for a migrant and his dependants. The majority of adult males who are employed as migrant labourers in the Republic of South Africa (and have been since the last century), are barred from settling in the urban industrial areas (which is the normal process in a situation of migrant labour - see Wilson,1972:145-152), by stringent influx control which masquerades as immigration laws. Thus, with little or no chance of permanent urban settlement and the added insecurities of contract migrant labour, the building of the homestead and all it entails becomes an essential source of rural security for the worker and his or her dependants.

Spiegel (1979:4-8) has related the process of establishing the homestead to the different phases in domestic development (see Fortes,1958). In describing the domestic developmental cycle, Fortes has pointed to the changing size and composition of the domestic group as it passes through various phases from the earlier phase of expansion (when children are being born to a young couple), through the zenith (a later phase when children are grown up and on the verge of leaving the natal home to marry and start their own home), to the decline (when an elderly couple are alone after the children have left the natal home).

In Lesotho, during the phase of expansion, the process of establishing a homestead starts with the granting of a residential site for the construction and furnishing of the physical homestead dwellings and marks the householder's membership of the community. It also includes accumulation of livestock and sharecropping arrangements which extend householder's rights to grazing on communal ground, and arable land (see Spiegel,1979:50-52). The household in the zenith is frequently depicted as one with access to arable land, and a number of dependants, one or more of whom are wage earners (see Spiegel,1979:6-7). Households in the decline are small, dependants have left the natal household and are frequently without access to migrant earnings. But during the decline of domestic development, earlier investments in arable land and livestock, during the process of homestead building, are useful means towards strategising for survival (see Spiegel,1979:7).

Homestead building, or the process of shelter, requires considerable expenditure which is broadly related to the different phases of domestic development. This needs to be kept in mind when examining the day-to-day strategies for survival. Here the categories of material differentiation are useful.

The significant material differentiation in conditions of generalised poverty which is reported for Lesotho (see Murray,1981:86), is also related to the different phases in domestic development. Households with arable land and direct access to migrant earnings, in the zenith of domestic development, are more advantaged than wage-dependent, landless households in the expanding phase or, landless, landless and wageless households which are in the decline of domestic development (see, for example, Spiegel,1979).

The categories of material differentiation which are used to present the ethnography provide a framework whereby factors which affect food consumption patterns, such as size of

household and numbers of wage income-earners can be kept constant. At the same time there is a time depth which measures the demands of homestead building on a household budget.

The categories of material differentiation are also useful for some of the broader aims of this study. The material differentiation noticeable in Lesotho is related to a dependence on migrant labour (Murray,1981). By using the categories it is also possible to trace some of the effects of a dependence on migrant labour on the health of rural communities.

The villagers' disease experience is examined against the background of health outlines in chapter three. Householders' disease experiences (ie the name of the condition, its perceived cause, choice of therapy and reasons for that particular choice) over a period of time, are elicited from the question schedule. This information provides some quantifiable disease data of the villagers' view of their disease burden (see, for example, Lewis,1975; Frankel,1981), and is the basis of the disease ethnography.

When discussing disease ethnography, some writers make the distinction between 'disease', the biological or biomedical conceptualisation, 'sickness' the social or recognition by others of an individual's affliction and 'illness' the individual's subjective experience that all is not well (see, Frankenberg and Leeson, 1976:277; Young,1976:6). Other writers distinguish between 'disease' the biomedical notion, and 'illness' the popular perception (see, for example, Kleinman,1980:72-80). Hahn and Kleinman who have subsequently modified the distinction, define 'illness' as the first stage in the affliction process and 'disease' as the 'diagnosis', either by a biomedical or indigenous healer, following consultation with a patient (Kleinman,1983:97-99).

By allocating different meanings to various commonly used alternative terms for disease, there is a danger of implying rigid distinctions between popular, folk healer and bio-medical views of affliction. To avoid this danger, especially as this study is concerned to move away from an emphasis on differences and to explore areas of shared understanding, I use the term disease in its broad sense as the complementary aspect of health. Where I do use alternatve terms, such as sickness, illness, ailment or affliction, especially when discussing the villagers' disease experiences, it is largely to break the monotony of a continuous repetition of the same term.

The disease ethnography covers two chapters. Chapter four examines the householders' responses to disease episodes against the background of health, discussed in chapter three. Evidence suggests that numerous factors come into play in the recognition of disease and choice of therapy, such as relative wealth, size and composition of the household, cost of therapy and transport, availability of healing resorts in a geographical area and expectations of quality of service rendered. Supernatural explanation as a determinant of therapeutic action plays a minor role. Indeed, incidences of invocation of the supernatural, as well as the more unusual conditions are rare when examined against the baseline of quantifiable disease data, and a belief in natural causation predominates.

In Chapter five, the significance of a predominant belief in natural causation is examined, particularly for what it suggests about the sharing of medical ideas and the similarities between so-called different medical systems. Some incidents where supernatural causation of disease is invoked are also examined which, when analysed in the

context of contemporary Lesotho, are found to be unquestionably 'rational'. Furthermore, a belief in witchcraft as a possible cause of disease presents no barrier to the use of health-care services, nor to the recognition by the people of the value of biomedical therapy in a number of areas of prevention and cure of disease.

The villagers' views on health also tend to be very practical. Most of the respondents stated that clean water systems are the priority if diarrhoea, which they consider to be their major disease burden, is to be controlled. The need for clean water systems is also expressed by the residents of other rural settlements (2FYDP:209). Yet, a new hospital was built in Qacha's Nek between 1979 and 1982. An examination of some of the reasons why the hospital was built, rather than clean water systems or sanitation (also poorly supplied) were implemented, reveals that political and economic considerations play a major role in directing contemporary development aid strategies. In addition, the constraints imposed by the regional power, the Republic of South Africa, serve to exacerbate the poverty and under-development which is largely to blame for the present morbidity and mortality profies.

In chapter six, some ideas from the scholars of local level conflict are proposed for viewing the disease in its relationship with health. As mentioned earlier, the extended research focus of the study requires some alternative to the largely disease-orientated medical system. A review of the ethnography presented in chapters three and four reveals that, at a general level, the health-disease relationship can be viewed as a conflicting one. At the level of analysis Turner's notion of the 'social drama' (1972(1957):xvii and 91-93, which he uses to examine local level conflict in the process of social life, can be employed to examine a disease episode in the context of health.

Epstein's notions of local level conflict are also useful. He views episodes of conflict as 'internal inconsistencies' (1973(1958):xvii), which 'provide part of the momentum to further adjustment and change' (1973(1958):228). His notion when applied to a disease episode, illustrates that a disease experience does not result in a return to a state of pre-disease equilibrium but, on the contrary, is the 'momentum' or stimulus for changes in disease-related beliefs and practices.

In the concluding chapter I address some of the wider issues raised by the findings of this study. The findings point out that, broadly, the nature of health is an egalitarian one, and the villagers have a very commonsense view of disease. Furthermore, the rarity of incidences of natural causation against a predominant belief in natural causation, suggests significant sharing of ideas about disease between the villagers and biomedical practitioners. This makes it extremely difficult to draw rigid distinctions between 'traditional' and 'western biomedical' medical systems.

Finally, it is suggested that on the basis of shared high infant mortality rates, low life expectancies and common disease profiles, these findings are reasonably representative of popular health and disease strategies in other parts of black rural Southern Africa.

Method of Fieldwork

A preliminary visit was made to the fieldwork area in April 1982. During this visit I obtained permission to carry out my study from the hospital authorities in Qacha's Nek and from the Ministry of Health in Maseru. I was also able to gain an initial impression of Qacha's Nek and its surrounds and to meet a number of people. The bulk of my fieldwork was carried out between November 1982 and March 1983, and a final visit was made to the villages in June 1983. Immediately after my arrival in November 1982, I found accommodation in the home of a family at 'Ngoe and later while researching at Peli, I also lodged with a family.

During the first six weeks of fieldwork, being a trained nurse, I was able to work at the hospital as an assistant in the Out Patients Department. This had the advantage of helping me over my initial nervousness and insecurity. I was able to meet a variety of people, was invited to a number of village and hospital Christmas activities and attended the official opening of the hospital in December 1982. I was therefore able to gain some general impressions and to make myself and my research known to the people I met.

Naturally I was also aware of the disadvantages of working at the hospital. For example, it can be said that my association with the official government and major health-care institutions in the district jeopardises the freedom with which people can discuss beliefs and practices re-

garding disease (especially the more 'unusual) and their perceptions concerning the quality of service given by the institutions. With this in mind I tried to dis-associate myself from an official nursing role. I did not wear a nurse's uniform and my tasks included weighing babies, testing urine, which were similar to those done by other village women who assisted at the clinics. I also made a point, during the subsequent more formal household survey, of including questions on whether 'witch-craft' is a cause of sickness, also what their thoughts were regarding 'motheketheke'. (I discuss this condition in greater detail elsewhere, but for now it can be under-stood as a typically 'African' disease, see Ashton,1952: 284).

One can never be entirely sure whether one's efforts are successful, and my findings must be interpreted against this possibility. However, during the following months of my fieldwork, I was re-assured by responses and peoples' reactions to me, that my association with the hospital did not prove a significant barrier to the openness with which they responded to the questions. I give some examples.

I was re-assured by the wide range of answers to the questions regarding 'witchcraft'. Some answered a definite 'no', others said 'sometimes', some chuckled and others, among whom were patients in the hospital where I worked, expressed their beliefs quite freely. Villagers were also quite frank about their perceptions, both good and bad, of the various health-care institutions, which included the hospital. Also, the indigenous healers were most co-operative in giving of

their time and discussing their healing rituals and practices in detail. What was most revealing to me was my role in diagnosis and therapy decision-making in the village.

It is a well known fact that the major part of therapy decision-making occurs among family, friends and neighbours (see Kleinman,1978:86; Elliott-Binns,1973). The participating researcher becomes part of this network. Many anthropologists have remarked on how they have been called upon to visit and diagnose the sick, for 'disprins' and to do 'first aid'. It may seem surprising but I was seldom asked to intervene in any way. On a few occasions when my opinion was sought it was more a matter of politeness to draw me into the conversation and to tell me what decisions had been made, rather than to ask my professional advice.

One can put forward a number of reasons for this. For example, I did not have transport which the villagers may have called upon to get them to hospital. I must admit that I did not offer advice unless I was asked for it. After all, I had come to learn not to teach and, as the findings reveal, the problems the villagers face are not in diagnosis and in knowing what to do in the event of disease. The villagers are very well aware that the major obstacles to improving their health status lie in factors beyond their control (and mine too), such as a lack of clean water systems. The point is, however, that although I spent the first six weeks of my fieldwork working at the hospital, I was not necessarily seen as anyone with specialised knowledge.

After the first six weeks I commenced the more formal household interviewing. Because my command of the language was inadequate to conduct interviews, which included questions on some sensitive and intimate issues, I

was assisted by a very able translator. Mamafahla had learnt her English while in domestic service in Durban. The unfailing warmth and sensitivity of this remarkable woman ensured our acceptance by the villagers at all times.

For the more formal interviewing I used a question schedule. This schedule guided interviews with 50 percent of randomly selected households at both villages. A copy of this schedule is attached as Appendix A. The first part is designed to elicit some basic household socio-economic information (such as household demographic data, material resources and employment profiles). It is directed at probing household health strategies. The second half examined villagers' disease experiences. Respondents were asked about the diseases they, or their dependants, had encountered during the preceding ±6 months, what they considered had been the cause and how they had responded. This information provided the basic quantifiable disease data. I also observed and noted, in addition to this reported information, several disease episodes as they proceeded through the various stages of diagnosis and therapy.

I include the latter episodes in an effort, within the limitations of a project of this nature, to control for the problem of recall. Recall of symptoms is said to distort the original experience and is a major problem in studies of disease. Frankel remarks that the longer the recall period the greater will be the under-reporting of minor symptoms (1981:86). To control for the problem he used a 'fortnightly recall period' (1981:80). His team of three assistants visited the people who took part in his study to observe and enquire about symptoms and illness experience over the two week time span. Unfortunately, considering the limitations in both time and funding of my project, Frankel's thorough-going methods were not possible.

Zola also notes the 'notoriously poor recall that individuals have for past medical experiences'(1978:125). He tackles the problem by studying patients 'in the procees of seeking medical aid' (1978:125). Studying individuals in the process of therapy is widely used in medical anthropology and has the obvious advantage of controlling for the problem of recall. But by using this method, researchers tend to focus on the more obvious lengthy disease episodes. The lengthy disease episodes are the more discernible in on-going social life because they involve the use of a number of healing options. Nevertheless, for reasons I have mentioned, this study has as one of its specific goals the investigation of disease episodes which do not necessarily reach the healing resources. It is for reasons such as these that I have used recalled disease experiences as well as those directly observed.

It must also be pointed out that questions, such as those concerning infant deaths, are extremely sensitive issues. This was brought home to me very clearly on one occasion shortly after I had commenced the formal interviews. I opened each interview saying that the respondent was under no obligation to answer the questions or to discuss any specific area that they did not care to. However, when discussing the circumstances surrounding the deaths (some years earlier) of one of her infant children, one woman was extremely distressed. It was clear that her immediate situation was also causing her much anxiety. Her remittances were late, she did not know how she was going to feed her children, and there were school fees to be paid. The memories sparked off by the interview were very painful.

It was also an upsetting experience for Mamafahla and myself. I was prompted to question my right, or those of any researcher in a project of limited academic scope, to

probe these sensitive issues. It was nevertheless a valuable warning and thereafter we proceeded very cautiously and I made the point of repeating my opening proviso before the second half of the interview where I questioned circumstances surrounding infant deaths and other personal matters. Notwithstanding, most people were more than willing to discuss their disease experiences and it was only on three subsequent occasions that individuals declined to talk about an infant death, the death of a spouse and barrenness.

For the dietary information I used food diaries. All householders interviewed were asked to keep a list of what they and their dependants consumed over one week. Again, there are some problems with this method. But, it must be noted that for any study of dietary habits it is a problem to control for the numerous variables that can affect food intake (such as individual preferences, individual appetites, availability in a geographic area, food costs and so forth). Moreover, it must be remembered that this is not a study of food consumption in the nutritional sense of what constitutes an adequate diet. Such a study would require weighing and analysing food portions by trained nutritionalists using sophisticated laboratory equipment.

One of the problems I encountered was that although I gave paper and pencils and the diaries were collected, returns tended to be poor, especially amongst the most impoverished members of the villages. Literacy may be a factor, but not entirely as literacy standards are relatively high in Lesotho. In addition, the women are busy as household managers, agriculturists and child-minders. They also use their spare time supplementing their cash remittances from their husbands with informal income-earning activities, which leaves little time or inclination to do 'extras' such as the completion of food diaries. There may also have

been a reluctance to share this information, especially by those who are relying on hospitality of kin and neighbours.

They may have been shy to expose their dependence on kin and neighbours, their meagre and irregular diets or the extent of their poverty. In fact, when I first arrived, and later among some people whom I knew less well, there were often whispered consultations with Mamafahla, or my hostesses, as to whether I ate 'Basotho' food, before I was offered refreshment or a meal (hospitality to strangers despite a drought and general poverty, is a custom that endures). I did not press for dietary information which may have been forthcoming if I had done so. It seemed unnecessary to pry further into poverty and distress that was clearly evident from the interview information.

I also need to point out that a measure of food consumption over a week will not reveal seasonal changes in diet, or whether people may eat better at different times of the month, or perhaps immediately after the receipt of remittances. Nevertheless, the food diaries are a useful broad indicator of what is occurring at the village level. In this capacity, as the thesis goes on to show, they are a useful research tool.

In addition to village interviews and food diaries, I visited a number of healers, the 'pharmcaist', the mission clinic and had discussions with patients and hospital staff. Many of the cafe owners and shop assistants in the town also proved to be valuable sources of information.

Overall, it needs to be said that participant observation in the area of health and disease is an invaluable research method. Experiencing village living conditions gave me, as a nurse, an intimate knowledge of local life that is seldom available to health-care people. One sees, first-hand, the difficulties facing villagers and their anxieties

in the face of these difficulties. But one also notes their remarkable and admirable resilience in the face of sometimes overwhelming odds. The insights gained are inestimable and as a means of creating a better understanding of the 'patient' towards improved health-caring skills, participant observation is to be recommended.

I also note a number of events that occurred during my visit. Shortly after my arrival in Lesotho in December 1982, the South African Defence Force raided the African National Congress bases in Maseru and 40 people were killed. There were also repeated rumours of armed attacks and prior to my June 1983 visit the Lesotho Liberation Army was reported to be responsible for bus bombings and a sniper attack in the town. Naturally, being a South African, I was concerned that this would jeopardise my acceptance in the villages. Fortunately, as far as I could ascertain, this was not the case.

A severe drought was also in progress during the time I did fieldwork. Droughts in Southern Africa are not uncommon and in Lesotho extended droughts are said to occur in about one year in five (Murray,1981:1). People are aware of some of the additional problems which accompany droughts - such as its effect on available water resources, agricultural produce, livestock - and a rise in diseases such as gastro-enteritis and typhoid. Clearly a drought will affect the strategies people adopt - but possibly not markedly - considering the frequency with which they occur. However, what makes this drought an especially difficult time is the accompanying economic recession in Southern Africa. The findings must be viewed against this background.

Perhaps the most distressing part of fieldwork is to come face to face with the effects of a drought, the recession and rising unemployment on a poverty-stricken people. One is powerless against such odds. All I can do is to record the situation as I saw it. In the words of one woman 'you can tell them, we cannot - tell them we are starving and need jobs'.

Notes to Chapter One

Note 1 Biomedical model of Disease and Health Care

A few remarks about the biomedical model of disease is necessary in order to understand the term 'health care' and below, 'medical practitioner'. The biomedical model of disease describes the university-trained professional medical practitioners' view of disease (Mishler,1981:2), or that of 'modern medicine' and is said to be guided by four basic assumptions (see Mishler, 1981:2-19). The practice of medicine based on these assumptions is criticised for its narrow physical and biological orientation and failure to recognise the social, political and economic dimensions of disease and health (see Navarro,1976; Kennedy,1980; and Powles,1973).

The assumptions include the following:

(i) Disease is defined strictly, as deviation from normal biological function. Apart from difficulties encountered with respect to what is 'normal' (Ryle,1961), disease defined thus tends to deny subjective feeling of illness without obvious deviation from a specified biological norm or the fact that people may not experience feelings of illness despite evidence of deviation, as for instance in hypertension or the early stages of cancer.

(ii) The 'doctrine of specific etiology' implies briefly that each disease is seen to have a specific cause, a specific set of symptoms, a course and a resolution. Although the trend is changing, the 'doctrine of specific etiology' may mask the multicausality of some of the more urgent and widespread contemporary problems such as cardiac disease and the neoplasms. It also tends to direct research away from the social towards biological causative factors within the organism (Dubos,1961).

(iii) The assumption of generic diseases is that each disease has universally specific and distinguishing features which are the same at different times in history and in various social contexts (Mishler,1981:9). Yet medical anthropology, in particular, has pointed out that disease is not necessarily perceived the same universally (see, for example, Topley,1970).

(iv) The scientific neutrality of medicine assumes that the practice of biomedicine is a pure science and practitioners themselves are bioscientists. Consequently many are encouraged to adopt the scientific values of objectivity and neutrality which tend to direct attention away from the political, economic and social dimensions of disease.

It must be stressed, however, that the biomedical model is just that, a model, and does not account for the enormous variation that will be found among individual practitioners. Nevertheless, much of their training is based on this model and tends to direct practice, the personnel (in addition to practitioners this includes nurses and para-medical staff such as physiotherapists and occupational therapists) and institutions (such as hospitals and clinics) in a recognisable biomedical direction.

Health Care

Although I go to some lengths later in the chapter to discuss the difficulties of defining health and how I intend to operationalise the concept, the term 'health care' is also widely used to describe the therapeutic practice, personnel and institutions based on the biomedical model of disease. Therefore, despite the broader approach to health the study as a whole takes, I use the term 'health care' in the familiar sense.

Note 2 Medical Practitioners

There appears to be little consensus at present in medical anthropology regarding terms for describing the practitioners of biomedicine (Boonzaier,1984). They have been referred to in a variety of ways such as 'cosmopolitan' (Leslie, 1978: xiii) and 'western' medical practitioners (Janzen,1978), but the terms are problematic. As Leslie points out 'western' medical practitioners and institutions are to be found in countries which would not consider themselves 'western' - Asia, China and Russia are examples (1978:xiii). His own term 'cosmopolitan' covers the worldwide geographical spread of biomedicine, but the same could possibly be said for a number of alternative therapeutic avenues, such as homeopathy. As a result of lack of consensus, I prefer to use the more specific description of biomedical practitioner or, to avoid a clumsy text, an abbreviated form - medical practitioner.

Note 3 The Five Year Development Plans for Lesotho - since Independence (1966) are referred to at other times in this thesis thus:

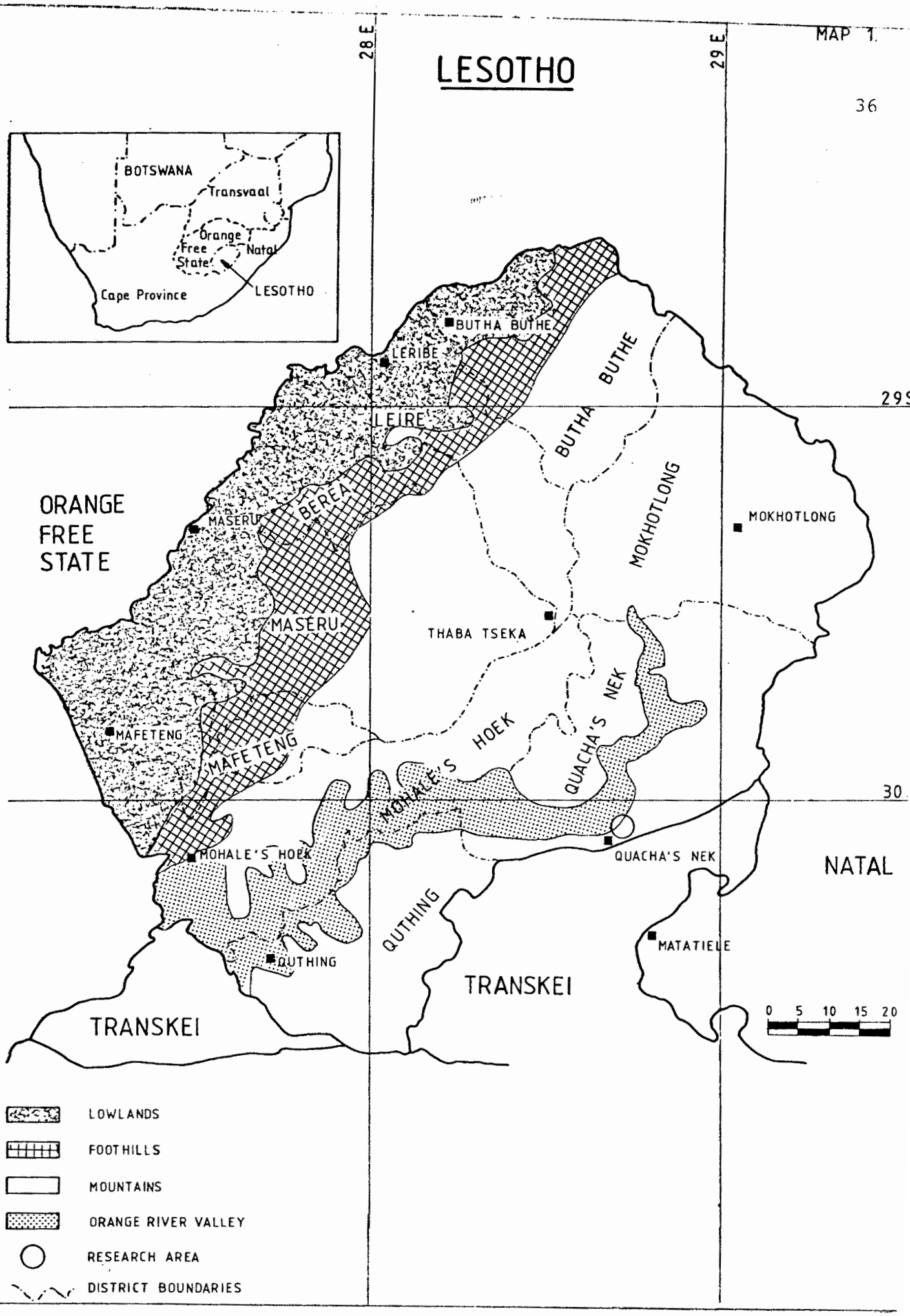
1FYDP	=	First Five Year Development Plan	1970/1 - 1974/5
2FYDP	=	Second Five Year Development Plan	1974/5 - 1979/80
3FYDP	=	Third Five Year Development Plan	1980 - 1985

Note 4 No actual figures for incidences of reported diseases are given in the Third Five Year Development Plan. Actual figures were difficult to obtain - some which appear in the World Health Organisation Statistical Records are listed below:

Infectious Diseases: Annual Figures - Lesotho 1979

Typhoid and paratyphoid fevers	298
Other food poisoning (bacterial)	293
Intestinal infections due other org.	15 087
Pulmonary tuberculosis	2 861
Leprosy: incidence	334
Diptheria	25
Whooping Cough	2 261
Acute Poliomyelitis	40
Meningitis due to enterovirus	22
Chickenpox	379
Measles	8 753
Rabies	8
Mumps	1 799
Other Typhus	31
Syphilis and Sequelae: incidence	7 540
Gonoccal infections: incidence	12 625

Source: World Health Statistics Annual,1983:358



MAP SHOWING RELIEF DISTRICT ADMINISTRATIVE HEADQUARTERS AND APPROXIMATE AREAS OF FIELDWORK

Chapter Two: THE SETTING FOR THE ETHNOGRAPHY

> ... the process of underdevelopment ... has reduced the indigenous population of Southern Africa from a position of adequate subsistence cultivation and pastoralism to a state of chronic hunger and malnutrition (Webster,1981:7).

Introduction

A village-based investigation of peoples' efforts to maintain health, prevent and treat disease in conditions where food, shelter, income, water and sanitation (see Note 1) are inadequate, will have little meaning unless examined against some of the broader historical, political and economic processes giving rise to the present situation. This chapter attempts to provide such a setting for the ethnography which follows.

The first section examines the contemporary national position of 'essential services' in Lesotho and some related factors. After some brief general remarks about Lesotho, I present some background to the process of migrant labour, which is the major source of cash incomes (and is central to much of the investigation). Some information on land distribution, food imports and policies relating to the provision of clean water, sanitation and health care is included. The second section focusses more narrowly on the local setting of Qacha's Nek town and the two villages where most of the research is centred and introduces some general, largely quantitative background information.

The National Setting

Lesotho, which is recognised as one of the poorest nations in the world (Leys,1979:104; Lye and Murray,1980:136), is situated

in the Drakensberg mountains of Southern Africa, completely surrounded by the Republic of South Africa. Being two-thirds mountainous, the climate is said to be temperate and healthy but it is also subject to extremes. Summers are hot and there are heavy frosts and snowfalls in winter with temperatures often dropping below freezing. Annual rainfall occurs in summer between October and April, but varies considerably. The country is subject to drought about one year in five.

The present boundaries of Lesotho - which covers an area of 30 344 square kilometres - were set in 1869 at the Treaty of Aliwal North. Shortly afterwards, in a final effort to save his country from land-hungry Boer and British settlers, Moshoeshoe I, paramount chief and founder of the Basotho nation, appealed to the British government for protection. Thereafter, apart from a short period under Cape Colonial government rule (1871-1884), the country remained a Colonial Protectorate of the Imperial British government until its Independence in 1966.

Since 1966 the kingdom of Lesotho has been ruled by Prime Minister Leabua Jonathan's Basutoland National Party (BNP). His party won the first post-independence elections from the Opposition Basutoland Congress Party (BCP) by a narrow margin. During the following elections (1970), in the face of almost certain victory by the BCP, Prime Minister Jonathan halted the elections and declared a state of emergency, which has not as yet been lifted; neither, in subsequent years, have any further general elections been held.

The country is divided into ten administrative districts each with its own district capital. The national capital and seat of central government is Maseru.

Lesotho has a population of 1 390 000 (1982 estimate - see Report on Joint Mission to evaluate the Lesotho Expanded Programme on Immunisation,1982:11). The majority, or 92 percent reside in rural villages which vary in size from 40-1000 persons (3FYDP:123; Murray,1981:3). Estimated population density according to the latest census (1976) is 35 persons per square kilometre. However, if the actual 13 percent of available arable land (3FYDP:2) is considered, this population density rises to 275 persons per square kilometre (Murray,1981:3). Given this relative shortage of arable land and the rapidly increasing population growth at a rate of 2,3 percent per annum (3FYDP:3) people can do little more than 'scratch a living from the land' (Lye and Murray,1980:137). The majority are thus reliant for their income on migrant labour in the industrial capitals of the Republic of South Africa.

It is well known that the majority of Lesotho's adult male population (like the 'homelands' of South Africa) supply a proportion of the labour for the Republic's mines and industry. The process which has reduced Lesotho and other parts of rural Southern Africa to a dependence on migrant labour is well documented (see, for example, Murray,1981:7-36 for specific reference to Lesotho; and Bundy,1979; Palmer and Parsons,1977 for elsewhere in Southern Africa), but some brief points might be noted here.

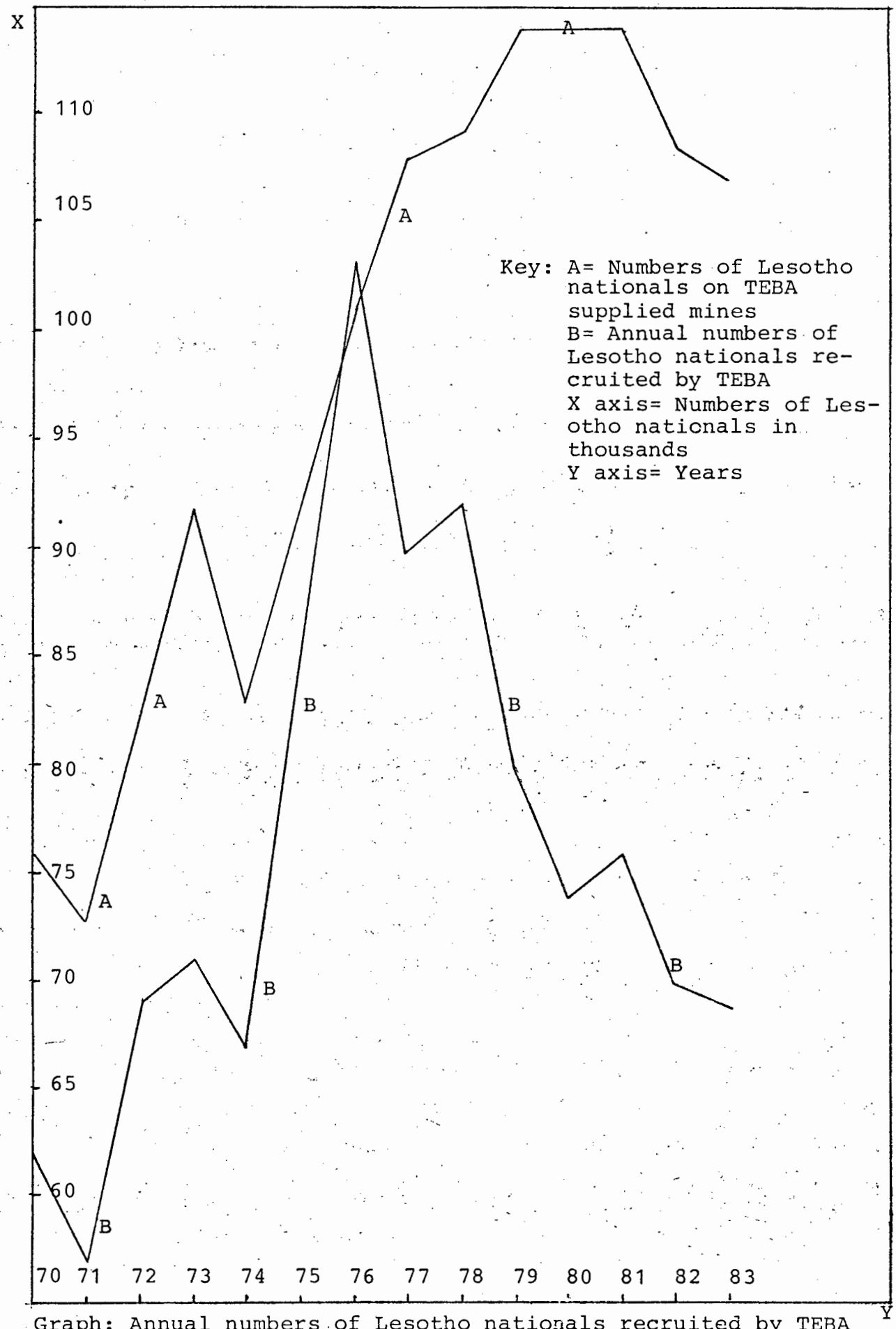
It should be mentioned, for example, that in the 19th century many Basotho farmers responded vigorously to the newly created agricultural markets after the discovery of diamonds in Kimberley and gold on the Witwatersrand. It was largely a series of coercive measures (such as colonial government tax and import controls on maize by the Orange Free State and Transvaal governments to protect the less efficient white

farmers), coupled with a number of natural disasters (for example, the droughts of 1884 and the Rinderpest of 1896) that eventually forced the successful peasant farmers into wage labour. As early as 1875 some Basotho were already engaged in wage labour (Ashton,1952:162). By the 1930's 50 percent of the male population are reported to have been engaged in wage labour (Murray,1981:14). Today, 21,27 percent of the South African mining workforce is from Lesotho - more than 100 000 of Lesotho's adult male population (TEBA, 1983:10 - see Note 2).

Migrant remittances are a major source of revenue for the country, supplying 42 percent of the Gross National Product (3FYDP:iii); they are also the major source of cash for rural dwellers, providing about 71 percent of the rural household income (Van der Wiel,1977:88). Since migrant earnings constitute the major source of income for the country and its people, Lesotho is totally dependent economically on its powerful neighbour, the Republic of South Africa. This means that it is also extremely vulnerable to changes in the regional economy.

Numbers of Basotho employed on the mines are declining (see Figure 2.1). This is partly due to the industry's efforts to internalise the workforce and reduce the numbers of 'foreign' workers from independent countries such as Malawi, Mozambique and Lesotho (Murray,1981:28). The plan is eventually to confine recruitment to the 'homelands' where (largely on account of their political dependence on Pretoria) there is greater control of workers and flow of labour (Murray,1981:29-36). Declining numbers are also due to the mining industry's present needs to stabilise its workforce (Spiegel,1980:4).

Figure 2.1



Graph: Annual numbers of Lesotho nationals recruited by TEBA and on TEBA supplied mines 1970-1983
Source: TEBA Annual Reports

In general it is found that a need for a skilled and stable workforce in a developing economy gradually outweighs the benefits (to the employer) of engaging migrants (Wilson, 1972:149). In South Africa the twin goals of economic growth and apartheid have meant that successive governments, since the 19th century, have passed legislation which has controlled the flow of labour to the urban industrial areas while at the same time restricting permanent urban black settlement (Murray,1981: 26-36). Permanent urban settlement of the worker and his or her dependants is part of the usual process of transition from unskilled contract migrant to skilled urban-based employee (Wilson,1972:144-152).

As the need for skilled labour forces itself on the mining industry, the Chamber of Mines (see Note 2) plans to answer the need by stabilising a migrant workforce. The new Chamber of Mines employment policy makes provision for re-employment of experienced miners. They have first option on their contracts which they are encouraged to renew as soon as possible with attractive incentives, such as bonuses (Spiegel, 1980:5).

A stable migrant workforce will continue to maintain the twin goals of economic growth and apartheid but will have severe consequences for unemployment in the rural areas of Southern Africa which includes Lesotho (Murray,1981:35). Available employment opportunities will remain in the hands of a select few and less contracts will be open for the unemployed and new aspirant miners (Spiegel,1980:5). Traditional employment opportunities in Lesotho, as a result of this policy, are acutely curtailed. Unemployment is rising and dire consequences of increasing impoverishment are predicted for the 1980's (Murray,1981:35; Spiegel,1980:6).

It is often assumed by employers and protagonists of a labour

reserve policy that in a system of migrant labour the land will serve the function of housing and feeding the migrants' dependants, the retired, the unemployed and returning migrants. Leys cites evidence from wage levels which are set to provide for a single worker (1979:101), and Wilson notes that employers in a system of migrant labour do not see themselves as responsible for any of the social infrastructure (such as subsidised housing) which would be necessary to support a settled urban workforce (1972:149). The net result is that a country like Lesotho or the 'homeland' areas of South Africa act as reserves of cheap labour where the labour force is reproduced at little or no cost to capital (Webster,1981:15). But the availability of arable land on which employers base their labour reserve policy which leads to neglect of the migrant worker and his or her dependants, is declining.

Lesotho's boundaries have remained fixed since 1869. The constant rise in population since that time has resulted in an ever-diminishing supply of arable land for the households. During the first few years of British protectorate status, Moshoeshoe I's system of land tenure, based on the maxim that 'land is invested in the nation', held sway. This meant that all Basotho, subject to certain criteria such as citizenship, sex and marital status, were eligible for usufruct rights to arable land; 'that is the right to cultivate and dispose of the products' (Murray,1981:70). These rights granted by the chief were held by an individual for his lifetime, or in the case of a widow, her lifetime (for it is and has been difficult for unmarried, divorced and deserted women to obtain land). An amount of three fields was allotted to each household (see Murray, 1981:71 and Ashton,1952:146).

However, even during the early decades of this century scholars report a 'general shortage of land' (Ashton, 1952:145) which is becoming increasingly fragmented, eroded and exhausted. Recent studies show that there are growing numbers of landless households or households without access to fields (see, for example, Williams, 1972:3; Spiegel,1979:90 and 159). It is also documented that even households with access to fields seldom produce sufficient to meet their sustenance needs (see, for example, Wallman,1969:66-67) which, for the annual consumption of an average household of 5,8 members, is estimated as 20 bags of maize (2 bags = 200 lbs or approximately 90 kilograms - Houghton and Walton,1952:159).

Lesotho, which was once a successful exporter of maize, now imports over 50 percent of its requirements (3FYDP: 157). In addition, 'food aid' to Lesotho is 'massive in size' (3FYDP:108). Clearly, where a country's major food item is imported or donated, the land is no longer a source of subsistance and it has been shown that a majority of households purchase their sustenance requirements (Spiegel, 1979:58).

Agricultural activity is no longer economically viable. The costs of agricultural inputs is generally greater than the value of the produce (Spiegel,1979:58), and only those with direct access to cash incomes can afford to farm (Murray, 1981:87). In effect, the assumption that land will feed the migrant's rural dependants, and the retired, the unemployed and returning migrant is simply no longer valid.

Yet, land retains a considerable value for the rural dwellers. In the face of the insecurities of migrant labour, agricultural property is perceived by most Basotho to offer an alternative source of security (Wallman,1969:107; Hamnett,1975:66). But their security lies in their perception of the potential and not in its realisation (Spiegel,1979:57).

The failure of agriculture and the increasing fragmentation of land has led to a number of State controls over land, the most recent being the 1979 Land Act. This Act, in making provision for inheritance of land, is ostensibly aimed at preserving the larger tracts and thereby improving agricultural yields. Eckert and Mohapi predict that arable land will come to be concentrated in fewer hands (1980:13) and for a growing majority any access to land will become increasingly difficult to obtain.

Spiegel predicts that with land and contracts becoming the prerogative of a few, as a result of declining availability of arable land and growing unemployment, rural differentiation will increase in the 1980's (1980). A small majority with access to land and cash wage incomes will become materially better-off while an ever-increasing majority will become steadily more impoverished (Spiegel,1980). These predictions of a generally increasing poverty in the rural countryside are noted as part of the general background for the ethnography of health and disease to follow.

The rural countryside is also poorly supplied with clean water and sanitation. Lesotho has an abundant natural supply of water (3FYDP:253) but only 8,9 percent of the population have piped water systems (3FYDP:147). Sanitation in the rural areas is in a considerably worse position. Only 4-13 percent of the lowlands' population have 'individual pit latrines', and this figure is even lower in the mountainous areas (3FYDP:150) such as where this study is carried out.

Reasons for the present inadequate distribution of clean water and sanitation can be traced to the almost total neglect of social infrastructure during colonial government rule. During the 19th and early 20th centuries the system of Indirect Rule was favoured by Britain as the least expensive means of maintaining her colonies. Under this system the establishment of social services was the responsibility of local district governments. Funds were supplied by taxes collected from the

local people but the majority of the tax was sent to a central government which left little for implementation of local (and expensive) infrastructure such as piped clean water and sanitation (Van Etten,1976:18-20). What tended to occur was the lack of or poor services in the rural areas, while in the urban centres piped water and sanitation were funded and implemented by central government to serve the needs of the colonial administrators settled there (Van Etten,1976:24).

After the 1920's Britain's policy towards the colonies changed. Then their potential as important sources of raw material for the manufacturing capitals of Europe was recognised and in 1926 the Colonial Development Fund was established to provide funds to establish the infrastructure necessary for export of the raw materials (Van Etten,1976:27). But the situation in Lesotho (or Basutoland as it was known during the colonial era) was slightly different.

Britain never wanted the colony and with large sums of money invested in South African industry, tended to favour South African development at the expense of Lesotho's interests (Wallman,1969:13). However, after Amery's visit in 1927 and Pim's commission of enquiry into the financial and economic position of the country during the early 1930's, Britain started to provide small budgetry aid (Jones,1977:20). But it was only in 1948/49 that the first substantial grants in aid were provided (Wallman,1969:13). Development came late to Lesotho and has been unenthusiastic, slow and uneven. (Table 2.1 depicting implementation of clean water from 1952 to 1966 is an example). The result is that at Independence, the Basotho inherited an underdeveloped and neglected country, particularly poorly serviced in the rural areas.

Table 2.1 An approximate indication of the Colonial government's contribution to implementation of water schemes, 1952-1966

Year	New water schemes	Reconstruction/ repairs
1952	12	5
1953	14	10
1954	36	5
1955	12	not specified
1957	4	2
1958	4	2
1959	not specified	not specified
1961	not specified	not specified
1962	50	
1963	not specified	
1965	not specified	
1966 Independence	not specified	

Note: Table compiled from a selection of Colonial Annual Reports

A concentration of health-care institutions and manpower in the urban centres is also largely a legacy of colonial government administration. Today the majority of Lesotho's 17 general hospitals (3FYDP:322) are to be found in Maseru and the district capitals where, as elsewhere in Africa, they were originally established to cater for the needs of the colonial administrators and their families (Van Etten,1976:24). In addition, there are 143 clinics and outstations, but distribution is uneven 'with the mountain areas being seriously underserved' (3FYDP:322). (See Note 3).

Table 2.2 shows the distribution of health-care manpower in Lesotho. It also shows to what extent health-care personnel are concentrated in Maseru where only 20 percent of the population reside, but 40 percent of the health manpower are employed (Smith,1980:8).

Table 2.2 Health Manpower by District

District	Doctors		Clinical Nurse		Nurse Midwife		Asst Nurse		Health Insp	Health Asst	VHW
	Gov	Pvt	Gov	Pvt	Gov	Pvt	Gov	Pvt	Gov	Gov	
Butha-Butha	2	1	2	-	14	5	3	3		2	40
Leribe	3	3	1	-	14	16	12	-	1	3	41
Berea	2	5	-	1	9	34	2	15		1	45
Maseru	36	24	5	2	146	55	21	18	4	11	16
Mafeteng	3	1	2	1	11	3	9	-		3	28
Mohale's Hoek	3	2	1	-	12	6	8	-		2	31
Quthing	2	-	-	1	11	4	6	-	1	2	110
Qacha's Nek	2	1	-	-	9	15	9	2		1	40
Mokhotlong	2	-	1	-	15	3	3	-	-	1	56
Thaba-Tseka	-	3	2	1	2	16	-	13	1	3	18
Total	54	40	14	6	243	157	73	51	7	29	425

Public Health Nurse - one per district Six in Maseru District

Source: Report on a Joint Mission to Evaluate the Lesotho expanded programme on immunisation, 1982:13

Note: With the exception of Maseru where there are medical practitioners in 'private practice', private refers to mission

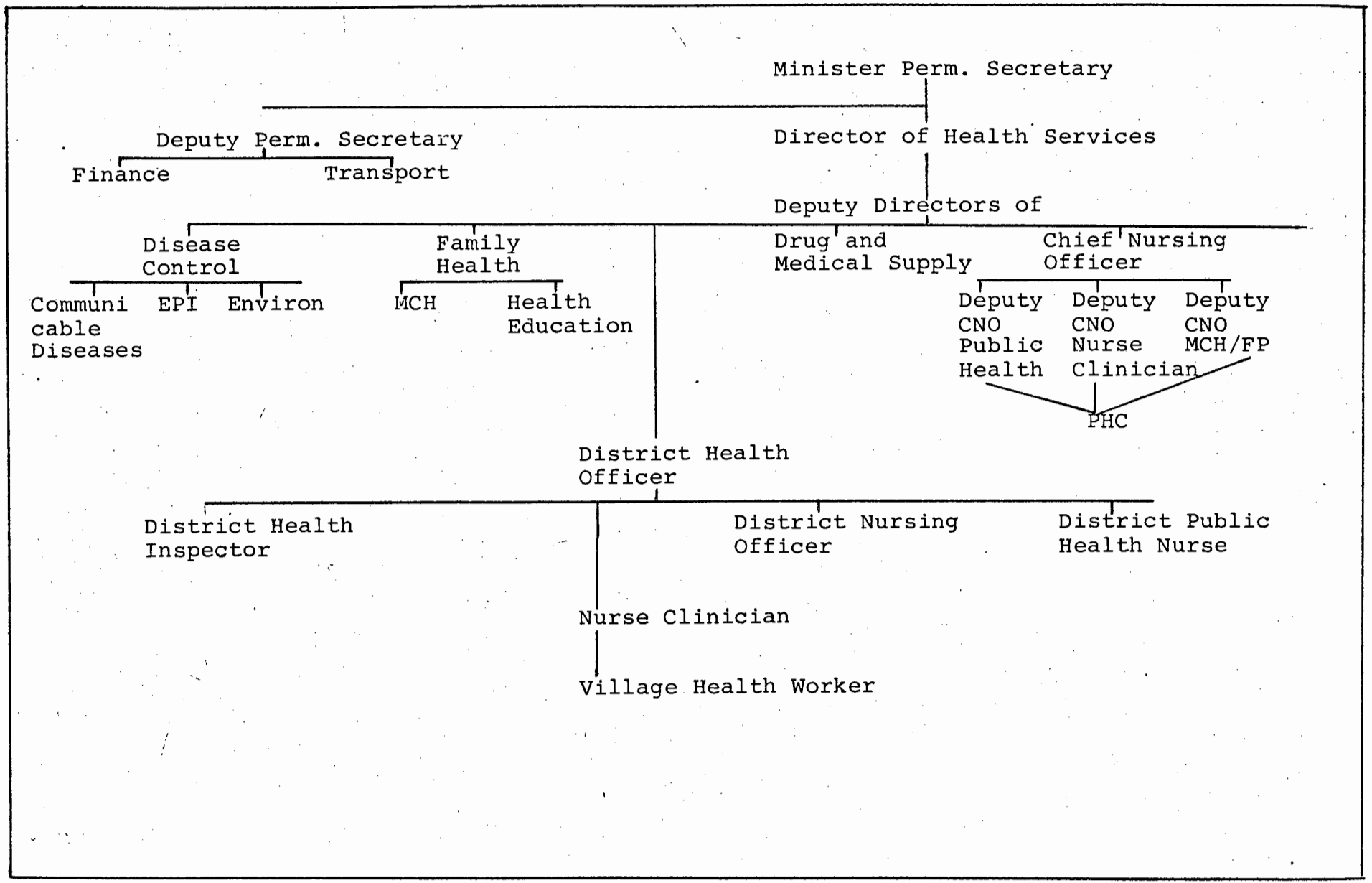
VHW = Village Health Worker

Lesotho's present health services are administered by the Ministry of Health which is centred in Maseru with district offices in each of the administrative capitals (Figure 2.2 shows the hierarchial organisation of the Ministry). The missions (see Note 4) co-ordinate their activities with the Ministry through the Private Health Association of Lesotho (PHAL - Report on a Joint Mission to evaluate the Lesotho expanded Programme on Immunisation, 1982:12).

The missions have always been active in providing health care, starting in 1844, some 50 years before the first colonial government medical officer was appointed (Hailey,1957:1074). Today their contribution, both in manpower and in nunber of health-care institutions is considerable, especially in the rural areas. They run 8 of the 17 general hospitals and, in conjunction with the Lesotho Red Cross Association, 69 of the clinics and outstations (Report on a Joint Mission to evaluate the Lesotho expanded Programme on Immunisation, 1982:12). Table 2.2 gives an estimate of the mission health manpower contribution.

An obvious effect of a largely curative institutionalised health-care system and a poor record of implementation of water systems and sanitation will be evident in a country's disease profile. It is implied that one can almost trace the spread of imperialism by the spread of infectious fevers (Doyle,1979:101). The prevalence of malnutrition, deficiency disease and a general lack of resistence to infection is noticeable elsewhere in Africa as early as the 1930's (see, for example, Richards,1939:B). In Lesotho, the diseases of poverty and malnutrition are mentioned as early as 1936 (Williams,1971:39). Later studies show evidence of declining nutritional standards and increasing malnutrition among the Basotho (Williams,1971:32-35). Generalised malnutrition is bound to reduce the resistance of the population to infectious

Figure: 2.2 ORGANISATION OF THE MINISTRY OF HEALTH(abbreviated)

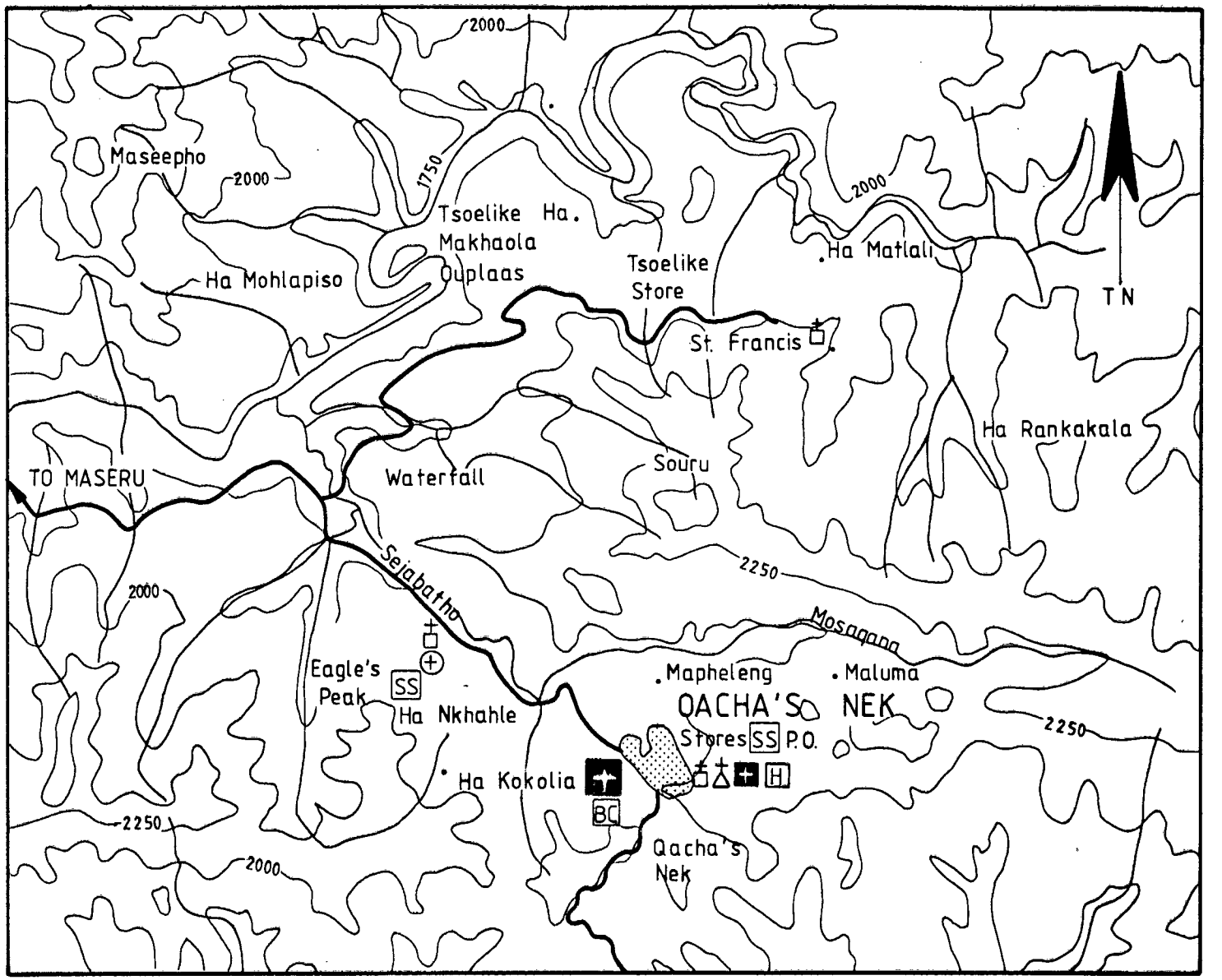


Source:Report on a Joint Mission to Evaluate the Lesotho Expanded Programme on Immunisation (1982:66)

fevers, gastro-enteritis and some of the scrourges of poverty such as typhoid and tuberculosis, which are amongst the commonest of the reported diseases in Lesotho today (3FYDP:327).

The first section of this chapter has endeavoured to provide a general picture of contemporary Lesotho which can be summarised as a poverty-stricken, underdeveloped labour reserve. Unemployment is on the increase as the Chamber of Mines attempts to stabilise its workforce, thereby threatening the major traditional source of cash for numerous rural households. Availability of arable land continues to decline and it is some time since agriculture has yielded sufficient to feed the nation. Rural water systems and sanitation, as well as health-care institutions, are poorly supplied and unevenly distributed. The reasons for this general inadequacy are largely due to factors beyond the control of the people, who nevertheless face a rising incidence of the diseases of poverty. This, in summary, is the broader background for the ethnography to follow. The following section narrows down to a focus on the local setting.

RESEARCH AREA



LEGEND

- Airstrip
- Mission R.C.
- Mission Anglican
- Clinic
- BC Border Control
- SS Secondary School
- H Hotel
- Hospital
- P.O. Post Office
- Road

SCALE 1: 125000

The Local Setting

Qacha's Nek Town

Qacha's Nek town, with a population of approximately 5000 (1976 census), is the nearest urban centre to the two villages where fieldwork was conducted. It originated in 1888 as a tax-collecting depot (Ambrose,1976:188). Today it is the capital of the mountainous south eastern district of Lesotho, Qacha's Nek, and is the seat of local district government. The town lies 2 kilometres from the South African (Transkei) border and 34 kilometres from the South African town of Matatiele. Its situation on the south eastern border of the country makes it relatively isolated from the rest of Lesotho. There is a daily airflight to the capital, Maseru, and a daily bus service via Mount Moorosi, Quthing and Mohale's Hoek but in general, road- and tele-communications with the rest of Lesotho are very poor. As a result of this the town has always maintained strong ties with the relatively large urban centre of Matatiele in South Africa.

The ties are based on an historical association which dates back to at least the Gun War (1880-1) when Basotho migrated from Matatiele to the Qacha's Nek area and kinship bonds persist today. Matatiele is also a useful commercial centre and until 1976 labour migrants were still being forwarded through Matatiele. In 1976, when Lesotho (with the rest of the world) refused to recognise Transkei independence, the border was closed to the Basotho. It has since been opened (around December 1982). In the meantime, however, a number of efforts were made to upgrade Qacha's Nek in order to overcome some of the inconveniences caused by the closure of the border.

Various Matatiele-based supermarkets and wholesalers transferred to Qacha's Nek during this time. In addition, funds from the United Nations Emergency Fund (which was created at the time of the closure of the border to assist the Lesotho government plans to develop the neglected south-eastern districts), were used for the South Perimeter Road Project to improve road transport to the capital (Lesotho Weekly, 2.7.1977; 1.10.1977). Plans to construct a new government hospital to replace the old hospital which was built in the 1920's, were part of this development phase. Funds and expertise were supplied by the Danish government (Lesotho Weekly 4.2.1978; 25.2.1978).

The hospital is the centre of the district official health-care services and the link in the hierarchial system with the Ministry of Health in Maseru. Approximately 66-bedded (1976 Qacha's Nek Hospital Report:5), the hospital has a staff of about 57 (Smith,1980:13). Besides the in-patient service, the hospital also provides daily out-patient consultations and a number of weekly clinics which include 'Well Baby', Ante-Natal and Nutritional clinics and Family Planning services.

The district is also served by the Tebellong mission hospital which is situated across the Orange River, approximately 35 kilometres from Qacha's Nek town. This is a 36-bed hospital (1976 Qacha's Nek Hospital Report:5), with a staff of 30 (Smith,1980:13) and in- and out-patient services are similar to those of the government hospital.

Clinics and outstations in the district vary in the type of services offered and it is difficult to elicit exact numbers (see Note 5). However, from the point of view of the ministry

the 8-9 clinics manned by qualified health-care staff which provide Out-Patient, 'Well Baby', Nutritional and Ante-Natal clinics would be the most important. Some of these clinics maintain close links with their nearest hospital. The clinic at Sekake falls under the jurisdiction of Tebellong and receives a monthly visit from the mission doctor. The two government clinics at Sehlabathebe and Rankakala receive a similar support service from the government hospital doctor and the clinic at Sehonghong is visited on a regular basis by the Flying Doctor service, but four of the private mission clinics run more or less independently (1976 Qacha's Nek Hospital Report:5).

As for the country as a whole, the missions contribute significantly to the district health-care services. In Qacha's Nek district they run one of the hospitals and five of the clinics. Table 2.3 gives an indication of their contribution to the health manpower.

Table 2.3 Distribution of Health Manpower, Qacha's Nek district

Doctors		Clinical Nurse		Nurse Midwife		Asst Nurse		Health Asst		VHW
Gov	Pvt	Gov	Pvt	Gov	Pvt	Gov	Pvt	Gov	Pvt	
2	1	-	-	9	15	9	2	1	-	40

Source: Report on a joint mission to evaluate the Lesotho expanded programme on immunisation, 1982:67

Note: Pvt = Private = Mission
VHW = Village Health Worker

The health-care institutions and staff listed in Table 2.3 above are of course not the entire range of therapy options available to the people, and in Chapter four I discuss some of the alternatives.

As district capital, Qacha's Nek town is a major (relatively speaking) shopping centre and has a number of amenities which include a post office and a bank. In addition, there are two primary schools, a secondary school and a day-care centre for the children of working mothers. The Catholic, the Anglican and the Lesotho Evangelican Church (LEC) all have churches in the town. Just outside the town, at the mission station between Qacha's Nek and Ha Mpiti, there is a Catholic Cathedral, a boarding high school and a primary School. TEBA also has an office in the town. The area outside the TEBA offices and the nearby Qacha's Nek-Quthing-Maseru bus terminus is called the 'market'. A number of women from the nearby villages, who have the necessary permission, sell plates of cooked food to the job-seekers and bus commuters. These women remark on the decline of available contracts and recount distressing tales of starving job-seekers who wait in vain for contracts. Some are reduced, they say, to eating the scraps of 'papa' (cooked maize porridge) that fall on the ground. There is also a rumour that two men were found dead from starvation under a tree outside TEBA where they had slept the previous night.

Clearly, rumours such as these, and the news that fewer and fewer contracts are available, travel to the more remote rural areas. Men are understandably reluctant to make the expensive, lonely and possibly fruitless journey to Qacha's Nek. Thus, while one would expect that larger queues would reflect rising unemployment, the reverse seems to apply. Potential work-seekers recognise the futility of applying to the TEBA office and consequently many don't bother to make the journey. As a result, the market women, most of whom are from villages close to Qacha's Nek (including 'Ngoe), report that their livelihood is threatened.

The Villages

'Ngoe and Peli are situated in the Orange River valley of Qacha's Nek district. 'Ngoe, which is approximately four kilometres from Qacha's Nek town, lies between the main Qacha's Nek-Maseru road and the river Sejabatho, a tributory of the Senqu (Orange River). The Sejabatho borders the north west of the village and a shallow sandstone plateau forms the opposite boundary. Dongas flanking the village on either side separate it from government land on the one hand, and the home of the area chief on the other. Peli lies set back from the Tsoelike-Qacha's Nek road, approximately 20-25 kilometres from Qacha's Nek town and is an old established community comprising two small adjacent settlements.

'Ngoe and Peli are similar in that each is controlled by a headman, and each falls under the jurisdiction of its own area chief; however, they differ in regard to access to arable land, length of establishment and proximity to Qacha's Nek town.

Government land was made available for the establishment of 'Ngoe at the end of the 1960's and the majority of residents moved in during the 1970's. It is a village of residential plots only, no land being made available for allocation of fields, and thus qualifies as what is frequently termed a closer settlement.

Geographically, 'Ngoe is conveniently placed for schools and churches and the commercial amenities which the Qacha's Nek town offers. In the village itself there is a Zion church, as well as three cafes which are run by local residents. The major advantage of a village cafe in a community such as 'Ngoe is the credit that it offers. Cafe credit, especially at

times when cash remittances may be delayed, can sometimes mean the difference between eating and starving. It is also interesting that the competition posed by the supermarkets and wholesalers tends to keep 'Ngoe cafe prices relatively lower than other villages, such as Peli, which are further away from Qacha's Nek.

Peli lies some distance from Qacha's Nek. Some may walk the distance but a trip to Qacha's Nek, especially for shopping, to the bank or to the post office (important for households dependent on migrant remittances), usually means the additional cost of transport. A privately-run bus from Tsoelike passes daily and taxis are available from a village some distance away, but transport is relatively expensive (80 cents to R1 for a one-way journey).

There is a small cafe in the village itself and a larger one in an adjacent settlement. The owner of the latter, for a small annual fee of 30 cents, will collect post for residents who may also make use of his postal address. Caught up in the larger problems facing Southern Africa's rural population, we tend to overlook smaller issues such as postal addresses and postal services which are vitally important to families dependent upon, yet divided by the system of migrant labour.

Children at Peli may attend the primary school in the area under their own chief, or the school in a nearby village which falls under the jurisdiction of a neighbouring chief. For those who choose to further their education, secondary and high school means boarding at Qacha's Nek or elsewhere in Lesotho. (High school education for 'Ngoe residents also means attending boarding school).

Church-goers attend either the Catholic Church at the Mission which lies between Ha Mpiti and Qacha's Nek town, or the Anglican, the LEC or Zion services at a nearby village.

The villages each have their own particular ambience. 'Ngoe, the closer settlement, seems to lack the feeling of spaciousness which the fields and grazing lands at Peli appear to create. The apparent community cohesiveness at Peli, which is possibly largely the consequence of neighbourly and kinship ties nurtured over a lengthy period of time, is also not as noticeable at the more recently established settlement of 'Ngoe. This may be partly due to the differences between the two villages, mentioned above - access to town, access to arable land and length of establishment.

The numerous travellers passing through 'Ngoe on their way to town could be another reason. One of the main bridle paths which links some of the rural villages beyond the river Sejabatho with Qacha's Nek town passes through 'Ngoe. Not only are the travellers a valuable source of trade for the many 'joale' (home brewed beer) sellers, but they are also a welcome break from the boredom of village life with their store of interesting local gossip. On the other hand, Peli's geographical location makes travellers infrequent and there is little to break the monotony of the daily round of routine tasks.

At both villages there are of course always the Christmas and long weekend visits of the migrant husbands and sons. The villages buzz with excitement. 'Joale' sales improve; there is extra cash from bonusses, and for a while life for a few fortunates becomes lighter. Nevertheless, as soon as the husbands return to work the responsibilities of household management devolve once more on the shoulders of the women left behind.

I do not discuss the daily round of routine tasks (see, for example, Gay,1980:135-138), nor annual agricultural activities (see, for example, Spiegel,1979:57-66), as these have been covered elsewhere. But before proceeding with the household data, it is necessary to mention briefly the position of clean water systems and sanitation, which are matters of infrastructure and more particularly community rather than household issues. The discussion on water and sanitation, at this point, is brief because I enlarge on the subject in Chapter five, especially some of the difficulties associated with the implementation of clean water systems which villagers encounter at a number of levels.

Application for a clean water system, which means construction of a piped supply from a natural ground spring, must come from the community. All the residents of a village must agree on the need for a piped water supply and they are obliged to produce, with their application, a 'reasonable cash contribution' and a promise of labour (3FYDP:146).

'Ngoe and one of the two small settlements that comprise Peli (as is the case for the majority of the rural villages in Lesotho), collect their water from unprotected ground springs. Ground spring water is vulnerable to contamination by animals and man, and collection is tedious, time consuming and laborious.

One section of Peli does have a clean piped water supply which it shares with a larger adjacent community. Some residents, for an extra fee, have taps in their gardens. Others collect from the water tanks at specified times. The section of Peli without access to a clean water system apparently (or so the rumour goes) refused at the time of application to commit itself to a cash contribution and the promise of labour. 'Ngoe

has applied for a clean water system, made its 'reasonable cash contribution' and promised labour.

Sanitation in the strict sense of an adequate sewerage system is absent at both villages. At Peli, two homesteads have pit latrines and a similar number at 'Ngoe. 'Ngoe being a closer settlement is much more densely populated and householders are finding it increasingly necessary to install pit latrines, which necessitates the purchase of corrugated iron and wooden doors - all additional demands on already strained cash incomes.

The following quantitative information is based on a total of 70 loosely structured interviews. The question schedule on which the interviews are based appears as Appendix A. Forty randomly selected households out of a total of 80 were interviewed at 'Ngoe and 30 out of a total of 51 were interviewed at Peli. (All tables are based on the sample population).

Village Populations

In view of the number of people who are in South Africa (generally as a result of migrant labour), or elsewhere, census practice since 1911 has been to distinguish the 'de facto' from the 'de jure' population. 'De facto' population refers to those present at the time of enumeration and 'de jure' refers to those present plus those recorded as absent (Murray,1981:4). The distinction is useful for some of the following computations which provide a quantitative baseline for the ethnography to follow.

Table 2.4 Estimated de jure and de facto village population by village

Village	Number of households	Population de jure	Population de facto	Percentage of absentees
'Ngoe	80	390	330	15,3
Peli	51	290,7	243	16,3

Note: Estimate = number of village households x average household size

Table 2.5 Sample de jure and de facto population by village

Village	Number of households	Population de jure	Population de facto	Number of absentees
'Ngoe	40	195	165	30
Peli	30	171	143	28

Table 2.6 Age characteristics of the de jure population by village

	Age Cohorts					
Village	0-15 years	16-59 years male	16-59 years female	60+ years male	60+ years female	Total de jure population
'Ngoe	95	36	47	5	12	195
Peli	76	39	37	8	11	171

The percentage of absentees at both villages is lower than findings elsewhere (see, for example, Spiegel,1979:45-47; Murray,1981:47), which could be indicative of the effects of reduced wage employment opportunities on the South African mines. The majoriity of absentees are male migrant labourers. A few women and children were also away at the time interviews were conducted. At Peli, one female is presently working as a domestic in Durban and three scholars are boarding with kin in Qacha's Nek in order to attend school there. One woman from 'Ngoe and her child are living with the husband in Maseru, another works at the woolshed at Sehlabathebe but she spends weekends and her off-times at her home. Of the children who are absent at 'Ngoe, one is at boarding school in Maseru and three, who are under school-going age, are with their grandmothers in Leribe and Maseru.

Household Profiles

The domestic group is an important unit in any micro investigation, both as an analytical unit and also as a descriptive one for presenting data. But for anthropologists working in areas where migrant labour is the norm, defining the basic domestic group has always presented some difficulties. Because of the constant flux in the number of residents in a homestead (as a result of migrant labour) households cannot be defined simply in terms of residence (Murray,1976:54). Murray also points out that because people living in the homestead may not necessarily be relatives, kinship in itself is not a

particularly useful defining characteristic (1976:54). What distinguishes households, whether members are resident or not, is a 'continuing responsibility to contribute towards its maintenance' (Murray,1976:54). And on the basis of this premis Murray proceeds to define the household as

> an aggregate of individuals within which are concentrated the flows of income and expenditure generated by the activities of its members (1976:54).

The household is thus primarily the vehicle for channelling the cash wage incomes so vital for the survival of rural communities.

According to Spiegel there is some ambiguity in Murray's definition. The definition, he argues

> may equally be describing the community at large if we allow for less intense relationships (1979:50).

Murray's definition and Spiegel's comments are important. The writers describe a set of relationships which are interrelated. There are the more intense household relationships of shared responsibility to immediate members. There are also the less intense relationships with kin-related households in the same village or in villages elsewhere. In addition, there are the ties of friendship and neighbourhood.

Cash from the regional economy which is the major source of employment is, 'on entry' into Lesotho, concentrated in those households with direct access to migrant labour earnings.

But it is not confined to these households. Spiegel (1979) has described the redistribution of migrant labour remittances from households with direct access to migrant labour earnings to those without. Redistribution of migrant labour earnings is essential as cash from the regional economy is fundamental to survival in Lesotho's rural countryside.

The point here is that the household is not a bounded and separate unit in the reality of day-to-day social life. It is an important analytical tool and a useful aid to the presentation of data.

Table 2.7 Mean de jure and de facto household size and range of the de jure and de facto household populations by village

Village	Mean household size		Range of household population	
	de jure	de facto	de jure	de facto
'Ngoe	4,8	4,1	1 - 9	1 - 7
Peli	5,7	4,7	1 - 11	1 - 9

The above Table 2.7 points out that the mean household size is slightly lower at 'Ngoe but the difference is not marked and does not differ significantly from findings elsewhere in Lesotho. For example, Spiegel reports a mean de jure household size of 5,98 (1979:52) and Murray 5,09 (1976:59).

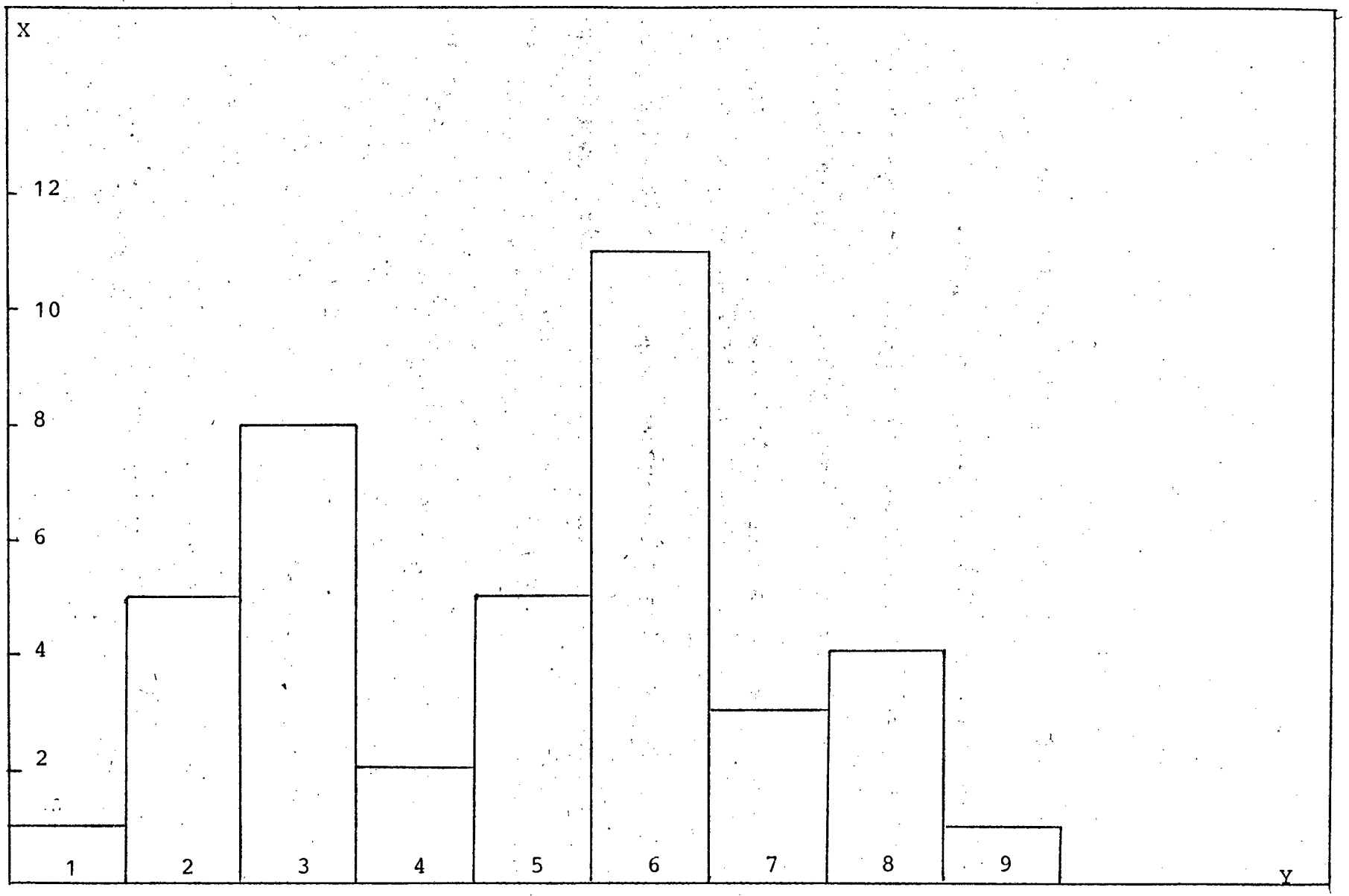
At 'Ngoe there appears to be a higher incidence of nuclear families (ie units comprising husband, wife and children under the age of 15). Incidence at Peli is 36,6 percent

while it is 52,5 percent at 'Ngoe. What may account for this is the deliberate choice by some younger householders (ie. those at an earlier stage of the household domestic cycle) in this sample to set up homesteads in a village near town and the facilities if offers.

Regarding size of household, writers distinguish between small and large households for convenience of presentation of data, and for reporting general trends of these broad distinctions. Murray makes the distinction between small households of one to four members and large households of more than four on the basis of the household distribution in his sample (1981:53-54). The distribution of households at 'Ngoe and Peli (see Figures 2.3; 2.4) reveals a similar cut-off point. At Peli there is a distinct mode at four and at 'Ngoe at three and six. On the basis of earlier findings (in addition to Murray,1981:53-54 see also Marres and Van der Wiel,1975:22), and those of this study, a household of one to four is small and one with more than four persons large.

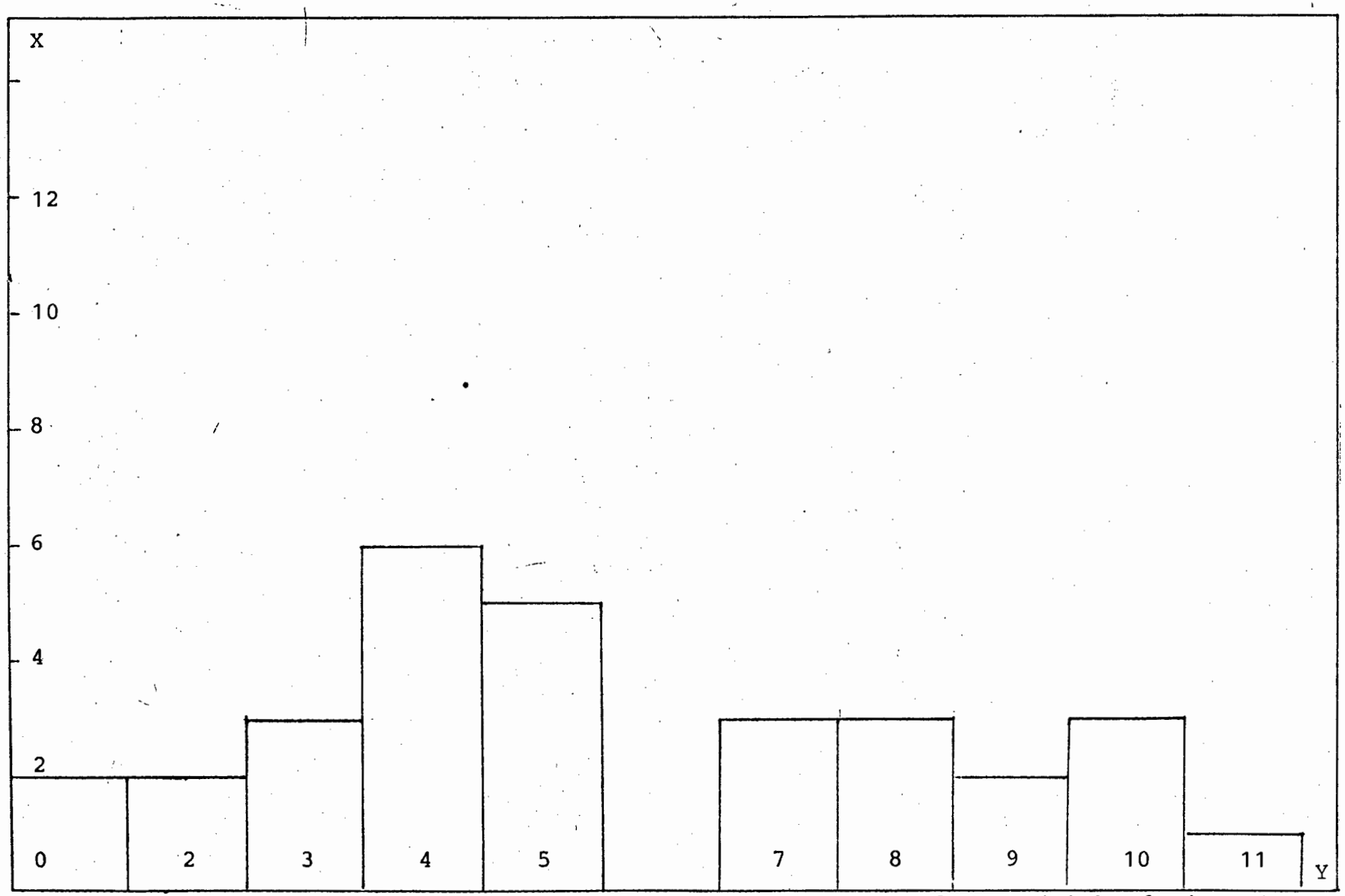
An additional characteristic, sex of household head, is considered when discussing broad trends for large and small households. Female-headed households, both large and small, are on the whole relatively more disadvantaged than their male counterparts (Murray,1981:55). They face greater constraints in the area of wage-labour in South Africa (Gay, 1980:8) and it is also reported that extreme poverty is concentrated in small female-headed households (Lye and Murray,1980:109).

Figure 2.3



Histogram showing frequency distribution of 40 households at 'Ngoe (X axis) by de jure household members (Y axis)

Figure 2.4



Histogram showing frequency distribution of 30 households at Peli(X axis) by de jure household members(Y axis)

Table 2.8 Distribution of households by de jure household size and sex of household head, 'Ngoe

De jure household size	Sex of household head		All households
	male	female	
(1-4)	13	3	16
(4+)	19	5	24
All households	32	8	40

Table 2.9 Distribution of households by de jure household and sex of household head, Peli

De jure household size	Sex of household head		All households
	male	female	
(1-4)	9	4	13
(4+)	14	3	17
All households	23	7	30

The distribution of households on the basis of size and sex of household head is not unlike findings elsewhere in Lesotho, with large male-headed households being in the majority (see, for example, Murray,1981:55). But in comparison with other findings, the incidence of female-headed households tends to be slightly lower at both villages (23 percent, Peli; 20 percent, 'Ngoe). Reports on distribution of female-headed households range from 27-44 percent (Murray, 1981:54).

Murray warns that comparisons are difficult as criteria for identifying household heads are not uniform (1981:54). Household heads in this study are individuals, both male and female, who perceive themselves and are perceived by others to be the

'owner', i.e. the individual in whom rights to arable land, the residential site, the physical homestead and the major portion of household property are vested.

Murray also makes the point that comparison of incidence of female-headed households will also vary with the 'intensiveness of fieldwork on which results are based' (1981:55). The survey of just over half, instead of all the households at 'Ngoe and Peli, is quite possibly the significant factor accounting for the lower incidence of female-headed households in this study.

However, some general differences between female-headed households at 'Ngoe and Peli do emerge which reflect differences between urban and rural female-headed households reported elsewhere. At Peli, all female household heads (in this sample) are widows and with the exception of one, who lives on her own, have access to arable land and cash incomes. At 'Ngoe, on the other hand, of the eight women (in this sample) who head households of their own, only one is widowed and the remaining seven are divorced, deserted or unmarried women with children. Four of the households have cash incomes but four are wageless, three of which, as mentioned above, are large households.

Gay (1980:221-292) discusses the plight of women in Lesotho and Van der Vliet (1982) and Obbo (1981) their situation elsewhere in Africa. They point out that where women (usually with dependants to care for) are without a rural resources such as land, or a husband to provide a cash wage income, the opportunities for supporting their households are perceived to be greater nearer the towns. For the female household heads at 'Ngoe, many of whom are forced to become self-supporting through no fault of their own and are barred from earning a wage in the Republic of South Africa, a district capital like Qacha's Nek is one of the few options open to them.

Cash Earning Activities

As mentioned earlier, cash is essential for survival in rural Lesotho. The following section discusses cash earning activities at both villages. It examines regular wage employment in the working age group (16-59 years) and includes pensioners who contribute a regular cash income to a household. (Pensions are contributory ones from South African organisations such as South African Railways and private firms. The mines do not have a pension scheme and there is no social old age pension in Lesotho). The discussion also mentions some of the informal income-generating activities of the villagers.

Tables 2.10 and 2.11 point out that the Chamber of Mines in South Africa and the Lesotho government are the major employers (all those employed in Lesotho at both villages, with the exception of the domestics, are government employees).

At both villages the number of males in the sample population active in wage labour (69,4 percent,'Ngoe; 66,6 percent,Peli), is slightly lower than studies carried out in the 70s (see, for example, Spiegel,1979:56) where he reports 73 percent of males in wage labour. The difference may be due to sampling techniques or indicative of rising grassroots male unemployment for which there is evidence at national level (see Graph 2.1),

For males, there are few cash-earning alternatives to migrant labour in South Africa and the Lesotho government civil service. Some examples include shepherding, plastering and construction of concrete brick houses (women tend to build the mud-walled houses), 'odd jobs' such as mending primus stoves, gates and fences, and thatching. In general the opportunities are meagre and cash returns poor and irregular.

Table 2.10 Distribution of regular wage employees (16-59 years) and pensioners by sex, country of employment and occupational category, 'Ngoe

Country of employment	Occupational category	Male	Female	Total
South Africa	Pensioner	1		1
	Mining	20		20
	Photography	1		1
Sub-total		22		22
Lesotho	Agricultural officer	1	1	
	Police	3		
	Clerical		4	
	Domestic		1	
Sub-total		4	6	10
Total		26	6	32

Table 2.11 Distribution of regular wage employees (16-59 years) and pensioners by sex, country of employment and occupational category, Peli

Country of employment	Occupational category	Male	Female	Total
South Africa	Pensioner	4		4
	Mining	19		19
	Supervisor	1		1
	Domestic		2	2
Sub-total		24	2	26
Lesotho	Domestic		1	
	Police	5		
	Teaching	1		
Sub-total		6	1	7
Total		30	3	33

Women are barred from working in the Republic but a few manage to obtain regular wage employment there (see Table 2.11). In general, they are confined to the cash earning opportunities in Lesotho itself. The government is a source of regular wage employment, but more particularly for women living at 'Ngoe (see Table 2.10). Other opportunities for regular wage employment, such as domestic service, are extremely scarce (see Tables 2.10 and 2.11). Nevertheless, the women make the best possible use of other informal income-generating opportunities.

Opportunities for informal income-generating activities tend to be better at 'Ngoe. 'Ngoe is close to the town, the bus station and the hospital, which are all useful avenues for selling homemade bread, homemade doughnuts and fruit.

'Joale' (home brewed beer) is the most lucrative activity, but by law is confined to the villages. However, even in this activity 'Ngoe is better off. The numerous travellers using the main bridle path which links villages from across the Sejabatho with Qacha's Nek town provide a valuable source of passing trade. For this reason the plots bordering the track are some of the most highly prized in the village. At Peli, set back from the main roads, 'joale' selling is limited to custom from within the village itself.

Activities such as bread-making and beer brewing, which require significant initial cash outlay (to buy the ingredients) may be dependent upon the receipt of cash wage remittances or regular cash wage incomes. These informal income-earning activities are largely directed at generating additional household cash resources.

Without a cash wage income informal earning opportunities are limited to tasks that do not require cash outlay, such as collecting firewood, washing of clothes, helping in the homestead and at Peli, helping in the fields. Payment is often in kind rather than in cash.

There are also resourceful individuals (market women and 'joale' sellers) who do not receive cash remittances. Yet, through constant activity they endeavour to generate sufficient cash to maintain their regular livelihoods, as well as to run their households.

Land Distribution, Maize Yields and Livestock Holdings

A discussion on land distribution is basic to a study which centres on food and shelter at the household level. As indicated earlier, access to rural land is essential in a situation of migrant labour where urban settlement is strictly curtailed. We also need to examine agricultural yields in order to find out whether, or how, they contribute to a household's sustenance requirements.

The following tables 2.12 and 2.13 illustrate the distribution of land at both villages. It is extrenely difficult to obtain exact sizes of fields, plots and gardens (see also Wallman, 1969:136). Fields or arable landholdings vary between 0,1 and 4,1 acres (Spiegel,1979:221). Plots which are residential sites, allocated for the building of the homestead, also vary considerably in size. Few villagers make the distinction between a plot and a garden. At Peli, one respondent specifically drew my attention to the fact that her site was a 'garden' on account of its being significantly smaller than a plot and therefore not suitable for cultivation. Some plots at Peli are large enough to grow some vegetables and

fruit for household consumption, but not so for most householders at 'Ngoe, which is situated on a sandstone plateau.

Table 2.12 Land distribution by households, 'Ngoe

Landholdings	Number of households	Percentage households
Field	0	
Plot	33	82,5
Rented accommodation	7	17,5

Table 2.13 Land distribution by households, Peli

Landholdings	Number of households	Percentage households
3 fields	3	10
2 fields	6	20
1 field	7	23
Plot	13	43,3
Garden	1	3,3

Tables 2.12 and 2.13 reflect the general shortage of arable land which is reported for Lesotho (see, for example, Ashton, 1952:145; Hamnett,1975). Sixteen of the 70 households in the sample have fields. Forty-seven have residential sites and there are seven households at 'Ngoe which are renting accommodation.

Households renting accommodation include two male-headed households in the early phase of domestic development who have selected to apply and wait for a residential plot at 'Ngoe. 'Ngoe appeals, despite its lack of arable land, because of its access to Qacha's Nek and its amenities. The householders are prepared to rent accommodation in the village until a site becomes available.

Females heading households of their own are also renting accommodation at 'Ngoe. They are prepared to rent accommodation and earn a living from the better informal cash-generating activities until they can claim a permanent residential site.

Some households renting accommodation at 'Ngoe are not necessarily altogether without a residential site. In some cases where the male household head is unemployed, the household has moved to 'Ngoe from a rural village where they have a plot. The move in three cases was precipitated by unemployment. The ethnography below suggests that it becomes increasingly difficult for a large household without a cash wage income to survive in a rural village, and the villagers may move to the outskirts of a district capital where informal income-earning opportunities are better.

At the level of the individual householder, renting accommodation may be a temporary phase. The young householders and the female household heads may eventually be granted a residential site. Should the unemployed males manage to renew their contracts on the mines, they may return to their residential sites in the rural villages. Nevertheless, at a more general level, 'lodgers' appear to be seen as a permanent category of persons, to the extent that some shrewd entrepreneurs are building accommodation for rental. A row of three rooms, or 'flats' as they are called, was built between 'Ngoe and the hospital during the time I was there. In 'Ngoe itself an 'hotel' or lodging house was in the process of construction. Renting accommodation is not confined to 'Ngoe and seems fairly common practice in the settlements close to Qacha's Nek town. One enterprising widow has put her arid plot at 'L' to good use. Over the years she has extended her homestead room-by-room. She now has eight rooms, numbered in the conventional manner, which she rents out.

It would seem that where individuals see little possibility of gaining access to arable land in a rural area, or they are faced with unemployment, they are moving to the district centres (see also Wilkinson,1982; Spiegel,1984). An influx of people to the district centres places increasing constraints on residential land in the peri-urban areas, the availability of which is possibly also going to decline.

The year in which I did my fieldwork the yields were nil as a result of the drought. However, for some general discussion Table 2.14 lists the average yields at Peli for 1981, which was considered to be a good year for agriculture. The net yields are 'bags' in hand after sharecropping and other payments have been made. Fertiliser can be purchased at reduced cost and a government tractor may be hired. Payments for government assistance are fixed at three out of every five bags of maize produced, but farmers are given the option of repurchasing grain at reduced prices. (Householders making use of government assistance are marked (*) on the Table).

It is clear from Table 2.14 that yields fall short of the 20 bags which is the estimated minimum necessary to feed an average household for one year (Houghton and Walton,1952:159). Wallman (1969:66-67) and Spiegel(1979:58) report similar findings. Consequently, there is little alternative open to villagers but to purchase the staple maize and additional food for most of the year.

Farming demands a cash input. Fertiliser and seeds must be purchased and arrangements made for ploughing which may include the hire of a tractor. Government assistance is available at Peli, but it is interesting that only five of the sixteen households with fields claim that they make use of the availability of fertiliser at reduced cost, or use the government tractor.

Table 2.14 Land distribution, sharecropping arrangements and maize yields for 1981 at Peli

Household	Number of fields	Plots	Sharecropping arrangements	Net yield (bags)
1	-	1	-	-
2	-	1	-	-
3	2	1	-	6 *
4	1	1	1 +	6
5	-	1	1	2½
6	-	1	-	-
7	-	1	-	-
8	2	1	-	7
9	1	1	-	2½*
10	3	1	-	5 *
11	-	1	helps in fields	1 tin
12	-	1	-	-
13	1	1	-	7 *
14	1	1	-	2½
15	-	1	-	-
16	2	1	-	5
17	3	1	-	8 *
18	-	1	-	-
19	-	1	-	-
20	-	1	1	2½
21	-	1	3	8
22	2	1	-	(not planted)
23	-	1	1	2
24	-	garden	-	1 tin
25	1	1	-	3
26	2	1	s/cx2	5
27	3	1	-	8 *
28	2	1	-	4
29	1		-	(not planted)
30	1	1	s/c	2½

Notes: * = farmer made use of government assistance of fertiliser, seed at reduced prices or hired government tractor

1 bag = 200 lbs maize = 80-90 kg
6 tins= 1 bag. A tin consists of an empty oil or paraffin tin and thus contains ± 14 kg maize

\+ = sharecrops an additional field

Reasons why more villagers do not make use of government assistance are difficult to ascertain. Some may consider the fixed payment of three out of five bags of maize not a great incentive. Then there are those who may be involved in ploughing and sharecropping arrangements which involve important social relationships with elements of reciprocity which are of consequence in other aspects of their lives. There is evidence for this in some of the ethnography that follows.

It was difficult to elicit the exact cost of agricultural activities. However, other studies in rural Lesotho point out that agricultural activities are often unprofitable (see, for example, Murray,1976:129-130; Spiegel,1979:58). The unprofitability of farming is not necessarily denied by the villagers. But, as mentioned earlier, the value of land is in its perceived potential as an alternative source of security to the insecurities of migrant labour (Wallman, 1969:107; Hamnett,1975:66). In order to retain this alternative source of security the land must be farmed. If a field remains uncultivated for a period of more than two successive years, a landholder may be obliged to forfeit the land (Murray,1981:71).

The point is that the cash demands agriculture makes for the poor yields it provides, does not place arable landholding households in a better position to provide sustenance for depandants. In fact, landless households, although they do not have the long-term security of arable landholdings, without the drain of agricultural investment on the household budget, may have more available cash for day-to-day needs.

Livestock has traditionally played an important role in rural Southern Africa and Lesotho. The diplomatic use of the system of 'mafisa' (see Note 6), helped Moshoeshoe 1 in his

dramatic rise from headman to paramount chief (for biographical accounts of Moshoeshoe I see Thompson,1975; Sanders,1975). Formerly, livestock in the form of bride-wealth payments created links between clans. Today they primarily serve to maintain ties between the migrant husband and his rural kin (Murray,1981:119-148). Livestock are also important for establishing a household's rights to grazing land (Spiegel,1979:59). Consequently, because there is a demand for livestock, they are a valuable investment and can be converted into ready cash when needed.

However, since the 1930's there has been a general decline in livestock holdings (Murray,1981:91) and Tables 2.15 and 2.16 show the present situation of livestock holdings in the two villages.

Table 2.15 Distribution of livestock by de jure size of households, 'Ngoe

Livestock units	Size of household Small (1-4)	Large (4+)	Total households	Percentage
None	-	-	31	77,5
1-4,9	3	4	7	17,5
5-9,9	-	-	2	5,0
10-19,9	-	-	-	-
20+	-	-	-	-

Note: 1 livestock unit = 1 bovine/equine = 5 sheep/goats
Pigs and poultry are not accounted for in this unit (Quirion,1948:71).

Table 2.16 Distribution of livestock by de jure size of households, Peli

Livestock units	Size of household Small	Large	Total households	Percentage
None	-	-	14	46,6
1-4,9	1	8	9	30,0
5-9,9	3	1	4	13,3
10-19,9	2	1	3	10,0

Tables 2.15 and 2.16 point out that the majority of households at both villages do not have livestock and that there are fewer livestock-holding households at 'Ngoe. It suggests that decline in livestock holdings continues and appears to be more noticeable in the more urbanised areas.

Recent studies also show that livestock tends to be concentrated in the larger households (Van der Wiel,1977:86). This is evident to some extent at Peli. However, small households with considerable livestock are also listed. It is quite possible that these smaller households, with fewer consumers making demands on the household budget, have the surplus cash available to invest in livestock. I enlarge on this point in Chapter three.

Some quantitative data which provides a baseline for the following ethnography has been presented. Here a few final points are made regarding differences in apparent poverty.

Tables 2.17 and 2.18 reveal that the incidence of wageless households is considerably higher at 'Ngoe (35 percent) than at Peli (13,3 percent). Tables 2.17 and 2.18 also reveal that wageless households are larger at 'Ngoe (range 1-8) than at Peli (range 1-4). At Peli, there is one household which could be described as the typically extremely impoverished female-headed household which is described in the literature (see, for example, Lye and Murray,1980:109). However, at 'Ngoe, eight of the fourteen wageless households are large (5 male

Table 2.17 Distribution of wage incomes by range of de jure household population and sex of household head, 'Ngoe

Number of wage incomes per household	Sex of household head and range of de jure household population				Percentage of households
	Male	Range	Female	Range	
3	1	9+	0		2,5
2	3	6+	0		7,5
1	18	2-8	4	3-8	55,0
0	10	2-8	4	1-8	35,0

Table 2.18 Distribution of wage incomes by range of de jure household populations and sex of household head, Peli

Number of wage incomes per household	Sex of household head and range of de jure household population				Percentage of households
	Male	Range	Female	Range	
3	2	10-11	0		6,6
2	3	11+	0		10,0
1	15	3-8	6	1-8	70,0
0	3	2-4	1	1	13,3

and 3 female). In terms of size, in relation to lack of cash income, they appear to face an even greater level of poverty.

Increasing impoverishment is predicted for the rural dwellers of Lesotho in the 1980's (Spiegel,1980). Spiegel bases his predictions on arable land and cash wage incomes becoming the prerogative of a few, while increasing numbers become landless and wageless. Findings to support these predictions would require a longitudinal study of some time depth which is not the brief of this thesis. Nevertheless, it can be tentatively put forward that on the basis of household size, in relation to lack of cash wage resources, increasing poverty does appear more apparent in the newer closer settlement, in contrast with the older rural community of Peli.

It is against this background of apparently increasing poverty in the rural countryside that the health strategies and responses to disease episodes of the villagers of 'Ngoe and Peli are examined. Because Peli is the older of the two villages, and being a landed village, more representative of previous social anthropological investigations in Lesotho (see, for example, Spiegel,1979), I discuss this settlement first when presenting the ethnography.

In addition, although I recognise the importance of acknowledging the interrelationship between health and disease (see Chapter one), I treat them separately for the practical purposes of presenting the ethnography. As Lewis states:

> Since this is a practical aim there is no harm in accepting working assumptions such that dualist language is unavoidable here and that the fictions health and disease serve a useful intellectual purpose, though we know they refer merely to uplands and lowlands in a continuously graded and terraced country (1953:110).

Notes to Chapter Two

Note 1 To avoid cumbersome repetition of income, food, shelter, water and sanitation, I refer to them as 'essential services', especially as they are considered to be 'essential' for the health of a population (see, for example, Morris, 1979:20).

Note 2 TEBA is the recognised abbreviation for The Employment Bureau of Africa Limited. It is the recruiting arm of the Chamber of Mines (Murray,1981:19), which as an organisation collectively represents various mining companies in South Africa in a number of common areas of interest, one of which is labour. TEBA publishes annual statistics of numbers recruited and employed on the mines from various countries in Southern Africa and the 'homelands'.

Note 3 A certain discrepancy exists in regard to the number of clinics and outstations; 143 (3FYDP:322), 95 (Report on a Joint Mission to evaluate the Extended Immunisation Programme, 1982:12), 85 (Smith,1980:9). It needs to be recognised that some outstations employ unqualified staff who offer a minimal service and are thus not officially recognised as health-care institutions. In addition, some non-government institutions may be arbitrarily opened and closed 'depending on a host of factors' without necessarily communicating with the Ministry (Smith,1980:9). These points may explain the discrepancies in the number of clinics and outstations listed,

Note 4 Much has been written on the role of the missionaries during the colonial expansion into Africa and elsewhere, both for (see, for example, Wilson,1971: 72-74) and against (see, for example, Keesing,1976:451-462). But their impact was not necessarily a question of either one or the other. It depended on a variety of factors, not least of all the response and acceptance of missionaries by the local people, which was not necessarily always enthusiastic (see, for example, Etherington,1978:47-144). Moreover, the missionaries themselves were individuals and but one aspect of the wider process of colonial expansion.

Lye and Murray provide a balanced view of the impact of the missionaries among the Southern Sotho (1980:64-69). Moshoeshoe I invited the French Protestant missionaries to settle on his land. He recognised their usefulness as literate people, in matters such as the continuous land disputes with the Boers and the British. Casalis and Arbousset, the first French Protestants to work in Lesotho, were soon followed by Catholics, Anglicans and the Methodists. The missionaries played an important role in education, the emergence of Sesotho as a written language, Sotho literature and health-care services. However, they also attacked local customs such as bridewealth payments and polygamy and have been involved in the country's politics. Today, missionaries are still to be found in Lesotho, largely in the fields of education and health care.

Note 5 According to a personal communication, there are 14 assorted clinics and outstations. But other sources state 8 (1976 Qacha's Nek Hospital Report: 5), and 5 (Smith, 1980:6). Furthermore, during my stay there was a project to upgrade some of the clinics and a new clinic was being

built at Matebeng. Reasons for the discrepancies in clinic figures are most probably similar to those mentioned earlier (see Note 3).

Note 6 'Mafisa' is a practice whereby a stock owner entrusts a portion of his stock to the care of another who acts as caretaker in return for certain usufruct rights over the stock (Sheddick,1954:109).

SOME OF THE PEOPLE OF 'NGOE AND PELI

INFANTS

TODDLERS

CHILDREN

YOUNG HOUSEWIVES

THE DECLINING YEARS

Chapter Three: HOUSEHOLD HEALTH STRATEGIES

> Health will be considered ... from a more practical point of view, not as an ideal state of well-being achieved through complete elimination of disease but as a 'modus vivendi' enabling imperfect men to achieve a rewarding and not too painful ecistence while they cope with an imperfect world (Dubos, 1977:32).

Introduction

This chapter describes how the residents of two villages in Lesotho 'achieve' or strategise to maintain health. The primary focus of the chapter is their health strategies at the household level and how these may be affected by differential access to material wealth. However, there is also variation between the villages. For instance, the residents of 'Ngoe do not have access to arable land in the village itself (which may be associated with providing food and shelter) and there is also a higher percentage of impoverished households than at Peli (see Table 2.17). They are, however, closer to the district capital and it has been documented that chances of physical survival for the impoverished are greater in the vicinity of an urban centre (Lange, Financial Mail:12.10.1979). In order to ascertain whether at the village level, variation in access to some resources associated with providing food and shelter, and variation in geographical access to an urban centre affect health strategies, the villages are examined and presented separately. The chapter also outlines the context of health or 'social normality' for the investigation of disease episodes in the following chapter.

Food, shelter and income are the focal issues for the investigation of household health strategies. As pointed out earlier, food and shelter are both dependent on access to cash.

Agricultural yields are insufficient to feed an average household over one year (see Table 2.14) and consequently the majority of sustenance requirements must be purchased.

Shelter, or the process of building up the homestead (Spiegel, 1969:50) also requires substantial cash outlays (see page 19). The building of the physical homestead, its furnishing, the acquisition of livestock and investments in agriculture during the various phases of domestic development (see Spiegel,1979:6-7) serve to establish a householder's rights, or sense of belonging to a community, his or her rights to community grazing land and to arable land (Sheddick,1954:16; Spiegel,1979:51). In the case of the migrant worker employed in the Republic of South Africa, this process is vital in providing a secure home base, as permanent urban settlement for the worker and his/her dependants at, or near, the workplace is prohibited by law.

To feed a household requires regular daily or monthly expenditures, but at the same time establishing the homestead also makes constant additional, but necessary, demands on the household budget. Thus food, shelter and income are inter-dependent. But for the purposes of analysis, food diaries, despite their limitations (see Chapter one), provide some immediate indication of what is occurring at the household level, while shelter and all it entails is a measure of the varying demands on the household budget over time.

What is immediately striking from an overview of the food diaries (examples - see Note 1 - appear as Appendix B) is the sameness of the diet. Maize is the staple food and constitutes the bulk of the diet. A few households may include meat or eggs once or twice a week. Some are eating three meals a day, but others less frequently. But the inclusion of a minimum of protein, and the regularity and irregularity with which meals are taken are the only differences that can be detected in the eating patterns of households.

In contrast with the uniformity of the eating patterns there is significant material differentiation between households in both villages. Tables 3.1 and 3.2 illustrate the categories of material differentiation which are based on land and wage income criteria (see Spiegel,1979:3). (As discussed in Chapter one, landholding wage-dependent households are materially more advantaged than landless wage-dependent households and/or landholding wageless households, while landless wageless households are the most impoverished).

It might be surmised, without the additional evidence of the food diaries, that a materially advantaged household may be in a better position to provide food and shelter for dependants than an impoverished household. Segar reports evidence for this in the Transkei (1982:42-49). In her study there is a marked correlation between material wealth and diet. The materially advantaged households provide a much more varied and nourishing diet - 'meat, rice, jelly and custard' (see 1982:49), while the most impoverished members of the community exist on a diet consisting largely of 'field mice and wild vegetables' (see 1982:42). There is also some evidence for a relationship between material wealth and diet in this study. For example, at Peli the consumers of a large male-headed landholding wage-dependent household regularly include meat in their diet and also eat more regularly (see food diary 1) than a small male-headed household dependent on a single wage (see food diary 6). But it is extremely difficult, on the basis of material differentiation alone, to account for some of the variations the food diaries reveal. For example, dependants of a large male-headed wageless landless household at 'Ngoe (see food diary 13) eat more regularly than members of a small male-headed wage-dependent household in the same village (see food diary 11). They also eat more regularly than the dependants of a large male-headed wage-dependent landholding household at Peli (see food diary 2). An investigation into some of the processes behind the significant material differentiation between households on the one hand, and little marked variation of eating patterns on the other, is an important aim of this chapter.

Table 3.1 Arable landholdings and cash wage-income distribution for 70 households at 'Ngoe and Peli by numbers of de jure households, mean household size and range of de jure household population

Landholdings cash wage incomes	Numbers of De Jure households & Percentage		Mean De Jure Household	Range of De Jure Household
	Numbers	%	Size	Population
Landholding wage-dependent households	14	20	7,2	1 - 12
Landless,wage-dependent households	38	54,2	5,3	3 - 8
Landholding wageless households	2	2,8	3,5	3 - 4
Landless, wageless households	16	22,8	4,1	1 - 8
Total Households	70	100,00		

As landless wage-dependent and landless wageless households are found at both 'Ngoe and Peli, Table 3.2 is included to provide a breakdown of these categories for the respective villages.

Table 3.2 Breakdown of landless wage-dependent and landless wageless households at 'Ngoe and Peli

	Number of De Jure households			
	'Ngoe		Peli	
	Number	%	Number	%
Landless wage-dependent households	26	65	12	40
Landless, wageless households	14	35	2	6,6

Apart from factors such as individual appetites (which a study of this nature cannot account for), there are a number of possible explanations. Those (some employers, for example) who erroneously believe that arable land is equitably distributed among the rural population would say that eating patterns are similar because everybody is deriving similar yields from agricultural production. But it has been noted that land is not equitably distributed (see Table 2.13) and agricultural yields are inadequate for the average household's annual sustenance requirements (see Table 2.14).

Others may say that eating patterns are similar because maize is the 'traditional' diet and villagers are eating what they enjoy most. Certainly the majority do enjoy their traditional staple food, maize, as the Italians like their spaghetti, but in moderation! The villagers can be heard to bemoan the endless monotony of 'papa and moroho' - maize porridge and cooked green vegetable, usually cabbage which, when well seasoned, is a tasty meal. But unlike other available staple foods such as rice, bread or potatoes, maize meal is relatively inexpensive and filling (see Note 1).

Villagers claim they would like to include more milk and eggs in their diet and are well aware of their value, especially for their children. But milk is difficult to obtain and eggs are expensive, costing up to 17 cents each at the village cafe. Meat is a favourite and a luxury but more often than not is confined to feasts and funerals. Even so, fewer and fewer people can afford to provide meat at all. Thus, it is not because the people of 'Ngoe and Peli especially prefer 'papa' and 'moroho' that they eat it day in and day out, but because it is the most inexpensive way of providing a palatable and filling meal.

The drought of the summer of 1982-1983 may also be a factor accounting for the lack of variation in the dietary patterns. During a drought as food becomes more scarce, prices rise. It could be said that the villagers have little alternatives but to eat the relatively cheap maize and readily available cabbage, which they claim is a sturdy survivor of droughts.

Food prices did, in fact, rise during this period but interestingly (although there are no specific figures from my data to substantiate the claim), according to the manager of the TEBA offices in Lesotho, so did remittances from workers to the rural areas. He explains the rise as a response by urban workers to the additional difficulties (such as rising food costs) facing rural dependants during a drought (letter 20.1.1984 in response to my query of a South African Broadcasting Corporation news report, 12.1.1984). Thus, increased food prices during the drought were compensated for in some cases by additional cash incomes and the drought cannot therefore be considered the major factor responsible for the similarity in eating patterns.

In addition, the dietary patterns noted in this study are not inconsistent with earlier reports. For example, Williams points to the lack of meat in the diet and cites the old Basotho proverb 'meat is the visitor and porridge stays at home' (1981:37), which would suggest that the situation has been the same for some time. He also discusses findings that make no mention of drought as a factor in diet and which reflect almost exactly the same minimum protein, high maize intake and irregular meal-taking of the present study (1971:35).

Variation in household size may partly explain the sameness of eating patterns. The materially advantaged landholding wage-dependent households tend on the whole to be larger than

the less well-off households. They are therefore providing sustenance for a greater number of individuals. This has the effect, at a broader level, of evening out the dietary pattern. However, considering the variation in size of household populations both within and across the different categories of material differentiation (see Table 3.1, column 4), size on its own is not sufficient explanation.

Because food and shelter are both cash dependent, the ratio of rural household consumers to number of wage incomes, which Murray describes as a Dependency Ratio 2 (DR2 - see 1981: 55-56), must also be considered. He puts forward the DR2 as an alternative to the conventional Wage Dependent Ratio (WDR - ((children 0-15 years + elderly 60+ years) ÷ (workers 16-59 years)), to give a more accurate picture of Lesotho's labour status and the additional constraints facing the majority of the working age group in a situation of migrant labour . He defines the DR2 as the ratio of 'de facto household members' (or rural consumers) to 'paid employees' (Murray, 1981:55). 'Paid employees' include those wage earners employed in Lesotho and South Africa (Murray,1981:50). Although the DR2 gives a more accurate picture of the rural household situation than the conventional WDR it is still, nevertheless, a fairly rough estimate.

It is extremely difficult to elicit exact data on wages, which vary in the mining industry from R129 per month for unskilled labourers to R290 per month for some semi-skilled workers (Work in Progress,1984:38). It is also difficult to elicit exact information about remittances; and there is also the additional cash generated by informal-earning activities, petty traders and 'piece' workers for which a DR2 does not account (see, for example, Spiegel,1979:8-9). However, it is a useful guide to rural consumer demands on household cash incomes.

Tables 3.3 and 3.4 list the DR2 for large and small male- and female-headed households and Tables 3.5 and 3.6 by wage income distribution. They range considerably (see, for example, Table 3.3 where DR2 range from 1:3,5 to 1:14,5 and Table 3.5 where they range from 1:1 to 0:6,6). Again one would assume that a household where a DR2 is 1:1 would be eating a more varied diet than one where the DR2 is 1:14,5. But this is not evident in the food diaries (see, for example, food diaries 1 and 15). Thus, the ratio of rural consumers to numbers of paid employees per household also does not entirely explain the similarities in eating patterns.

The findings of Spiegel's (1979) study are, nevertheless, useful. He points out that in response to poverty, which he relates to a dependence on migrant labour in a regional economy, migrant remittances are redistributed throughout a community. Although he does not focus on the particular interest areas of this investigation, it can be suggested that redistribution of migrant earnings also serve to provide food and shelter for the greatest number of individuals. In the process of redistribution, as the food diaries suggest, the effects of the apparent differences in material wealth between households in these areas of social life are levelled out.

The channels of redistribution, or the social relationships directed towards providing food and shelter, are the health strategies of primary interest in the following ethnography. Maintaining health in conditions of poverty is revealed as

Table 3.3 Dependency Ratio 2 by de jure size and sex of household head, 'Ngoe

De jure household size	Sex of household head		All households
	Male	Female	
Small	1:3,8	1: 3,5	1:3,5
Large	1:5,6	1:14,5	1:6,2
All	1:4,7	1: 9,0	1:5,7

Table 3.4 Dependency Ratio 2 by de jure size and sex of household head, Peli

De jure household size	Sex of household head		All households
	Male	Female	
Small	1:4,3	1:2,0	1:3,6
Large	1:4,3	1:5,0	1:4,4
All	1:4,3	1:3,5	1:4,2

Table 3.5 Dependency Ratio 2 by wage-income distribution, size and sex of household head, 'Ngoe

Income Distribution	Size and Sex of Household Head			
	Large Male	Small Male	Large Female	Small Female
3 incomes	1:1,0	-	-	-
2 incomes	1:2,1	-	-	-
1 income	1:5,4	1:2,0	1:5,5	1:3,0
0 income	0:6,6	0:2,4	0:5,6	0:1,0

Table 3.6 Dependency Ratio 2 by wage-income distribution, size and sex of household head, Peli

Income Distribution	Size and Sex of Household Head			
	Large Male	Small Male	Large Female	Small Female
3 incomes	1:2,8	-	-	-
2 incomes	1:3,0	-	-	-
1 income	1:5,6	1:2,8	1:5,0	1:1,6
0 incomes	-	0:3,0	-	0:1,0

a matter of strategising for survival. Thus, health in many cases becomes synonomous with survival especially among the more impoverished households. Both terms are used in the following discussion: health on the one hand to maintain the broad health-disease dimension of the study, and survival on the other hand to emphasise the enormous difficulties the villagers face.

The ethnography is presented making use of the categories of material differentiation, considering at the same time, variables which will affect sustenance (such as size, sex of household head, and number of wage earners per household). The categories of material differentiation are closely related to the different phases of homestead building in the process of domestic development (Spiegel, 1979:3), and therefore provide a measure of the demands of shelter on a household budget. Furthermore, because differences in material wealth between households is closely related to a dependence on migrant labour (Murray, 1981; Spiegel,1979), by using categories of material differentiation it is possible to trace some of the effects of a regional dependence on migrant labour on the health of village communities.

Household Health and/or Survival at Peli

All of the four categories of material differentiation which are based on land and cash criteria (see Spiegel, 1979:3) are to be found at Peli (see Table 3.1). The ethnography for the village commences with a discussion of the landholding wage-dependent households.

Landholding wage-dependent households

Landholding wage-dependent households at Peli vary with respect to size of household, sex of household head, number of cash wage incomes and phase in domestic development. The discussion centres around these variables, all of which influence the health strategies a household may adopt.

Large male-headed landholding households with two and three incomes comprise 16,6 percent of village households. They range in size from 9-11 members, and can be said to be in the zenith of domestic development (see Chapter one, page 19). Homestead building is complete, including the accumulation of some livestock (4-15,2 units). Agricultural activity, however, still demands considerable cash investment.

Households are multi-generational and the senior male (age range 55-65) is the head. With the exception of one household head who is still in government employment, the majority are retired from wage employment. Two receive pensions (from the South African Railways), but the major cash income is from sons who are working either in South Africa or elsewhere in Lesotho.

Where there are two or three wage earners, employment tends to be divided between the government service in Lesotho and the South African mines.

This spread of wage-earning activities has some distinct advantages for a household. Government employment in Lesotho offers security of tenure and civil servants can expect a pension. Housing may be provided for some government employees wherever they are stationed. Some males may have their wives and children living with them. Nevertheless, because government housing is temporary, a civil servant has the same need as a migrant worker to establish a secure home base. Thus government employees frequently send remittances to a rural household with this in view.

Although contract mine labour lacks long term security of government service, it is perceived as desirable because it has the advantages of bonuses and substantial lump sums of deferred payments (see Note 2) at the end of a contract. It also allows a working man lengthy periods at home in the village to sort out homestead building tasks such as buying livestock or arranging sharecropping contracts and so forth.

Thus it appears that households with more than one wage-earner tend to spread their energies in order to reap the benefits of the relatively well paid mine labour, on the one hand, and the long term security of the civil service on the other.

The food diaries from these apparently materially advantaged households (Food Diaries 1 and 2) are not markedly different from other households, either at Peli or 'Ngoe. Evidently

their material resources and additional cash incomes are providing for a greater number of individuals. It can be suggested that large materially advantaged households are in themselves a health strategy. As Murray has said, landholding wage-dependent households are large because they have the material resources to support a greater number of dependants (1981:88). The following case study is an example:

Case 3.1
Mr A heads a large household of eleven members including himself, his elderly frail mother, his two sons, their wives and children and his unmarried daughter. He owns one field, has no livestock, and the household receives three cash wage incomes. Mr A is a pensioner, his one son is in Lesotho Police Force and is presently stationed at Quthing, the other is a miner in South Africa.

The wife and children of the policeman visit him at Quthing for short periods, but his post there does not provide for family accommodation. For most of the year, therefore, there are five adults and four children to be fed. The yield from Mr A's field (approximately 3 bags of maize), despite some government assistance is inadequate to feed the household members and the major portion of foodstuffs is purchased. Meals are provided regularly but consist almost entirely of maize and wild spinach - when it is available. During the drought even the wild spinach was in short supply.

There are some almost accidental factors (see Case 3.2 below) which may contribute to a more varied diet among large male headed landholding wage-dependent households with two and three incomes. For example, a member of a rural household in government employment may be living with his wife and children elsewhere in Lesotho. He continues to send remittances home but he and his dependants are not making substantial immediate demands on the rural household's budget. In addition, members of a household who are employees of that household (shepherds, for example), do not necessarily have the same claims to household resources. Age of dependants is also a consideration as children, especially breast-fed babies, are not making the same demands on food resources.

Case 3.2
Mr B heads a multi-generational household of eleven members, including himself, his wife, his two sons and their children, as well as two shepherds. He owns two fields (which yield 8 bage of maize in a good year), and 7,2 units of livestock. His two sons, one a miner and the other a civil servant, send cash remittances regularly. In addition his wife runs a small cafe and keeps some poultry.

With the migrant son away and the wife and children of the civil servant in Maseru, there are only six de facto residents. The shepherds are not related to Mr B and their status is more that of employee. They spend most of their time in the mountains where they supplement their maize rations with rabbits and field mice. The migrant miner's son is a baby who is still being breast fed. Thus, in actual fact there are only three adults to be fed regularly. The eight bags of maize, when available, are a useful supplement to the purchased food items for part of the year. Some additional surplus cash allows the resident household members to eat meat once or twice a week and Mrs A's poultry supplies them with eggs.

Large male headed landholding wage-dependent households with one wage income tend to be fewer in number (incidence 10 percent) than those described above and they also appear to be smaller (ranging from 5-8 members). With one exception all household heads tend to be younger and still active in wage labour. Some have not completed homestead building and are still in the expanding phase of domestic development. Hence, agriculture, the process of setting up house and feeding dependants are all making constant calls on a single wage income.

The demands on a household's cash resources that the process of providing shelter makes may be reflected in its dietary intake. If the physical homestead is complete, and some livestock has been accumulated, cash expenditure is narrowed down to investments in agriculture and food requirements. Some households at this stage can therefore afford to eat meat.

Case 3.3
Mr C is a miner, approximately 45 years old and married to his second wife. He has five children by his present wife, all under the age of ten years (apparently it was the barrenness of his first marriage that prompted a divorce). His physical homestead is complete and well furnished and he owns 4 units of livestock and two fields (yield not available as the field was not planted during 1981 when Mrs C was in Johannesburg with her husband). Remittances are received regularly by his wife and spent on agricultural activities and food for herself, a herdboy and four of the children, one being an infant who is breastfed. The household takes regular meals and meat is included in the diet approximately once a week.

Apart from being in a position where he has established the major part of his homestead, composition and age of household dependants are working in Mrs C's favour with regard to providing sustenance. The children are young, the baby is being breastfed and the shepherd supplements his maize rations with field mice and rabbits.

However, there are landholding households with one wage income where demands of homestead building can affect dietary patterns.

Case 3.4
Mr D heads a household of five. He is a younger man who is a migrant miner. His wife claims that they 'bought' their plot when they moved to the village in 1976. The three children are still young, but the demands on his single income are great. The physical homestead is incomplete, he has no livestock and the fields must be worked. The yield (approximately 3 bags) is inadequate for the rural residents' needs and they eat irregularly with little variation in their largely maize-based diet.

Given the opportunity of access to arable land most rural residents (like Mr D) would jump at it. The value of land does not lie in its immediate productivity (see Chapter two, page 44). Farming is neither profitable nor capable of satisfying an average household's food demands over one year (see Table 2.14). As other writers point out, what renders land desirable is its value as the perceived alternative source of security to the insecurities of contract migrant labour (see, for example, Hamnett,1975:66).

Arable land works as a valuable asset which attracts cash to a household, particularly when a male household head is retired from wage labour (Spiegel,1979:138-140). The landholding households with two and three incomes are good examples of this. The usefulness of arable land as a means of gaining access to cash to ensure sustenance is illustrated in some of the case studies which follow. The point is, that Mr D, by gaining access to arable land early in his career, is investing in the future survival of himself, his wife and his children.

Large female-headed landholding households with one wage income comprise approximately 10 percent of the village households. They are similar in size to their male counterparts (ranging in household population from 5-8 members). Most are widows with children who took over household responsibilities and control of household resources after the deaths of their husbands. Their homesteads were established by then. Some have livestock holdings, but agriculture continues to require considerable cash investment.

With regard to material resourcs, the female-headed households are similar to many of the male-headed households already described. However, as women they face additional problems, particularly in the area of wage labour (Gay,1980:8). Employment opportunities for women are in general limited to Lesotho. Therefore they are largely reliant on sons to secure a cash wage income. The composition of the household, therefore, can affect the strategies they adopt.

Case 3.5
Mrs E took over the administration of the household including three fields and a number of livestock (approximately 5 units) when her husband died. At present she and her four unmarried sons comprise the household. The eldest is a policeman in Maseru and sends remittances regularly, and the three younger boys are at school. They help her in the fields and care for the livestock. In a good year their maize yield is approximately 8 bags. Their diet is monotonous but meals are regular.

With young men in her household to assist with agricultural activities, Mrs E is not involved in any sharecropping arrangements which would entail the sharing of crop yields, and thereby reduce the amount of maize available to her household.

Her sons are also all potential wage-earners who, once employed, and assuming that arable land retains its perceived value, would continue to contribute cash remittances to ensure the household's future. However, in the following case study, a widow has similar material resources, but the composition of her household is such that her position is different.

Case 3.6
Mrs F, also a widow, inherited two fields and 4,8 livestock units after the death of her husband. She heads a household of five. De facto residents include her son of 19 (who is retarded) and her two grandchildren. The mother of the children is a domestic worker in Durban. Because of her poorly paid position her remittances are small. Mrs F has no male dependants in her household who can assist in agricultural work and therefore has a sharecropping arrangement with her late husband's brother. After a good harvest she may have 4 bags of maize in hand but this is not sufficient for her needs. She claims that she does make use of low cost food available at the clinic where she regularly takes her grandchildren.

Mrs F appears less secure than Mrs E, but land for both women is a valuable asset. Mrs E's sons will continue to contribute,

considering the possibility of inheriting the land one day. Mrs F, despite the disadvantages of the composition of her household, has two fields and is reasonably assured of future sharecropping arrangements with relatives in the village. Alternatively, as some householders do (see Case 3.8 below), she may lease her land and thereby secure the necessary cash to maintain at least a minimal level of sustenance.

Small female-headed landholding wage-dependent households with one wage income comprise a small percentage of the village households (6,6 percent). They are small in size (range is 1-2 members), tend to be in the decline of domestic development, and comprise widows who inherited arable land after their husbands death.

On the basis of a wage dependency ratio (1:1) or size of household in relation to material resources, these households would appear to be in a particularly good position to provide food and shelter. But reality presents a different picture. What emerges from comparing the situations of two widows is the benefit derived from having a number of offspring or a 'large family'.

The question of 'large families' seen in the context of the relationship between population growth and economic and natural resources is a subject that receives considerable attention. In Southern Africa, large families amongst the poor and rising population growth are sometimes credited with accounting in part for the perceived threat to resources (see, for example, Sunday Times,29.3.1983; with specific reference to Southern Africa see Cape Times,24.3.1983; Argus, 23.3.1983; Argus, 24.3.1983 reporting on findings of the Presidents Council Study on Population trends released in March 1983).

'Uncontrolled breeding' (see Argus,15.4.1983) or 'customary beliefs' in 'large families' are sometimes put forward as reasons. There is, however, a growing body of literature that examines the political, economic and historical factors surrounding the relationship between population, hunger and resources such as food. These studies show that -

> Measured globally, there is enough food for everyone now. The world is producing each day two pounds of grain - more than 3000 calories and ample protein - for every man woman and child on earth (Moore Lappé and Collins,1982:21)

Moore Lappé and Collins go on to refute views such as 'uncontrolled breeding' stating that for the poor -

> Reasons for increasing family size reflect their powerlessness and poverty not their ignorance .... Survival for them often depends on having children to bring in extra food or money for the family and to provide minimal old age security for the parents (1982:33)

The following case studies illustrate the security children provide in old age. They contrast the situation of two widows in similar material positions, but the one is childless and considerably less secure than the other who has a number of children. The widow with children receives a remittance from her wage-earning son with whom she shares her household. Her married daughters and daughter-in-law who live in Peli assist her in the fields, and particularly in times of need also provide an important supportive network of female kin. Gay reports co-operative ties between women are one of the major keys to their economic survival (1980:51).

Case 3.7
Mrs G shares her small household with an unmarried son who is a miner in South Africa. She has two fields and gets assistance in working them from her married daughters and daughter-in-law, who are living in homesteads of their own at Peli. In return for their assistance, she gives them 'three tins of maize'. However, the yield from Mrs G's field and the three tins of maize her female relatives receive for helping her in the fields are not sufficient for their requirements. They purchase the major portion of their sustenance requirements, but cash received from her son and the other womens' husbands is also not always sufficient to meet these needs. When this happens Mrs G says they help each other either by sharing their food or lending each other cash.

The childless widow on the other hand, has to fend for herself. She works as a domestic at the mission and leases her field. Her field is a useful asset in producing cash income but, without the support of kin-related dependants, she is hard pressed to meet her basic survival needs.

Case 3.8
Mrs H inherited a field after the death of her husband some years ago. She did not have any children and the subject is one she declines to discuss for personal reasons. She leases her field to a young householder in the village, but the cash she receives is insufficient for her sustenance needs and she supplements this by working as a domestic at the mission station.

Landless wage-dependent households

The landless wage-dependent households comprise the majority of households in Peli (40 percent). Each of the households in this sample group is headed by a male who is the sole wage-earner. There appear to be no households in the landless category at Peli that receive more than one income. The majority of the male wage-earners are migrant miners with the exception of one pensioner and a man who is employed at a private firm in Durban.

All of them with the exception of the pensioner, can be said to be in the expanding phase of domestic development and are in the process of establishing and furnishing their homesteads, acquiring livestock, and organising their rights to land through sharecropping arrangements.

Size is the major differentiating variable and tends to affect the strategies people adopt to secure food and shelter. Where there are large numbers of children to be fed, food has primary claim on income and cash for investing in sharecropping arrangements and the purchase of livestock - both useful for obtaining cash for sustenance requirements, especially in old age (as shown in a case study below) - is seldom available. Smaller households where there are fewer children (largely as a result of barrenness) and thus a lower demand on cash incomes for food, more often have the resources to invest in livestock or sharecropping arrangements.

It appears, therefore, that material property is related to the number of children to be fed in a household, and thus that the attainment of material prosperity requires nothing more than sound family planning. However, if health strategies are examined as a process of maintaining physical survival over a period of time, the value of 'large families' is obvious. This is illustrated clearly in the contrast between the plight of the childless elderly with the relative security of those with children (see Case 3.8 in contrast with Cases 3.7; 3.5; 3.2 and 3.3).

The following case studies illustrate the effect of size on strategies among one-wage-dependent male-headed landless households.

Case 3.9
Mr and Mrs I have six children under the age of 15 years, constituting a large, male-headed landless wage-dependent household. Mr I is a migrant labourer working at Welkom and sends home approximately R200 every three months. The homestead comprises two dwellings which accommodate the dependants comfortably and are adequately furnished. But after building and furnishing the homestead and providing for the sustenance needs of a growing family Mr I has little cash over to buy livestock, or enter a sharecropping arrangement.

Small male-headed landless wage-dependent households by contrast appear to be in a position to invest in livestock and sharecropping arrangements as is evident in the following case study.

Case 3.10
Mr J is a miner of 49 years old and his wife is three years younger. They have one child but would have wanted more. (Mrs J has tried numerous therapeutic avenues but has not been able to conceive a second child). With fewer rural dependants to feed, Mr J has over the years completed his homestead, accumulated 5,8 units of livestock and at present has cash invested in three sharecropping arrangements. Mr and Mrs J also 'foster' an additional child who is the offspring of Mrs J's sister.

Gay gives extensive coverage to fostering in Lesotho (see 1980:77-92). She describes it as a 'continuum of arrangements for sharing in the activities necessary to raise and support a child' (1980:77). The arrangements can vary from short visits by a child to close relatives to more lengthy stays with grandparents when the mother may be obliged to work elsewhere to support the household (see, for example, Case 3.6). There are also circumstances like Case 3.10, where a household may take full long-term responsibility for the caring and rearing of the child of another household.

Long-term, full responsibility fostering appears most common among small wage-dependent landless households, where there is history of barrenness and infertility (see also Gay,1980:86). Moreover, in a situation where 'large families' are important, it may also function to enlarge the household and thus ensure some additional wage-earners to provide income for a retired worker. But it also functions to spread sustenance and sheltering responsibilities between households.

Where full responsibility for the child is taken, fostering tends to occur between kin-related households. The fostering household is small; the household from which the child comes is large. The relationship between size and fostering suggests kin-related households employ fostering as a useful health strategy in redistributing demands placed upon individual households.

Landholding wageless households

The incidence of landholding wageless households is low (6,6 percent), and such households are small in size (range of household population, 3-4 members). According to the model for domestic development in Lesotho they are in the decline of domestic development (see Spiegel, 1979: 145). Land may be an important asset but as wage-earning dependants have left the natal household to start establishments of their own, access to cash is a major issue.

Few households in the sample group seem to fit the model. For example, an elderly couple (the wife and husband are 56 and 60 years old respectively) had their children (2 boys who are now 9 and 16 years old) late in life. Thus

the circumstances of childbirth place this landholding household in a situation where a potential wage-earning son is just below the age for regular wage employment (usually 18 on the mines), and the father beyond the working age.

Unemployment may also be a reason for wagelessness among landholding households in an earlier phase of domestic development.

Case 3.11
Mr K, who is 32 years of age, heads a household of three which includes himself, his wife aged 23 and an infant. An older child lives with Mr K's parents at Peli. The parents also gave Mr K one of their fields some time back when, despite a Form C education, he was unable to find employment. The average annual yield from the field is 5 bags, which is sufficient for this small household's staple diet for some months of the year. The temporary fostering of the older child by Mr K's parents also serves to reduce immediate demands on their maize yields.

Wageless landless households

The incidence of landless wageless households is low (6,6 percent), they are small (range of household population 1-2 members) and can be said to be in the decline of domestic development. Among these households, female-headed households appear considerably more impoverished then their male counterparts. Male-headed landless wageless households in the decline of domestic development may reap the rewards of having accumulated livestock during the process of establishing the homestead.

Case 3.12
Mr L shares his homestead with his son, who cares for his livestock units (17) and thus spends most of his time at the cattle post. Mr L has been widowed for some time. His two other sons are married and living elsewhere with households of their own. He has no fields, no cash income, but through selling his livestock for between R60 and R100 he is able to provide for his sustenance needs. He is also the village handy-man mending pots, gates and primus stoves. It does not give him much in the form of a cash income, but it often means a well-cooked meal.

In contrast, an elderly childless widow who lives on her own, and has neither land nor a cash income, depends for her sustenance on food given in return for 'helping in the fields' and the 'hospitality' of her neighbours.

Of hospitality Ashton says -

> The Basuto pride themselves on their hospitality and, quoting the proverb 'The traveller is not chased away' boast that a person can go from one end of the country to the other and never want for food or shelter (1952:92).

He also notes that -

> Etiquette insists that a guest be given food and even on the most informal occasions, when a woman merely 'drops in' on a friend on her way home from the fields an effort should be made to give her something be it only a few boiled mealies (1952:90).

Case 3.13
Mrs M is a childless widow who lives on her own. Since her husband, a Lesotho government pensioner, died she has received no cash wage income. She has no livestock, nor arable land, and claims her'garden' is even too small to grow vegetables. During the year she may assist farming households in the fields and in return she receives a 'tin of maize'. The year (of the study) was particularly hard for her but she claims she also does housework for which she is given a plate of food.

The women in the village say that Mrs M is too frail to assist them with housework, but for the sake of her pride they keep up pretences that the food they provide when she 'visits' them is in return for work. In reality, they share a neighbourly concern to ensure that Mrs M (with no obvious other means of sustenance) eats fairly regularly. There is little the neighbours receive in return for the food they provide for Mrs M, suggesting the element of 'morality' to which Fortes draws attention (see Bloch,1973), rather than reciprocity underlies the relationship.

Social relationships between people are frequently analysed on the basis of reciprocity and there are examples from the case studies presented thus far. For instance (see Cases 3.1 and 3.2) it could be said that in return for cash wage contributions to a household, a migrant's dependants are being cared for by his parents (see also Case 3.6). Over the long term there are expected reciprocities, such as the 'hoped for' return from a 'large family' in providing support in old age (see, for example, Case 3.7 and also the wage-earning dependants of Cases 3.6; 3.11; 3.2). However, the overtly reciprocal nature of these relationships does not necessarily preclude a more subtle, but equally effective sense of 'morality'.

Fortes emphasises the role of morality in kinship obligations (Bloch,1973). He insists that individuals are willing to forego their political and economic interests for the sake of good, but has been criticised. However, he has received support from Bloch who states that reciprocity and morality need not be strictly either-or; that there are effects of morality on economic and political organisation at the level of micro analysis (1973).

The morality in Case 3.13 is obvious. But Case 3.13 is not an example of kinship obligations which are Fortes' central concern. Nevertheless, if the looser ties of neighbourly

relationships are influenced by moral considerations, the stronger bonds of kinship and marriage relationships are likely to show at least the same degree of influence. While reciprocal obligation is easier to identify for the purposes of analysis, moral obligation remains a powerful force which defies mechanistic analyses.

The ethnography discussed thus far points to a number of health or survival strategies, which ultimately serve to redistribute resources amongst the greatest number of individuals to provide food and shelter. For example, large materially advantaged households provide food and shelter for individuals within the same household (see Cases 3.1; 3.2). A co-operative network of female relatives provides support between households in the same village (see Case 3.7), and fostering is a means of redistributing resources among kin-related households not necessarily in the same village (see Case 3.10).

Material assets accumulated during the process of building up the homestead appear to be fundamentally useful in some of these strategies. For example, land seems a valuable asset for large landholding wage-dependent households (see Case 3.1) and can also be the means to cash for a widow with dependants to support (see Cases 3.5 and 3.6).

A 'large family' is important in conditions of poverty where offspring may be potential wage earners. The importance of 'large families' is best illustrated by the vulnerability of the childless elderly to extreme poverty (see, for example, Cases 3.3 and 3.8).

It is clear that migrant earnings, though not confined to the recipient households, constitute the major source of cash for securing food and shelter. In conditions of poverty, cash is redistributed via a number of social relationships of varying intentisy to ensure food and shelter. A consequence of redistribution is that noticeable differences in material standards are levelled out; and this is seen most clearly in the dietary evidence.

Household Health and/or Survival at 'Ngoe

At 'Ngoe, the closer settlement, there appear to be no landholding households. Although some households (as the case studies reveal) retain links with landholding households elsewhere, material differentiation is largely based on access to cash income. Household health strategies are thus discussed under two broad headings, viz landless wage-dependent households, and landless wageless households (see Table 3.2).

Landless wage dependent households

Households in this category vary with respect to number of wage incomes, size and sex of household head, and health strategies will be discussed - as for households at Peli - in relation to the effects of these variables.

Large male-headed landless wage-dependent households with two and three incomes comprise 10 percent of village households. Size of households range from six to nine members and sample households are in the expanding phase of domestic development, when efforts to establish the homestead are greatest.

All the male household heads (ages between 30-45 years) are in wage employment. All are migrants, with the exception of a civil servant who commutes daily to Qacha's Nek town. However, his wage-earning wife works for the government else-

where in the district. Although she is able to come home fairly regularly, she can also be classed as a migrant.

The spread of wage-earners between government employment in Lesotho and migrant labour in South Africa that is evident at Peli is found in some households. However, what is more noticeable at 'Ngoe among households with more than one wage-earner, is the number of women in wage employment. Clearly the geographical location of 'Ngoe which is within walking distance of the town of Qacha's Nek is to their advantage.

Being within commuting distance of employment, a working woman at 'Ngoe can combine wage employment and household responsibilities. While she is at work her children might be cared for by an older child, or a reliable woman in the village who may receive some much needed cash remuneration for her services. As commuters, unlike a migrant mother, (see Case 3.6) working mothers at 'Ngoe have considerable time to spend with their children.

The women are employed mainly in the government service, where they can expect a pension. A pension, especially in a village such as 'Ngoe where there is no possibility of acquiring arable land to attract cash to a household after the head is retired from wage labour, is important. Whether a household can expect a pension appears to determine the strategies members adopt to ensure future security, as the following case studies reveal.

In the first case study below both wage-earners are contract mine employees. Like similarly employed males at Peli they are endeavouring to provide for their unemployment and retirement by investing in the alternative - arable land.

Case 3.14
Mr and Mrs N, their two young children, Mr N's mother and his brother make up this household. They moved to 'Ngoe in 1978. The two brothers working as migrants remit regularly to this household as well as to the household of a relative at their natal village. At this village 'T', they have a sharecropping arrangement and are building up their livestock units (total at present nine units), which are out on 'mafisa' (see Note 6, Chapter two).

Where both wage-earners are employed by the government and have permanent job tenure as well as a pension, the need to provide for an alternative source of security in retirement becomes less urgent. In the following example, where husband and wife are both civil servants, the household owns no livestock, and there are no sharecropping arrangements.

Case 3.15
Mr and Mrs O, who have four children, are both in government employment. Mr O works at Qacha's Nek and Mrs O works at the woolshed at 'S', which means that she is away from her home a great deal. The three elder children are at school and with the help and supervision of their father they care for themselves. The youngest child, aged two, is with Mrs O's mother in Leribe. In return for this caring they send regular cash remittances.

It will be noted that in both case studies mentioned above cash remittances received are redistributed to households elsewhere. Though the reasons for this differ - providing alternative security to migrant labour in the one case, and paying towards the care of a child by an elderly relative in the other - the consequences for eating patterns in both cases are the same. Cash resources do not remain in a recipient household but may be redistributed across villages with the effect of evening out the impact of apparent material wealth on consumption patterns-

Male-headed landless wage-dependent households with one wage income comprise the majority of households at 'Ngoe.

Estimated total incidence is 45 percent, with large households making up 25 percent and small households 20 percent. Large households range in size from five to eight members and small households from two to four.

Age of household head varies considerably from a young unmarried man (aged 25 years) who heads a household which he shares with his mother, to a pensioner of over 60 years. All household heads are in the process of establishing their homesteads, including the pensioner. He has a young wife and three small children and it is only since his retirement from the South African Railways that he has been actively involved in constructing a relatively large dwelling.

Among male-headed landless one-wage-dependent households, size is a factor which determines the pattern of homestead building and the health or survival strategies households adopt (see also similar households at Peli - Case 3.9; and Case 3.10).

Among the large households at 'Ngoe, surplus cash does not appear to be invested in the traditional alternatives to migrant labour during the expanding phase of domestic development. Only two households have livestock holdings and there are no households engaged in sharecropping arrangements in other villages (see, for example, Case 3.14). Homestead building appears to be directed largely at constructing and furnishing a physical homestead and surplus cash, if available, is invested in informal income-generating activities such as beer brewing. Additional cash thus generated is useful for providing the extra sustenance for a larger number of young dependants.

Case 3.16
Mr P, who works for a photographer in Roodepoort (Transvaal), heads this large household which comprises his four school-going children aged between seven and sixteen years, himself and his wife. Their homestead is established, attractively furnished and conveniently situated on the mountain track which passes through the village. Mrs P brews 'joale' one or two days a week, as her budget permits. This generates additional household income ensuring that they eat regularly, but not sufficient to add variety to their daily diet.

It is perhaps also worth noting that Mr P works in the Transvaal for a private firm that offers a pension scheme for employees. With a pension to look forward to after his retirement, securing the alternatives to contract migrant labour becomes less urgent. Cash which may otherwise go towards accumulating livestock or sharecropping can be invested in some lucrative informal-earning activities.

Some contract migrant household heads of small landless one-wage-dependent households, without the advantage of a pension, and with fewer dependants to feed are investing in livestock and engaging in sharecropping arrangements in other rural landed villages.

In this situation at 'Ngoe remittances received from the working migrant are divided between two households in two geographically separate villages. At the same time as the process redistributes scarce cash resources amongst more than one needy household, it also illustrates, partly, why small one-wage-dependent households at 'Ngoe are not necessarily eating more varied and nourishing diets.

A link with a rural natal village may also be retained in order to supplement sustenance requirements, not necessarily in a sharecropping capacity, but by 'helping in the fields'. In this case redistribution is reversed. A rural village is serving to provide sustenance for a closer settlement, but the effects on rural consumption patterns are the same.

There are also some small male-headed landless one-wage dependent households in the very earliest stage of the expanding phase of domestic development (applying for a residential site), which appear to have deliberately abandoned the rural alternative to migrant labour (livestock and arable land) for the amenities of the closer settlement.

Young male heads (20-30 years) of some small one-wage dependent households are renting accommodation until they are allocated a residential site at 'Ngoe. The reasons they give for moving to 'Ngoe include its proximity to Qacha's Nek and the fact that agriculture is seen as an unprofitable enterprise.

Agriculture is not only unprofitable (see Chapter two, page 44), but it is becoming increasingly difficult for younger men, in the expanding phase of domestic development, to gain access to arable land. For instance, at Peli, only three of the 16 landholding household heads are men between the ages of 30 and 45 (see, for example, Case 3.3 and Case 3.4). Of these only one obtained his land through the normal channels (see Chapter two, page 43). The others, either bought their land (see Case 3.4), or were given a field by a parent (see Case 3.11).

Young householders choosing to settle at 'Ngoe suggests that where arable land is becoming increasingly difficult to obtain, it may be losing some of its perceived value as an alternative source of security to migrant labour.

Case 3.17
Mr and Mrs Q and their young baby of eight months have recently moved to 'Ngoe where Mrs Q lives in rented accommodation. Mr Q is a miner who sends remittances regularly. At present they have no livestock, nor a sharecropping arrangement. When asked why they selected 'Ngoe, especially when there are no vacant sites, Mrs Q stated that it is better to be in the village where you can hear as soon as a site becomes vacant. In particular, she said that she wishes to be near the schools, the hospital and the post office at Qacha's Nek. It is better to be near town, she said, especially when fields are scarce and expensive to maintain.

Small households, where the head is older (40-50 age group) and construction and furnishing of the homestead is complete, may extend their cash resources to 'fostering'. In the following case study, fostering is not extended to children, but to the elderly parents of the couple. The interesting point (and particularly why I class this case under fostering) is the correlation between barrenness and infertility and extending resources to provide for the care and sustenance of other less well-off individuals or households.

Case 3.18
Mr and Mrs R are both in their forties. They have no children, but since they arrived at 'Ngoe, about 10 years ago, they have constructed a comfortable homestead. Within the last few years, as their elderly parents have become very frail, they have brought them to 'Ngoe to live with them.

There are numerous elderly parents, usually widows, who are dependants in the households of their children. Some may assist with housework, or child-caring, in return for their keep. Others spread their sustenance and caring demands among their offspring by visiting them for periods up to a few months at a time, thus spreading needs between a number of different but related households.

The incidence of large female-headed landless households with one wage income is relatively low (5 percent). Reasons may include the general lack of available wage-earning

opportunities for women in Lesotho. They can also include the lack of arable land at 'Ngoe. Without access to arable land, there may be less incentive for a wage-earning dependant to contribute to the household of a widowed mother. For example, in one case a mining migrant son of a women at 'Ngoe sends remittances to the landholding household of his wife's parents in a rural village.

In contrast to Peli, none of the female heads are widows who have taken over the control of the household after the death of their husbands. They have applied for and have been allocated a residential site in their own right, and are establishing homesteads by their own endeavours.

The decision to settle at 'Ngoe appears to be associated with circumstances. For example, one woman decided to leave her employment as a domestic in Durban when her husband, also working in Durban, died. She felt that she had to make a permanent home for herself and her children. (While the parents worked in Durban the children boarded with relatives in Lesotho). Faced with the choice of applying for residence either in a rural village, with little chance of ever obtaining arable land - note all female-headed landholding households at Peli acquired arable land by inheritance (see also Gay, 1980:5) - or at a closer settlement with better informal-earning opportunities, she chose the latter. With remittances from her migrant son and cash earned from her 'market' activities, she maintains a household of eight. Another example of circumstances leading to settlement at 'Ngoe may be a divorce as the case study below illustrates.

Case 3.19
After her divorce from her husband, Mrs S and her three children moved from Quthing to Qacha's Nek. She applied for and was allocated a residential site at 'Ngoe in 1975. She also managed to find a position as a domestic at the hotel in the town. Shortly afterwards she was joined by her unmarried and childless older sister. The sister, although frail and sickly, nevertheless assists with homestead tasks and the care of the children while Mrs S is at work.

This case study illustrates an interesting point about a partnership of two sisters (see, for example, Preston-Whyte, 1978). Mrs S's sister is a barren woman. Barren women face particular difficulties in Lesotho (Gay,1980:86&107). They have no wage-earning husband, or offspring, and frequently remain dependants in a father's household. But if the father dies and her brother succeeds to the father's household, an unmarried barren woman may not be welcomed by her brother's wife. A married sister, who is in need of assistance in a homestead, may be a useful alternative. In return for her keep in the homestead, the unmarried sister receives shelter and sustenance.

There are remarkably few small female-headed one-wage dependent households and the reasons are similar to those mentioned above, particularly the lack of available wage-earning opportunities. One of the few such households may be an exception, but it raises the interesting point of some wage-earning woman opting to 'stay single' as 'a strategy against poverty' (Van der Vliet,1984).

Case 3.20
Ms T is a young unmarried woman in her twenties, with one child who states that she intends to remain unmarried. She is well educated, has a good position in the government district service at Qacha's Nek. She has acquired her residential site in her own right and attached to the dwelling is a cafe. She employs a young man (no relative of hers) to assist her in the cafe which she says, will provide for her in her old age, in addition to her pension.

'Staying single' does not preclude children, and according to Van der Vliet, well educated wage-earning unmarried women with children are increasingly opting for this choice. It reduces dependence on an often irregular remittance from a migrant husband and gives a women freedom of choice as to where cash will be spent (1984:2-3). The relatively few women in a position to select to 'stay single' at 'Ngoe in comparison with what is reported to be an increasing phenomena of the more industrialised centres (see Mullins, 1982), is indicative of Lesotho's labour reserve status and the considerable constraints facing women in the area of wage labour.

Wageless landless households

At 'Ngoe, the incidence of wageless landless households, which are reported to be the most impoverished (see Spiegel, 1979:159-160) is significantly higher (35 percent) than at Peli (6,6 percent). While old age, or the decline of domestic development is largely the reason for extreme poverty at Peli (see Case 3.13), at 'Ngoe, circumstances surrounding extreme poverty also include unemployment, divorce and desertion (see also Spiegel,1979:159-160). Their situation is extreme and one suspects that people in this category at a closer settlement are at the forefront -

> of the continuing confrontation between external and internal forces (Comaroff, 1982:172).

Households seem to be caught between the 'internal' effects of diminishing arable land, and the 'external' effects of influx control and rising regional unemployment. The normal process of urbanisation in a migrant labour situation, partly accelerated by a decline in arable land, is arrested at the district capitals, largely as a result of South Africa's influx control laws. It is at a closer settlement like 'Ngoe that the plight of the extremely impoverished is most obvious.

Some remarkable resilience on the part of these people, in the face of apparently insurmountable odds, is also evident. Materially they appear to have nothing: ie. none of the conventional means of survival in Lesotho such as land or cash. Yet, at this critical level of poverty they survive. The case studies below illustrate their survival strategies, and size of household and sex of household head appear to affect the type of strategy adopted. But the case studies do not necessarily highlight those human resources such as courage and sheer guts which elude analysis, but are nevertheless essential elements of their survival.

Relatively speaking, small male-headed landless wageless households in rural villages are not necessarily the most disadvantaged (Murray,1981:55). Case 3.12 at Peli, illustrates that a small landless wageless household is maintaining a basic level of subsistence as a result of considerable livestock holdings. But an elderly male-headed household at 'Ngoe, with no material assets, appears especially disadvantaged.

Case 3.21
Mr and Mrs U are an elderly couple in their sixties who were some of the first residents to move to 'Ngoe. They have two children, married, and living elsewhere, who do not contribute to the household in any way. Since his retirement from wage labour some years back, Mr U has done occasional plastering 'piece jobs'. He also owns a horse which he hires out. His wife grows some vegetables on their small plot which she is sometimes able to sell. The couple eat only once a day, a diet based largely on maize.

At Peli, in contrast to 'Ngoe, there are few if any, large wageless landless households (among the sample households there are none). A small landless wageless household at a rural village may survive on the hospitality of kin and neigbhours (see, for example, Case 3.13). But clearly in terms of additional numbers of consumers, it becomes extremely difficult for a large landless wageless household in a rural village to maintain survival in the same way.

The fact that there are large landless wageless households

at 'Ngoe, in contrast to Peli, suggests that an event such as unemployment or loss of a contract which will render a household wageless, necessitates a move to a village such as 'Ngoe, near the district capital, where chances for survival are perceived to be better. Thus, the move from a rural village to a district capital is in many respects a strategy towards survival. The following discussion on large male-headed landless wageless households illustrates the point.

Heads of these households are all ex-migrants who have been unable to renew their contracts. At least three claim that they left a rural village after being unable to renew their contracts, and are renting accommodation at 'Ngoe.

'Ngoe has some distinct advantages. It is near a TEBA office where a man may attend daily while his wife earns some cash selling home-brewed beer, bread or doughnuts. Livestock accumulated during the process of 'building the homestead' may be sold to provide cash for sustenance needs. The benefits of earlier investments are thus obvious.

Case 3.22
Formerly a miner, Mr V has been unable to renew his contract. In early 1983 he had been unemployed for more than a year when he and his household of six moved to 'Ngoe. Since then they have occupied various rented premises in the village. Mrs V helps to support her household by selling 'ginger beer'. She also has credit at the cafe. During this period income has also been derived from the sale of some livestock. Mr V continues his regular vigil at TEBA. He also spends time at his natal village, helping with the agricultural tasks during the particularly busy times in the agricultural cycle. This opportunity arises out of a former sharecropping arrangement with a relative. Working the fields during unemployment thus keeps his land option open until such time as he renews his contract.

Informal-earning activities are the major source of income for landless wageless female-headed households at 'Ngoe. The sale of home-brewed beer, for instance, can provide the cash for sustenance for both large and small landless

wageless female-headed households. But clearly, the demands of a large household on an informally-earned income will be greater.

Case 3.23
Ms W was a domestic worker at an hotel in Kokstad, but in the early 70s she decided, after losing two children, to return to Lesotho with her last surviving child. She obtained land at 'Ngoe where she built her home 'stone-by-stone', single handed. Later her divorced sister joined her with her two children. Now they eke out a living by selling eggs and 'joale' from her homestead which is conveniently situated where the main mountain track enters the village.

Being unmarried, Ms W is responsible for establishing her own homestead. She has also, like other Basotho women working in South Africa where permanent settlement is prohibited, had to make the decision to resign from wage-employment and return to Lesotho to establish a permanent home for herself and her children.

Like others, she has applied for and obtained a residential site (see Case 3.19), which fortunately for Ms W is well situated for selling home-brewed beer. Her divorced sister has joined her at 'Ngoe and together they seem to be making remarkable use of the few options available to them in their circumstances. The cash generated is used to buy ingredients for brewing the beer, to keep poultry and to purchase maize, their staple diet which is regularly supplemented with eggs.

Other unmarried women with children sustain theselves and their dependants by selling plates of cooked food at the market. The nature or their trade is useful. The cash it generates is spent on maize, cabbage, samp and so forth which is cooked and sold to bus commuters and migrants awaiting contracts at TEBA, and it also provides household dependants with regular sustenance.

Regular informal income activities appear to generate enough cash to maintain at least a basic level of subsistence. But where there is little available cash, women are forced to rely on irregular and less remunerative activities such as the washing of clothes and collecting firewood.

Case 3.24
Mrs X states that she has not heard (received remittances) or seen her husband for a 'long time'. She has herself, her aged mother and three children to support. When she received remittances she sold 'joale' which helped to provide the members of her household with meals on a fairly regular basis. Now she says, sometimes she washes clothes, sometimes she collects water, and before winter she collects and sells firewood. The payment she receives is either in cash or food.

At 'Ngoe, the ethnography points to a number of similarities with Peli. As at Peli, some householders who are providing cash for sharecropping arrangements (case 3.14), perceive arable land as an alternative to migrant labour (Hamnett, 1975:66). There is also evidence to show that in fact unemployed males are making use of the alternative by engaging in agriculture when contracts cannot be resumed (Case 3.23). Investments in livestock also prove their worth during times of unemployment (Case 3.23), as they do at Peli, for those retired from wage labour (Case 3.12).

At both villages ties of kinship and marriage provide a valuable support system, both within and across households. At 'Ngoe, this is particularly noticeable in the care extended to the elderly (Case 3.19). Large households, both male and female-headed, in both categories of material differentiation point out that at 'Ngoe 'large families' are also seen as a useful survival (and therefore health) strategy, especially for the care and sustenance children can provide in old age. But for every similarity between Peli and 'Ngoe, there is also a difference.

For some householders, the value of arable land as an alternative to migrant labour, appears to be on the decline. For example, there are householders in the earliest phase of domestic development who have deliberately selected to forego the chances of acquiring arable land in a rural village, and have chosen to settle at a landless closer settlement (see Case 3.17). Householders who can expect a cash income from a pension after retirement from wage labour are not necessarily investing in the material assets of land and livestock (see Case 3.15).

There is evidence that arable land is not sufficient on its own to sustain a large household in a rural village. Unemployed male household heads have moved to 'Ngoe where a wife is in a better position to earn some necessary cash from informal-earning activities (see Case 3.23).

People at 'Ngoe tend, on the whole, to invest more in the immediate cash returns of informal-earning activities, rather than accumulating livestock and sharecropping (the normal pattern of 'homestead building') after the construction and furnishing of a physical homestead (see Case 3.16). Without the material assets accumulated during the process of homestead building, a household can be disadvantaged in the decline of domestic development (see Case 3.22).

In contrast to the 'large families' at 'Ngoe, there is evidence to suggest that some women want to limit the number of offspring they are prepared to have (see Case 3.21). It is worth noting that women who choose to limit the size of their families tend to be more secure in a number of areas. They have a regular wage income of their own and are therefore not dependent upon the sometimes irregular remittances of a migrant husband (see, for example, Case 3.24). They are generally employed in the government service where the position is most often

a permanent one and usually includes the prospect of a pension. Thus, where there is an alternative and reliable source of material security, the need for a number of offspring is less pressing and women are prepared to limit the size of their families.

The differences from as well as the similarities to Peli, suggest that within the limits of Lesotho's economic dependence on the Republic of South Africa, 'Ngoe offers a wider range of options in the overall strategy to maintain health and physical survival. The fact that large male- and female-headed households with neither direct access to cash nor land maintain at least the vestiges of physical survival seems proof enough.

In general, survival of households and villages appears related to the redistribution, in the form of sustenance and shelter, of cash derived from migrant labour earnings in the Republic of South Africa. The redistribution network follows the links of kinship, marriage, friendship and neighbourhood, and flows across villages as the sharecropping arrangements made from 'Ngoe to villages elsewhere demonstrate. The redistribution of cash in conditions of poverty serves to provide food and shelter for a wide range of individuals, and it is through this process that the effects of apparent material differentiation on the focal areas of health are levelled out.

Notes to Chapter Three

Note 1 Presenting all the food diaries which were returned seemed unnecessary as they were all very similar. In addition, attaching a food diary to each of the 24 case studies discussed in the chapter made for a very clumsy text. For these reasons, 15 food diaries were rendomly selected. They provide a representative overview of the eating patterns of the villagers and reflect households as they are discussed in the ethnography.

Note 2 Food prices fluctuate, but during the period of my fieldwork, the women estimated that an 80kg bag of maize meal at R28 (wholesale price), would feed an average household ± 5 people for a month, or 2,5kg at a cost of R1-09 (supermarket price), would provide six servings. In comparison, R3 worth of meat for example, provides only one single meal and a loaf of commercial bread at a cost of 50 cents, would be insufficient for a meal.

Note 3 Deferred payments
An agreement exists between the Chamber of Mines and the Lesotho government whereby a proportion of all wages earned by Basotho miners in South Africa is transferred to their country of origin. It is said to be a form of saving for the workers who can draw payments due to them in Lesotho at the end of a contract. But this is also a source of usable revenue for the government (3FYDP:17).

Chapter Four: HOUSEHOLD DISEASE EXPERIENCE

> Illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place. (Sontag, 1983:7).

Introduction

As Sontag implies, experiencing disease is part of social life. In this chapter, the responses of the residents of Peli and 'Ngoe to the diseases they experienced over a period of approximately six months is examined. The investigation aims to uncover the factors surrounding the recognition of disease, and choice of therapy. The fact that supernatural causation is rare and natural causation and 'don't know' (the cause of the disease) replies predoninate (see Table 4.1), suggests that other factors in addition to perceived causation play a large part in the villagers' responses to disease (see Last,1981).

Last calls attention to the importance of 'don't know' replies in the investigation of popular responses to disease and choice of therapy (1981:387). These replies tend to be underplayed by researchers who emphasise the more unusual supernatural explanation of disease and its role in choice of therapy. This type of analysis ignores the fact that people need not necessarily be concerned with seeking a cause, but are more concerned with finding a cure and resuming day-to-day activities as soon as possible (Last,1981:387).

Table 4.1 List of diseases reported by the residents of 'Ngoe and Peli for a period of ±6 months, perceived causation - natural, supernatural - and 'don't know' the causation, by number of disease incidences

Disease episodes	Disease	Perceived cause
	Natural causation	
15	diarrhoea	dirty water
1	sore throat & cough	a 'cold'
1	sharp pain in kidneys	hard work
1	swollen lips & feet	the cold
1	headache	high blood
1	kidney complaint	carrying heavy bags
1	pain in the legs	old age
1	sore shoulders	work
1	backache	work
1	diarrhoea	flies
24	Sub-total	
	Supernatural causation	
1	motheketheke (in progress)	dreams
1	stomach ache (last year)	Basotho poison
1	chest pain	Basotho poison
1	fever	Basotho poison
4	Sub-total	
	Don't know causation	
3	heacache	
4	diarrhoea	
1	sharp pain	
1	rash & sore throat	
1	sore eyes	
4	'high blood' (chronic complaints)	
1	sore head and shoulders	
1	sharp pains in chest	
1	sore womb	
1	sores	
1	heart (chronic complaint)	
2	backache	
1	sore throat & cough	
1	toothache & sore throat	
1	fainting	
1	sore chest & swollen feet	
24	Sub-total	

A narrow focus on the role of perceived cause and explanation of disease also underplays the role of other factors which may determine therapeutic action - factors such as availability of, and access to therapeutic resources in a given geographic area, the cost of a service and the quality of the service (Last,1981:392). These factors, other than explanation, can be expected to play a significant role in this investigation, especially as supernatural explanation and the unusual diseases are rare. The investigation of their role in the villagers' recognition of disease and choice of therapy is the major thrust of this chapter.

The disease experience of the residents of the two villages is presented separately. An important reason for presenting the ethnography in this way is to assess whether convenient access to a variety of therapeutic options plays a significant role in peoples' responses to disease. 'Ngoe, unlike Peli, is in walking distance of the hospital and a variety of alternative healing resources in Qacha's Nek (see below - 'some alternative therapeutic options').

At Peli, I examine the villagers' responses to a variety of disease experiences. At 'Ngoe, I pay particular attention to episodes of diarrhoea. This does not mean that the incidence of diarrhoea is higher at 'Ngoe. In fact similar diseases are reported for both villages and for this reason they are not listed separately for 'Ngoe and Peli (see Table 4.1). However, paying particular attention to episodes of diarrhoea at 'Ngoe gives some emphasis to the condition the villagers (and not the researcher) see as the most significant disease. In response to the final question of the interview (see question 10(a) of the question schedule - Appendix A), the majority of residents at both 'Ngoe and Peli reported diarrhoea to be their most common ailment and major problem area.

A report on rural villagers' responses to diarrhoea may also be of interest to health-care workers. Irwig, a bio-statistician, has called on social scientists to provide 'qualitative research' on 'selected issues', one of which is diarrhoea (1981:21). The qualitative research he suggests should complement the cold facts of broad statistical surveys. The ethnography on diarrhoea at 'Ngoe (although brief) is thus also partly an attempt to comply with interdisciplinary requests such as these.

Diarrhoea is not necessarily a disease in the strict bio-medical sense, but a symptom of a variety of possible under-lying causes from 'traveller's runny tummy' to more serious conditions of gastro-enteritis in children, typhoid, and it may also accompany cancer of the rectum. But in popular terms diarrhoea is widely perceived as a 'sickness', or 'disease' in the social sense (see Frankenberg and Leeson,1976:277); Young,1976:6). Diarrhoea may be given as a reason for sick leave and 'Diarrhoea and Vomiting' ('D' and 'V' in medical shorthand) may appear on medical certificates for sick-leave purposes. This use of symptoms in place of a diagnosis would imply that on occasions medical practitioners also perceive 'diarrhoea' to be a 'disease' in the popular sense.

In a place like Lesotho where clean water and sanitation are inadequate, few avoid an occasional bout of diarrhoea. It is well known, however, that the effects of the condition are most severe in infants and the elderly who may succumb to the sometimes fatal complications (such as dehydration). The commonness of the condition poses problems. Because it affects all strata of society, as well as all age groups, a bout of diarrhoea is not unexpected. Therefore, although it is perceived as the major problem, there is nevertheless a certain 'normality' about the symptom. The villagers' experience is that most episodes resolve themselves and

are treated with 'home' or patent remedies. Consequently, treatment for more serious underlying causes such as typhoid and gastro-enteritis in children may be delayed. Therefore, any delays in seeking therapy should be seen against the villagers' familiarity with the general condition of diarrhoea and their frequent encounters with the problem, which give diarrhoea a certain status of 'normality'.

Some available Therapeutic Options

An important preliminary in any investigation into peoples' responses to disease is to establish what healing resources are available. Some of the official health-care institutions in and around Qacha's Nek town and the district have been described (see Chapter two, page 54). But as mentioned, they are not necessarily the entire range of therapeutic options available.

Evidence from social investigations into disease in various social contexts suggests that in all societies people have a range of healing options (Mishler,1981:10). These include, as Maclean and Bannerman state 'lively manifestations of traditional medicine' in all societies (1982:1815). In Southern Africa it is known that indigenous or 'folk' healers (see Kleinman,1978:86-87 and a discussion below) are consulted by all sectors of the population. Wilson gives examples of white farmers consulting indigenous healers (1980: 338) and Galbraith, of white businessmen in Johannesburg consulting 'sangomas' (indigenous healers - Sunday Express, 30 5 1982).

In order to arrange these options conveniently for descriptive purposes, Kleinman postulates three types of therapeutic options which are found in all societies - the 'popular',

the 'professional' and 'folk' arenas (1978:86). They are useful for presenting some of the healing options available to the people of 'Ngoe and Peli.

The popular arena is the lay, non-specified, non-professional domain where illness is first recognised, defined and therapeutic action initiated (Kleinman,1978:86). The practitioners of the popular domain are family, friends, neighbours and people who may have long personal experience with a condition such as childbirth, barrenness or a chronic illness. Elliott-Binns, in a study carried out in Britain, found that 75 to 80 percent of illness is treated in the popular domain (1973).

The activities in the popular sector are difficult to elicit from formal questionnaires and interviews, but living and participating in village life provide useful insights. It becomes clear that family and neighbours do play an important role. In particular, the counsel of older women may be sought, especially those reliable and kindly women who have a reputation for sound commonsense. Some cafe owners and shop assistants also develop a reputation for offering good advice. MS is a kind and intelligent cafe owner whose guidance is often sought for day-to-day ailments. MT, a shop assistant at a general dealer in town, through her own experience, has become a 'specialist' on the problems of barrenness. She is also very knowledgeable about protective medicines for babies (see Chapter five).

The 'folk sector' generally comprises specialised 'healers', other than the registered professional biomedically trained health-care personnel. Kleinman distinguishes three kinds of healers in the 'folk sector' (1978:86-87). The sacred includes spiritual healers such as diviners and 'shamans'; secular healers are bone-setters, herbalists and midwives. A third group combines spiritual and secular healing. The five healers who practice in and around Qacha's Nek town,

to whom I was introduced during the course of fieldwork, would fall into the third category.

Three of the healers are males and they practise from premises in the town of Qacha's Nek. The two women healers operate from their homes in their respective villages which are very close to Qacha's Nek town. Consequently, all these healers are closer to 'Ngoe than Peli. The fact that there appear to be more healers in and near the town is easily understood. The potential for a thriving practice is much greater in and near a district capital which is more densely populated and where people are continually coming and going from rural areas for shopping, banking and to visit the post office.

The healers all have similar career histories. They claim they were called to their profession through dreams and all have undergone extensive apprenticeships. The healers simply refer to themselves as 'ngaka' (doctor) (see also Ashton,1952: 282), and do not identify themselves as 'diviners' or 'herbalists'.

The people consult the healers on a variety of ailments. Ordinary ailments, such as coughs and colds, for which they may prescribe and sell patent or herbal remedies, make up the bulk of their consultations (see also Ashton,1952:299; Maclean,1980:119). Nevertheless, they also claim a certain reputation for successful healing of specific ailments. For example, Mr AB claims that the majority of his patients consult him about VD (venereal disease). His rooms are close to the 'red light' district of town, thus conveniently situated for his speciality. Mr BC, on the other hand, always seems to have lengthy queues of women and children waiting outside his rooms. Physically he is a tall man with a certain patriarchial bearing which may be a factor in the way people perceive him and therefore consult him

for children's complaints. Mr CD claims he has an excellent herbal remedy for 'chests and stomachs' and that it is widely sought. Mrs DE claims she is a specialist in the cure of motheketheke (see Ashton,1952:283-284; Sheddick,1953:69).

Motheketheke does not play a significant role in this study. Only one respondent is presently undergoing treatment for which she visits a healer in Pretoria. However, because motheketheke is mentioned again in the thesis, at this point it is convenient to make a few brief remarks about the condition.

Motheketheke is discussed under various names in the literature (see, for example, Janzen,1982(a); Mills,1983). An individual with various physical symptoms which could vary from mild pains to fainting or fits, frequently accompanied by dreams, is prompted (usually in the dream) to seek treatment (Ashton,1952: 284). After a lengthy ritual treatment, he or she 'graduates' to become a 'mokomo', or indigenous healer and is considered qualified to cure patients with similar ailments.

The people in the village where Mrs DE lives recognise her speciality. But like the prophet who is not recognised in his own land, the local people tend to consult her for ordinary ailments and those seeking her specialist services come from much further afield.

Mrs EE, the second woman healer, has a similar history but does not appear to have as many 'in-patients' as her colleague. Mrs EE claims that in addition to coughs, colds and diarrhoea, people consult her for 'poisoning' and 'womens' complaints'. (I discuss 'poisoning' in greater detail in Chapter five).

These healers who treat a large proportion of ordinary ailments and also claim a certain reputation in some specialised areas, are aware of the limitations of their art and consequently

refer some patients to the health care-services. For example, during my stay I was told of one healer who referred a child with a severe epistaxis (nose bleed) to the hospital.

The healer's consulting hours are flexible. They start early in the morning, are usually readily available at night or at weekends and they do house calls. Their consulting rooms are also congenial meeting places. Clients and friends 'pop in' for a chat and thus much of the local gossip circulates.

It could be argued that such 'shared contexts' and interaction are at least as significant as the 'culturally shared contexts' between healer and patient, which have often been identified as one of the distinguishing characteristics of the successful folk healer (see, for example, Kleinman and Sung,1979; Bührmann, 1980). Kleinman and Sung imply that through sharing the cultural context, and therefore the culturally determined 'world view' of the patient, indigenous healers may heal better (1979). They may, as Wilson points out, have the advantage over the expatriot medical practitioner for example, of knowing the language and local expressions for particular symptoms (1980:341). But, she also points out that when healers diagnose a socially relevant cause for a patient, they may well be relying on a very shrewd knowledge of the local 'goings on'.

The local people appear to recognise all healers and this includes medical practitioners, as a group of individuals with specialised healing knowledge. They do not appear to distinguish between indigenous healers and medical practitioners and refer to them all by the same title - 'ngaka' (doctor), (see also Wallman,1969:58-59).

In Kleinman's terms (1978:87), the organised legally sanctioned professional sector is made up of biomedically trained practitoners, health-care personnel and the institutions where

where they dispense their services. The institutions most frequently mentioned by respondents at both villages were the hospital at Qacha's Nek, the mission hospital and the clinic at 'H' (see Chapter two, page

Nevertheless, as with consultation of healers, political and geographical boundaries do not preclude the use of 'professional' services elsewhere. Pietermaritzburg, Durban, Welkom, Johannesburg and Matatiele were all mentioned in this regard. Visits to Matatiele may have been made more difficult when the border was closed, but did not necessarily stop people if they cared to consult a service there.

Decisions to make use of professional services elsewhere depend on a variety of factors, which I discuss later. But it is interesting to note the mention of mining and other migrant centres. While migrant labour imposes constraints on almost every other aspect of social life, in Lesotho it has evidently opened up a wider range of healing options.

This is especially important in areas requiring specialist attention, such as infertility. The incidence of infertility and barrenness is remarkably high. Gay, remarking on women over the age of 40 years who had not borne children, reports an incidence of 8,9 percent (1980:86). In the present study where I have included infertile women (ie. those who have one child and are experiencing difficulty conceiving or carrying further pregnancies to term), the incidence is as high as 14,2 percent. In situations such as Lesotho, barrenness and infertility can cause untold unhappiness for the individual (see ethnography below). Yet, with an emphasis on family planning and population control there is very little sympathy or biomedical help for these women.

In addition to the indigenous healers and the professional health-care personnel and services in Qacha's Nek town,

there is also a folk healer whom the people refer to as the 'chemist'. He has not undergone an indigenous healing apprenticeship, nor has he any formal biomedical training. After 25 years general service in a pharmacy in South Africa he returned to Qacha's Nek where he opened his own shop in the town in 1976. He does not dispense scheduled drugs, but stocks many of the patent 'over-the-counter' remedies one would find in any conventional chemist's shop in the Republic.

The people consult him and he diagnoses and prescribes. He also offers a rudimentary and informal ambulance service in the sense that he sometimes transports very ill patients to the hospital in Qacha's Nek. By offering an ambulance service and being called upon to diagnose and prescribe, it seems clear that the people perceive him as providing a healing service beyond the realm of family and neighbourly advice. Moreover, by his dress (he always wears an immaculate white coat), it can be suggested that he also sees himself as providing a more specialised healing service than the popular domain.

From the numerous 'tonics' prescribed by this 'chemist' and the stocks of similar patent medicines in any general dealer, one gets a glimpse of the extent of symptoms such as lethargy, insomnia and anxiety which are not commonly mentioned during an interview, but are undoubtedly related to the overall stress of living in conditions of poverty (Murray,1979:347).

The womens' church groups (see Note 1) also play a useful role in dealing with the stressful living conditions of general poverty. Theirs is not necessarily an active healing function, but rather a supportive one. For example, I witnessed one occasion when a woman who had recently lost her 18 year old son, was able to express and share her grief in words and tears with such a group of concerned, understanding and caring women.

There is also the wider church community itself, especially the Zion Church, which provides a caring supportive community

with a healing function for some of the most impoverished members of the community (West,1975:91-124). At each service time is set aside for healing. The services are also entertaining and lengthy affairs which include singing, dancing, sermons, bible reading and 'open confession'. 'Open confession', similar to that in the womens' church groups is a way of sharing the burden of pressing problems and in many cases also a plea for help. But the singing and dancing to the accompaniment of rhythmic drums has an obviously cathartic function (see also West,1975:124), which appears to serve, partly at least, to release some of the pent-up symptom producing anxiety of the most impoverished members of the community.

Disease Episodes at Peli

The materially advantaged households (large male-headed landholding wage-dependent households with two and three incomes) appear to have a wider choice of therapy options (see, for example, Segar,1982:57-59). But this is not entirely dependent on material status, for it also depends to a large extent upon the size and composition of the households. Large male-headed landholding wage-dependent households with two and three incomes are not only large, but being multigenerational, comprise a number of adults.

Adults play a prominent role in the legitimation of disease. For an individual to be sick (see Chapter one, page 20) or adopt the sick role, the subjective feeling that all is not well must be acknowledged by others (Frankenberg and Leeson, 1976:277; Young,1976:6). In other words, the afflicted individual is given 'permission' to be sick, and this is usually given by immediate kin, such as those living in the same household or in the same village (see, for example, the role of the Lay Therapy Management Group, Janzen,1978). Sickness is not necessarily legitimated on subjective feelings of discomfort, or the evidence of physiological symptoms (Zola,1978:123). It is based rather on perceptions, most frequently by others, that

the afflicted individual is unable to continue normal personal and vocational activities (Zola,1978:123).

In situations of poverty, such as found in Lesotho, continuity of household tasks, daily and seasonal, needs to be maintained in times of sickness. Whether there are adults to take over the responsibilities and tasks of the afflicted individual during the period of the disease will therefore be a factor affecting legitimation. In large multigenerational households there are not only adults to acknowledge the sickness of an afflicted individual, but they can also take over and share the household responsibilities and tasks of the sick person until he/she resumes normal activities.

Case 4.1
Mr B (see Case 3.2) recently complained that his chronic kidney complaint was troubling him again. Holding his back he describes the dull ache he experiences which is making him tired and he is not able to get about as he should. Mr B puts the original cause down to 'carrying heavy bags' when he was a soldier in the British Army during World War II. Over the years when the pain reaches a stage when he cannot continue working he sees the mission doctor. This time he decided to go to the new government hospital which was nearer for him. The treatment he received did not relieve the symptoms, so after a few days he again consulted the medical practitioner at Tebellong.

The household is large and comprises a number of adults who legitimate the sickness, take over household responsibilities for the duration of the sickness, and authorise the use of household funds for therapy (which also includes the cost of transport to two hospitals).

Mr B demands quality from the therapeutic service, which he measures in terms of the relief of symptoms the treatment provides. When the first treatment did not relieve his symptoms he sought a second avenue of therapy. The successful outcome of the second consultation is partly related to the matter of security and comfort for the patient that a long-standing relationship with a doctor can provide (Last,1981: 392).

A preference for a mission hospital or clinic, particularly at an old established village like Peli, should be seen against the background, not necessarily of long-standing mission health care in the country and the district (see Hailey,1957:1074), but against the long-standing service of individual mission health-care workers. The mission nurse has been at the clinic close on 20 years and the doctor at Tebellong approximately 15 years. After such a long service in the area they know many of the villagers by name and they are equally well known to the villagers.

Government hospitals, on the other hand, are in many cases staffed by expatriot medical practitioners on two to four year contracts. While there is most probably little difference in the biomedical treatment given at both types of centres, patients' personal and family experience over many years with a particular individual is clearly a factor in their choice of biomedical service.

Among landless, wage-dependent households with one income in an earlier phase of domestic development, the cash demands of establishing the homestead as well as composition of the household - there is normally only one resident adult - may affect choice of therapy.

Case 4.2
(See Case 3.4) Mrs D manages a landholding one wage-dependent household and cares for her three children in her busband's absence. Recently her youngest child suffered a bout of diarrhoea. She felt she should have taken him to the clinic but did not have the money to do so. Fortunately, with a home remedy (lots of water with sugar and salt) he recovered.

A consultation at the mission clinic, I was told, costs approximately 70 cents but does not always include the additional cost of medication. Officially the cost of

an Out Patient consultation at the hospital is 50 cents, but patients also reported paying more than this. A visit to the hospital from Peli will usually mean the additional cost of transport - 80 cents to R1 for a single journey.

Mrs D, hard pressed to find the cash to feed her growing children and farm the land, does not have the extra cash to consult the clinic. However, as is also noticeable in a later example, had the child's condition not improved with home treatment, she would have sought alternative therapy.

For households where there is only one de facto adult, seeking therapy outside of the popular domain frequently means making arrangements with neighbours to 'keep an eye' on the homestead. However, as neighbours have their own responsibilities to bear there is a limit to the help they are able to give. In such circumstances, lengthy treatment may be curtailed or affected before a cure is achieved, as the following case study illustrates.

Case 4.3
Mrs YY (age 28 years) has one child of seven years. Her husband is a miner near Johannesburg who has accumulated some livestock and has a sharecropping arrangement at Peli, with his parents. The sharecropping arrangement also requires Mrs YY to assist in the fields.

Mrs YY has not been able to conceive a second child. For some time she has attended Baragwanath hospital for tests and treatment, necessitating long stays in Johannesburg. When asked how the treatment was progressing she replied that she had not been able to complete the series of tests because she had to return home to Lesotho 'to help in the fields'.

Mrs YY does not consider indigenous healers or any other 'alternate therapies' to be viable treatment for her condition. With few biomedical options available in Lesotho she must, of necessity, travel to Johannesburg to seek what she believes to

be the most effective treatment for her condition. The perceived severity of a condition is also an important consideration when examining disease responses, choice of therapy and the length to which people will go to obtain the most effective treatment.

Infertility and barrenness which has a high incidence in Lesotho (see page 146) is perceived as a serious problem. Failure to conceive a child is perceived by the afflicted individual and others to be 'abnormal' to the extent that it can be considered a 'disease' in the broad social sense. The severity and seriousness of the condition must be seen against the 'stigma' of barrenness (Maclean,1980:122). A woman who is unable to give birth to a child does not make the 'critical status change' which transforms a 'girl' into a 'motsoetse' or one who has crossed the reproductive threshold (Gay,1980:105). Barrenness and infertility can also interfere with 'bohali' (bridewealth) transfers (Gay,1980:107).

Gay points to the loneliness and sense of failure accompanying barrenness (1980:107) which is illustrated by the plight of the childless elderly (see, for example, Case 3.13). It has been suggested that 'large families' are an important health strategy in conditions of poverty and infertility and barrenness would clearly reduce the effectiveness of this strategy. (See Chapter three page 111). All these factors make barrenness and failure to conceive a child a serious problem, and women will go to enormous lengths to find a cure. Mrs YY and other examples in this chapter illustrate this clearly.

In other cases of severe disease, in the case of a child for example, kin who live in the same village may assist with diagnosis and cost of therapy (see, for example, Lay Therapy Management Group, Jantzen 1978).

Case 4.4
Mrs XX has three small children, her husband is a miner. Her young daughter suffered continual bouts of fever and she took her to a clinic at 'H'. However, after a short respite the fevers resumed. During a family consultation her mother-in-law, who lives in the village, suggested that the chronic nature of the fevers could be due to 'poisoning' which the young mother may have suffered during her pregnancy. With financial assistance from the mother-in-law she sought the services of an indigenous healer in Qacha's Nek in order to remove the effects of 'poisoning'. (see Note 2).

Mrs XX is part of the supportive network of women who are related by kin and marriage, discussed earlier (see Case 3.7). Evidently just as kin play a supportive role in maintaining health, they also provide support in times of sickness. (The role of health in the explanation of disease strategies is covered in detail in Chapter six).

Case 4.4 also illustrates a reassessment of a condition during the disease process,and the selection of an alternative healing resort on the basis of higher level explanation (see, for example, Janzen, 1978; Stiano,1981). It could be said that evidence suggests that a distinction is made between disease that can be cured biomedically at the hospital or clinic and disease that requires the services of the 'traditional' healer. In other words, from the popular perspective two distinct and separate medical systems are seen to operate for two distinct types of perceived causality (see, for example, Frankenberg and Leeson,1976). However, there are other considerations before this conclusion can be reached.

In any situation a range of healing options may be explored over time. On the basis of successful cure some of these therapeutic avenues may be regarded as more appropriate than others (see, for example, Case 4.1). In Case 4.4 the perceived cause of the ailment determines the choice of the indigenous

healer. Causation, however, is not necessarily central to choice of therapy. As the following discussion points out, attaining cure can be the overriding factor.

To make the point of the importance of cure rather than cause and explanation in the therapeutic process, Last likens it to a journey (1981:391-392). Embarking on a journey the goal is to proceed from A to the destination B. During the journey a variety of different means of transport may be used, such as walking, taxis, buses or horses (fieldwork in Lesotho is an apt illustration of Last's analogy). People do not resort to complicated explanations or reasoning as to why they use a particular mode of transport, nor do they necessarily distinguish between 'traditional' and 'western' types of transport. New types of transport are incorporated into the existing range of available options and are used on the basis of appropriateness (to a particular geographical terrain, for example) and availability (also within limits of place and cost).

Similarly, with therapy the destination or goal is cure. Cure rather than cause and explanation is the overriding factor which determines choice of appropriate healing resort within the limits of the affected individual's circumstances. The therapeutic process in cases of barrenness and infertility are apt examples of Last's notion.

Many of the barren women implied, in recounting their therapeutic histories, that they did not know the cause of their infertility and barrenness, nor did they seem particularly concerned with causality. Their most pressing concern in exploiting a variety of healing options is cure.

'Cure' is being able to resume one's personal and social identity (Stiano, 1981:331) which, in cases of infertility and barrenness, means conceiving and delivering a healthy infant. Seen against

the already mentioned background of the importance of children, it is not surprising that seeking explanation and causation can easily take second place (if it matters at all) as women exploit a range of healing options towards realising this goal.

Healing resources consulted range from indigenous healers, both local and those elsewhere in the Republic to health-care services, including mining hospitals, teaching hospitals, mission hospitals, as well as in one case a life-time of prayer. The woman's prayers were answered by the birth of a son at the age of 45 years. Another woman, after nine mis-carriages, delivered two healthy girls after two carefully monitored pregnancies. Both these women were cured in the sense that they attained personal and social identity (Stiano,1981:331) by carrying the pregnancy to term and delivering healthy infants. But cure may be attained indirectly through, for example, fostering.

It is noted in Chapter three that in households where there is a history of barrenness and infertility (see, for example, Case 3.10),the household head and his wife take over the caring responsibilities of children related by kin and marriage through fostering (see also Gay,1980:77-92). While fostering does not necessarily provide a biological cure, it is clear that in the social sense a woman resumes social and personal identity. This is also true for the male.

The social and emotional effects of barrenness and infertility as they affect the male are seldom mentioned. It is often assumed that a man will divorce a childless woman but many childless couples in this study remain married, thus sharing the anxieties associated with the condition. Consequently, for the male, cure either in the biological or social sense is just as important.

Thus far the ethnography has been largely concerned with the disease experience of individuals who are members of households at various phases in domestic development, but where there is at least one cash wage income. However, among the most impoverished members of the community where there is no direct access to a cash wage income, the disease experience is not easily identified by the observer.

The observing researcher frequently identifies for investigation, the lengthy disease episodes where a number of healing resorts are used, because they are the most observable in the maze of on-going social life. But the poor are usually unable to afford the costs of therapy and transport (see, for example, Segar, 1982:59). Consequently because they are not seen consulting a variety of therapeutic avenues, their disease experience will not be immediately recognisable to the researcher.

Furthermore, if poverty prevents a sick individual from evaluating certain signs of illness (Stiano, 1981:329), the sick poor will not only be hidden from the observer, but also less visible to members of the community where he or she lives. The following case study illustrates the points made.

Case 4.5
Mrs M, an elderly childless widow (see Case 3.13) who lives on her own, claims she sometimes becomes very ill. She gets 'severe pains' which she feels would improve with attention from the sister at the clinic or the medical doctor at the hospital. But she can afford neither. Her neighbours are good to her when they know she is sick, but most of the time she 'just goes on and waits until she feels better'.

Knowing the circumstances of this impoverished widow it is hardly surprising that she cannot afford the cost of therapy, even if she feels her condition warrants it. Most therapy outside the popular sphere of family and friends requires some form of payment, whether it be to buy 'disprin' from

the cafe, or an out-patient fee, or the cost of consulting an indigenous healer. At Peli, owing to its geographical distance from the majority of healing resorts, therapy more often than not will also mean the additional cost of transport.

If they are willing and within easy geographical access, kin may assist with funds in the event of disease (see Case 4.4), but Mrs M has no close relatives in the village. Moreover, without a nearby Zion church, she does not even have the support of a caring community outside of kin amd neighbourhood (Janzen, 1979; Comaroff, 1979). Evidently, if her neighbours are aware of her illness, they will care for her, as they do for her daily food requirements.

But if we accept that poverty, relative to the rest of a community, results in withdrawal (Townsend, 1979) and that the poor are the least visible members of a society (Hill,1972:148), the sick or diseased poor who may 'wait at home' like Mrs M, 'until they are better', are most likely to be even less visible.

For the poor sickness is not easily legitimated. Sickness is apparently most easily legitimated in materially advantaged households, largely on account of size and composition (see Case 4.1). Neighbours may play an affirmative role but not necessarily a major role in the diagnosis and selection of therapy. They cannot make decisions about whether household cash resources should be spent on therapy, nor will they necessarily take over important household responsibilities for another during the duration of therapy (see Case 4.3). Thus for Mrs M living alone, and largely dependent on her neighbours, her sickness episodes will not be easily acknowledged.

Mrs M depends entirely on 'visiting' and 'helping in homesteads and fields' for her daily sustenance. In order to

maintain a basic level of physical survival she must ignore or suffer her pains and 'just go on'. Thus, if sickness threatens to jeopardise a health strategy among the poor, such as 'visiting' or 'helping in the fields', it will be suppressed and not easily recognised by others.

What is perhaps most striking when reviewing the disease ethnography for Peli is the difficulty in making generalisations about disease experiences. Size and composition of large male-headed wage-dependent households with more than one income allows for easier legitimation of sickness. There appears to be a wider choice of therapy available to these households and they can be selective about the quality of therapy rendered (Case 4.1). Cost of transport and a consultation at a clinic or hospital may limit the choice of therapy (Case 4.2). But if the condition is sufficiently serious, kin within easy geographical access will provide financial assistance (Case 4.4).

The cost of maintaining health or establishing the homestead (Case 4.2) or household responsibilities, may interfere with a chosen mode of therapy (see Case 4.3) especially where there is only one de facto adult. An indigenous healer may be selected on the basis of perceived cause (Case 4.4). On the other hand, perceived cause becomes secondary to a driving search for cure. Finally, extreme poverty can prevent an individual recognising certain signs of illness if this means an inability to continue a strategy necessary to maintain health.

Disease Episodes at 'Ngoe

Experiences of diarrhoea are examined first among infants and later among adults, largely because the effects are not necessarily the same for all age groups, the condition being more acute and serious in infants. I also examine why so few of the less well-off adults, suffering from diarrhoea or other ailments, consult therapeutic options outside of the popular domain.

Case 4.6
PP is the baby daughter in a relatively wealthy multi-generational household with three wage earners, one of whom the mother, is employed locally at the hospital. PP had diarrhoea for some time and was given medicine by a neighbour which had been used for a similar condition. The grandmother and other female kin in the village saw the problem as 'normal' for a baby who was teething and beginning to crawl (coming into contact with dirty floors, eating food found on the floor and so on). However, when fever set in the child was taken to hospital where she received treatment and remained there until she was better. During her stay in the hospital her mother remained with her at night and the grandmother during the day.

The grandmother's reaction suggests that a certain amount of diarrhoea during the first year of a child's life is expected and may be considered 'normal' (see page 140), especially when a child is learning to crawl. Hence treatment outside of the popular domain of family, friends and neighbours is not immediately sought. But, if the condition deteriorates (which the well recognised signs of fever suggest), further action is prompted. The hospital, which is just a short distance from 'Ngoe, was consulted. In this instance the fact that the mother worked at the hospital probably also contributed to the decision - but not necessarily considering that the hospital is the most geographically accessible therapeutic service.

Because this household is relatively advantaged (although cash is sent to the parents of PP's mother for the temporary care of her small children, there are three wage earners and no share-cropping arrangements) hospital fees are unlikely to be a major consideration. Moreover the hospital is within easy walking distance and therefore therapy does not require the additional costs of transport.

As with similarly materially advantaged households at Peli (see, for example, Case 4.1) composition of this household is such that there is an additional adult (the mother of the household head, baby PP's grandmother) to share some of the household

responsibilities, which allows the mother to spend time with her sick child.

The practice of a mother accompanying and staying with a sick child in hospital is a commendable one and is encouraged by the hospital staff. It can help the child and mother through a difficult and often unpleasant experience. However, it is not always possible for a mother to leave her other children particularly if she is the sole adult resident in the household.

Were this mother the only resident adult in the household she would have needed to make arrangements with relatives or neighbours to care for her other children in her absence and keep an eye on her homestead (see, for example, Case 4.3). Making these arrangements can delay getting to a treatment centre. Delays only serve to worsen the condition and the anxiety of the mother of a sick child, as the following case study of a disease episode some time ago reveals.

Case 4.7
Mrs WW is the wife of a migrant miner. At the time of fieldwork she and her husband and three children comprised the household. Mrs WW described the anguish she experienced with a desperately ill child when they lived in a remote mountain village before coming to 'Ngoe. The process from diarrhoea to fever she related was not unlike baby PP's history. Faced with the decision to seek therapy she had to take into account the needs of her three other children, and the lack of transport, or nearby clinic, so she consulted the nearest indigenous healer. Treatment was not successful and her child died. The death of her child, which she feels might have been prevented if she could have reached a hospital or clinic, was one of the more important deciding factors which prompted the household's move to 'Ngoe.

Mrs WW was willing to pay for therapy for her severely ill child. But no amount of cash can overcome a lack of available transport. Walking from remote mountain villages to the nearest healing service is generally the only alternative. But walking long distances, especially in an emergency is not always practical.

Faced with her household responsibilities and a very ill child Mrs WW consulted a nearby indigenous healer in desperation. It was not, she said, because she considered him the best or most appropriate help, but because he was the healing resource most accessible to her, geographically. In an emergency there is strong motivation to act. As Beattie says:

> It is commonplace that in the face of actual or threatened disaster to do something is psychologically satisfying and a way of relieving anxiety; anything is better than just remaining passive and waiting for it happen (1970:207).

The case studies on infant diarrhoea point to the importance of easy geographical access to appropriate therapeutic services. They also point to the importance of size and composition of household in determining a successful outcome and, to a lesser extent, cash. The individual household's cash resources cannot always overcome a lack of appropriate therapeutic options or inadequate transport. These are matters of infrastructure largely beyond the control of the average household.

As far as an episode of diarrhoea among adults is concerned, size of household, demands of household responsibilities and access to more than one wage income significantly influence choice of therapy and the decision to adopt the sick role. As the following case study reveals, the circumstances of a large male-headed, two-wage income household is such that the resident adult can adopt the sick role because disease does not necessarily interrupt the household routine.

Case 4.8
Mrs QQ experienced what she perceived to be a severe bout of diarrhoea and vomiting. She went to the hospital where she works, was diagnosed, given treatment and sent home to recover. For the duration of her sickness her eldest

daughter cooked and cared for the children which she normally does during the day when her mother is at work. Mrs QQ's sickness also did not interrupt her lucrative 'joale' business which she runs on a regular daily basis with the assistance of a willing elderly woman who lives at 'Ngoe.

At the hospital Out Patient clinic Mrs QQ's disease was legitimated by the medical practitioner. In many respects this relieves Mrs QQ of the responsibility of deciding herself to take time off from homestead tasks. In other words, the medical practitioner gives her permission to withdraw from household responsibilities for the duration of her diarrhoea.

She also has a daughter who is old enough to care and cook for the other children under her supervision while she is sick. Secure wage employment and the sick leave benefits of the Civil Service ensure no loss of income as a result or illness. Neither was her lucrative beer-brewing home business interrupted.

Yet among some one-wage dependent households where there is only one resident adult few adults report actually resorting to therapy outside of the popular domain. They report episodes of diarrhoea and other ailments such as headaches and aches and pains which they treat with home remedies and patent medicines from the cafe or supermarket. One also notices in the course of fieldwork a considerable amount of over-the-fence diagnosing and dispensing (Helman,1984:55). Neighbours and friends give advice and frequently share medicines which they claim were successful in their experience of similar ailments.

The fact that few of the women - who manage households and care for children on their own - consult doctors (either indigenous or professional) does not necessarily mean that

an affliction such as diarrhoea is not severe. Considering the nature of the symptoms it is extremely difficult, especially among the adults, for an observer to measure the severity of diarrhoea. Nevertheless, the low frequency of adults resorting to therapy outside of the popular domain (especially as discussed in Chapter five, since diarrhoea is identified by the majority as the commonest ailment in the village) does suggest that household responsibilities can limit the range of therapeutic options available.

There is also a noticeably low frequency of reported diseases among women who work at the 'market' and who through their informal-earning activities frequently provide the major source of cash for wageless landless households (see, for example, Case 3.23). They give many instances of their children's ailments and therapy sought. But, although they may complain about pains and aches, they seldom report resorting to therapy for themselves. It may well be the case that they do not consider their symptoms warrant therapy, but it is also likely that in many cases they cannot afford to adopt a sick role and stay away from work (see Stiano,1981:329).

Some may argue that an under-reporting of disease amongst impoverished members of a community means little more than an actual absence of disease. In response, however, Segar makes an interesting observation on the 1982 Human Sciences Research Council Report on Sport (1982:8).

This report notes with 'consternation' that white South Africans lose more person hours per year off work through illness than do Britons, and they recommend 'more sport' to ensure healthier white South Africans (Segar,1982:8). Segar responds that the high rate of person hours lost through illness can best

be explained by arguing that white South Africans, with sick leave benefits, can afford to lose this time without significant detriment to their accepted lifestyles (1982:8 - see, for example, Case 4.8).

On reviewing the ethnography for 'Ngoe, an important point that emerges from a comparison of the two cases of infant diarrhoea, is the importance of convenient access to the therapy of choice to ensure a successful cure. The experience of losing a child through lack of access to a clinic or hospital actually promoted the household to move to 'Ngoe and to forego possible eventual access to arable land.

Health-care personnel, when faced with a severly ill child (or adult) brought in to the Out Patients' clinic, are often at a loss to understand why the villagers wait until the condition is fairly advanced (even life-threatening), before the patient is brought to hospital. Some even assume that it is ignorance or 'culture' that blocks a recognition of the benefits of biomedicine. But, before these assumptions are made one must consider the difficulties encountered by the residents of remote mountain villages. Many of these, such as lack of transport, need to be considered.

Apart from highlighting the importance of geographical access to therapeutic avenues of choice, the evidence from the disease ethnography at 'Ngoe points to factors similar to those at Peli regarding the disease experience.

It is not necessarily material wealth alone that allows members of materially advantaged households to adopt the sick role and to seek therapy more easily, but also size and composition of the household (see Case 4.1; Case 4.6).

Household responsibilities where there is one resident adult may confine therapy to the popular domain. Where sickness threatens a household's livelihood (the market women for example), the signs tend to be suppressed and individuals do not adopt the sick role. Thus, as at Peli, there is little reported adult disease and therapeutic action amongst the most impoverished members of the community.

Much therapy occurs in the popular domain of family and friends. It can also be suggested that diagnosis and decision to seek therapy are negotiated at this level (see, for example, Janzen,1978). Choice of therapy outside of the popular domain depends on a variety of factors, such as trust in a particular practitioner, based on previous experience (see Case 4.1), or convenience (the hospital at Qacha's Nek is geographically the most accessible to the villagers of 'Ngoe). Cash in wage-dependent households will be made available for therapy, especially in conditions which are seen to be severe. The lack of a cash wage-income, however, may limit therapeutic options exercised (see Case 4.5).

A perceived cause, such as 'poisoning' may direct therapeutic action to an indigenous healer (see Case 4.4), but consultation with an indigenous healer may also be determined by geographical factors (see, for example, Case 4.7). Moreover, seeking a cause is not necessarily all important, especially in an emergency, when practical concerns such as reaching a hospital predominates. The same principle operates amongst the women of Peli, whose desire to be cured of barrenness and infertility outweighs any need to know the cause of their condition.

Although generalisations about the disease experience and choice of therapy are difficult to make, the ethnography from both villages points to a very pragmatic approach to disease and therapy. This approach suggests that finding a

cure is a question of exploiting the appropriate and available healing resources (see Last, 1981:289) and exposes an underlying notion that all disease is curable. This view is supported by the minor role complex explanation plays in the disease process.

In conditions of poverty, disease must be curable: it is imperative, in most episodes of disease, that cure is secured as soon as possible so that afflicted individuals may resume personal and social identity (Stiano,1981:331), only thus can their day-to-day strategies for maintaining health and/or survival be carried out.

Notes to Chapter Four

Note 1 Womens' Church Groups

A number of church denominations have organisations especially for women, usually older women. Some denominations wear distinguishing uniforms (the LEC and Methodists are examples), which they may wear to Sunday services, but always to their 'during the week' meetings. These meetings are held regularly and are conducted by senior members of the organisation. They include bible readings, singing and dancing. They also provide an opportunity for sharing common problems and meeting women from other villages. This social aspect of their function is further enhanced through weekend outings to other parishes in the district, which breaks the monotony of village life and offers the probability of widening their social horizons.

Note 2

It was difficult to obtain exact information on the cost of indigenous healer consultations. It appears to vary considerably according to severity of the condition, length of treatment, whether the treatment requires in-patient care (at the home of the healer) and whether the consultation requires a house visit. A brief consultation for an ordinary ailment (such as advice on diarrhoea, or 'arthritis in the knees') could be as little as R1-00. However, other treatments are more expensive and all travelling expenses of the healer (house-calls and other visits at the request of relatives, to patients in Durban and Johannesburg), are paid by the patient or the relatives.

Chapter Five: NATURAL-SUPERNATURAL CAUSATION

Introduction

Biomedicine is generally portrayed as being scientific in orientation and based on an empirical tradition (Mishler, 1981:15). According to the notion of specific aetiology (one of the four assumptions underscoring the biomedical model of disease - see Chapter one, page 32), disease entities are seen to be characterised by a specific cause, a set of symptoms and a regular and predictable course - a conception which fits the general view of naturally caused disease (see Chapter one, page 4). Thus, it can be argued that in biomedicine the notion of natural causation of disease predominates. By contrast, 'primitive' ideas of disease causation (which include, in the South African context, those of black South Africans), have been viewed as unscientific and irrational (see Cheetham and Griffiths, 1982) - that is a belief in supernatural causation is seen to predominate (see Chapter one, page 4).

As mentioned in Chapter one (see page 1), much of the research on beliefs about disease in small-scale societies has tended to focus on incidences of invocation of supernatural causation of disease. These episodes are frequently considered the most interesting and are often the most obvious to the observer because they are 'unusual' or different (see Sperber,1979: 3-4). But this focus tends to emphasise differences in beliefs about disease causation and underplays areas of common understanding about disease. This is particularly so in the South African situation where there is a widespread belief that different beliefs or cultural systems are necessarily associated with skin colour. Black views about disease and its causation are seen to be fixed in an unchanging traditional black culture and vastly different from a dynamic predominantly white 'Western' biomedical system (see, for example,

Bührmann, 1984; and for a useful overview of works in this vein see Swartz and Foster,1984).

Yet, in this study incidents where supernatural causation are invoked are rare (see Table 4.1). The low frequency of higher level explanation, such as witchcraft, may be due to the open-ended questions posed regarding disease experienced over a period of six months. However, for reasons mentioned earlier (see Chapter one, page 25), I deliberately included an additional general question on whether witchcraft may be associated with disease. Even so, people may not have felt free to share this information with a stranger like myself. But, there is also the strong probability that natural causation is indeed the predominant belief.

Similar findings to the present study have been reported for Lesotho. Ashton reports that to say the Basotho attribute all illness and death to the 'malevolence of enemies' is to 'exaggerate the position'. He goes on to say that the Basotho recognise 'many illnesses as being due to natural causes' (1952:300). A predominant belief in natural causation has also been reported more recently in other parts of the world (see, for example, Frankel,1981; Gillies,1976:358). These more recent studies, unlike those which tend to highlight supernatural causation, include quantitative data on peoples' perceptions of disease and its causation. The trend emerging from these studies, which include an objective quantifiable baseline for perceptions of disease causation, suggests that natural causation is probably more common than the picture presented by studies which focus almost exclusively on incidences of supernatural causation. A higher incidence of natural causation will also be more representative of a society's beliefs regarding disease, and demands attention. The first part of this chapter focusses on the villagers' predominant and representative belief - natural causation of disease.

A focus on natural causation of disease suggests that far from being markedly different, there is considerable common understanding about disease and disease causation between the villagers and practitioners of biomedicine. Diarrhoea, which the villagers claim is their major disease burden, and its cause 'dirty water' (see Table 5.1), serve as a convenient focal example of their predominant belief in natural causation. The villagers' views are contrasted with those of biomedical practitioners on the same conditions and are found to be remarkably similar. I go on to point out, with examples, that the villagers' ideas regarding disease are not fixed in an unchanging traditional 'Sotho' culture. On the contrary, they are constantly changing through disease experiences.

Table 5.1 Summary of the villagers' perceptions of the commonest diseases and their causes

Disease	Cause	No of Respondents
Diarrhoea	'dirty water'	47
Asthma	cause not known	1
Kwashiorkor	'joale'	1
High Blood	cause not known	1
Tuberculosis (TB)	cause not known	2
No response given		18

Note to Table 5.1

This Table lists the responses to question 10(a) and 10(b) of the Question Schedule

In this chapter I also examine some episodes of disease where supernatural causation was invoked. Although rare, these cases do nevertheless provide important insights. 'Poisoning' associated with jealousy appears to be the most frequently invoked higher level explanation (see Table 4.1). 'Poisoning' perceived as malevolent action with evil intent, would be classified as sorcery or under the general heading of a belief in witchcraft (see Evans-Pritchard,1937; Mair,1969 for some general accounts of witchcraft and sorcery as social phenomena).

According to literature on the subject of witchcraft, witchcraft-type explanations can identify stress areas in a society (Mayer,1954:12). It was striking in answers to my question regarding witchcraft, and in general discussions on the topic, that the belief appeared more prominent in two groups of people - migrant workers and parents of small children. I attempt to relate their adherence to witchcraft beliefs to the tensions and insecurity of their respective conditions - as breadwinners in insecure jobs and as parents of children where infant mortality is exceptionally high. With respect to parents of young children, it is also very clear that a belief in witchcraft does not preclude the variety of biomedically sound strategies which they adopt in order to maximise their childrens' chances for survival.

Beliefs about health were difficult to elicit. However, there are some pointers which suggest a predominantly commonsense approach to health and few higher level health beliefs. Because this picture reflects markedly the ratio of natural to supernatural beliefs regarding disease, I include some discussion on 'natural' health beliefs in this chapter.

The majority of respondents expressed an urgent need for clean piped water systems in order to reduce the incidence of their disease burden and to raise the level of health of the community (in answer to question 10(d) of the question schedule). Clearly, the villagers recognise the inter-

relationship of health, disease and social conditions. This answer also suggests a very commonsense view of health.

There was little mentioned during the interviews or in general conversation that suggested any strikingly different beliefs about health, such as -

> ... everyone (in Zululand) must establish and maintain a balance with his surroundings (Ngubane,1976:327).

Janzen has classified this belief as 'utopian' or of a 'higher' level (1980:6). It is interesting to note that when 'unusual' or different health beliefs are given a greater emphasis the same effect tends to occur (as occurs when supernatural beliefs about disease are the major subject of investigation). The 'unusual' belief tends to be viewed as common to all, in this case to Zulus, and a characteristic of 'Zulus' as a distinctive cultural group. This is not to deny that some Zulu speakers may have such beliefs about health, but the individual differences among Zulu speakers based on the diversity of their individual experience over time and place, are underplayed. Their commonsense beliefs, which are the result of experience over time in social conditions, in many respects similar to those of Lesotho, (especially the lack of adequate essential services), are also underplayed.

Reasons for the lack of such 'utopian' or higher level beliefs about health found in this study may be due to the practical emphasis of the study. It may also be due to my lack of proficiency in the language which limited my grasp of symbolism and meaning. But one can argue for a generalised commonsense view of health on the basis of Maslow's hierarchy of needs (Maslow,1970).

According to this theory, man must satisfy his basic physiological needs for water, food and shelter before he can begin to pursue the higher aspects of life. The ethnography has demonstrated that in a situation where the physiological necessities are inadequate, life is a perpetual struggle to secure and maintain physical survival.

Following Maslow's argument, the apparent absence of higher level beliefs about health supports the view that the struggle to maintain survival is all-consuming. Whatever higher aspects exist, have been obscured by the primacy of the desperate struggle to survive, or as in the case of supernatural causation of disease, they are in fact rare. The condition of life is appropriately reflected in the more generally expressed commonsense recognition of the need for clean piped water.

The villagers' commonsense view of health, reflected in their recognition of the need for clean water, like their views regarding disease, is also shared with the practitioners of biomedicine at a number of levels. Again, rather than being markedly different, there appears to be considerable ground for co-operation between the villagers and biomedicine in order to combat diseases prevalent in Lesotho and to raise the level of health in the rural countryside. Certainly 'traditional' beliefs do not appear to be an obstacle.

However, despite a general inadequacy of clean water systems, a new hospital was built in Qacha's Nek between 1979 and 1982. Circumstances surrounding the building of the new hospital suggest that political and economic factors over-ride the villagers' expressed needs. At the same time, they also conceal the local peoples' commonsense views on health and disease. In the concluding section of this chapter I examine some of these factors.

Natural Causation of Disease

The villagers' views of their major disease burden and its causes coincide very closely with that of biomedicine. The hospital and clinic staff whom I interviewed locally all stated that diseases associated with diarrhoea, such as gastro-enteritis and typhoid, are some of the most common reasons for consultation. They all put the high incidence of these conditions down to the lack of adequate clean piped water in the area (see Note 1).

The national disease profile, which reflects the reported diseases for the country, lists a number of diseases such as typhoid, gastro-enteritis and the diseases of malnutrition - all of which are often associated with diarrhoea (see 3FYDP:327). At the international level of biomedical thinking, the Director General of the World Health Organisation (WHO) states that 80 percent of disease among the 2000 million inhabitants of the Third World (the underdeveloped regions of the world have similar mortality and morbidity rates and disease profiles to Lesotho - see World Health Statistics Annual,1983), is caused by inadequate clean water supplies and sanitation (WHO Chronicle,1981:261). Thus, from villagers through to the Director of WHO, diarrhoea and its associated conditions are seen as a major problem with 'dirty water' or a lack of adequate clean piped water, as a root cause.

The similarities between the villagers' views of their major disease burden and its cause, and those of biomedicine, suggest considerable sharing of ideas about disease. This makes it extremely difficult to distinguish between two distinct medical systems - for example a 'Sotho' and a 'Western biomedical' system. This suggests rather that beliefs or ideas about disease are not necessarily fixed in cultural tradition but are constantly changing through the disease experience.

The villagers' perception of diarrhoea and its cause must be seen against their frequent encounters with the ailment in living conditions which are, and have been for some time, marked by a shortage of adequate clean water and sanitation (see Chapter two, page 45). The sharing of ideas about disease between the villagers and health-care professionals at a number of levels, should also be seen in the context of contact with biomedical services over a lengthy period of time. For instance, mission health care has existed in the country since 1844 (Hailey,1957:1074), and migrant labour has resulted in regular contact with industrial biomedical services. Hailey notes that industry frequently anticipated the State in implementing public health measures through recognising that an unhealthy worker is 'expensive and ineffective' (1957:1105).

Many biomedical terms have been incorporated into the villagers' disease terminology, thereby inferring that learning about disease is an on-going process. For example, one of the healers, Mr AB (see Chapter four, page 143), claims his speciality is 'VD' (he uses this specific abbreviation for venereal disease) for which he gives a text book list of causes, signs and symptoms, and points out that his treatment would be far more effective if he could use 'penicillin'. His career history, which spans time in a laboratory in Maseru, army service in the medical corps in Abyssinia, urban practice in Durban (it is well known that venereal disease was a problem during the war and today is fairly widespread in the urban areas), and his present rooms near the 'red light' district of Qacha's Nek, speak of detailed knowledge of the problem gained through protracted first-hand experience and exposure to the ideas of biomedicine.

The two cases of tuberculosis (TB) listed in Table 5.1, are reported by individuals with a knowledge of the condition gained either through personal or family experience. For example, in the one case a woman reported that her husband's

TB was diagnosed while he was working on the mines in Johannesburg. Although she could not give me the cause of the condition, she described how her husband was diagnosed on a routine chest X-Ray and sent home to Qacha's Nek for treatment. She was aware of the aims of the treatment and the need at the time to continue regular maintenance medication. She was also well aware of the dangers of a relapse for her husband and of infection for herself and the children (although her husband is now better, he has not been able to renew his contract on the mines).

It is interesting to note how readily terms from biomedicine are incorporated into the local vocabulary. For example, 'cholera' was a term sometimes used by the villagers instead of diarrhoea. Although they all were describing 'diarrhoea' and not the more serious condition of 'cholera' with its characteristic 'rice water' stools, the addition of 'cholera' to their medical vocabulary followed closely on certain anti-cholera health education programmes which were relayed regularly by the South African Broadcasting Corporation during the Cholera Epidemic of 1981-1982.

At the same time, one should also note that the hospital staff use the popular term 'high blood' for hypertension (see Heap, 1981), which suggests that adoption of new terms for ailments is not necessarily a one-way process from hospital staff (or biomedicine) to patients.

Perhaps one of the most interesting examples of a 'new disease' is 'motheketheke' (see Chapter four, page 144). Among the residents of 'Ngoe and Peli only one patient claimed to be undergoing ritual treatment for this condition. Furthermore, an awareness of the condition was limited to a few households where there tended to be some family association with 'motheketheke', much like in the cases of TB and asthma mentioned above.

It might have been expected that the prevalence would be higher, especially as so much research has focussed on conditions such as 'motheketheke' (see, for example, Janzen, 1982(a); Mills, 1983). One also expected a greater general awareness of the ailment among the people. A condition such as 'motheketheke' is frequently portrayed in the literature as a traditional African disease - traditional implying that which is widely acknowledged and persisting over a long period of time. However, Ashton remarks that 'motheketheke' is 'new to the Basotho' (1952:283). There is no mention of it in the missionary writings and it is first mentioned in 1938 by Motlamelle who suggests that it was introduced to the Southern and Eastern districts of Lesotho from the Cape Colony by the Thembus (Ashton,1952:283) - just under 100 years after the introduction of mission health care in Lesotho (see Hailey, 1957:1074).

The discussion thus far has attempted to show that, rather than differences, villagers and biomedical practitioners have much in common regarding the understanding of disease and its causation. By looking at some disease terminology the discussion has also attempted to point out the changing nature of ideas about disease. The biomedical model has been the major standard for comparison, but this is not to confer superiority on the understanding and classification of disease according to this system. However, this system and its terminology is well known and widely available and it has been used in other anthropological studies as a standard for comparison (see, for example, Topley,1970).

Supernatural Causation of Disease

Despite the predominant belief in natural causation there are obviously instances where supernatural causation is invoked. I have mentioned that witchcraft-type explanation appeared most prominently amongst migrants and parents of small children. Before continuing, it should be pointed out that a belief in witchcraft is not necessarily specific to African societies. It is a phenomena present in various forms in many societies and at different times in history (Trevor-Roper,1967). Depending on the social context, witches may come in numerous guises from individuals who are perceived to have a 'snake in the belly' to 'communists' (Mayer,1954:5). They are frequently the invisible, vaguely defined 'scapegoat' who is blamed for the individual's, or a society's, misfortune (Parrinder,1963:202).

For the individual a belief in witchcraft is a resource for explaining misfortune in extraordinary circumstances (Wilson, 1951). Migrant labour is not a secure form of employment at the best of times, but at present the insecurity is aggravated by the rising regional unemployment (see Graph, Fig2.1, page 41), and the changes in the Chamber of Mines Employment policy (see Chapter two, page 42), and there is bitter competition for the few contracts that become available. When disease, without any subjective feeling of illness, leads to the loss of a contract just after a man had been successful in obtaining one, 'poisoning' caused by jealousy is perceived to be at the root of the matter.

Case 5.1 (see Note 2)
After a lengthy wait at the recruiting office in Qacha's Nek, Mr RS eventually secured a contract on the Mines. On a screening X-Ray in Johannesburg he was found to have TB, although as far as he was concerned he had felt no symptoms of illness. He was sent home to Qacha's Nek to be hospitalised for at least three to four months and even after his discharge from hospital it will be some time before he is given a clean bill of health to start the anxious wait for a contract again. In the meantime, he has the added anxiety of his wife's and dependants' survival. He puts the whole series of unfortunate circumstances down to poisoning caused by jealousy. On his discharge from hospital he intends seeking therapy from the indigenous healer to remove the effects of the poison which he perceives to be the root cause of his disease.

For Mr RS, a belief in witchcraft answers the 'why me, why now' questions? (Wilson,1951). Why should he, among a number of other successful job applicants, be singled out at a multiple X-Ray screening session when he did not feel ill? and then to be sent home, hospitalised and endure three months or more of painful therapy (regular intramuscular injections of streptomeycin are still part of the TB therapy at the Qacha's Nek hospital). Why this when he was on the threshold of a new job? The circumstances surrounding his misfortune only confirm for him that jealousy, in an increasingly competitive work situation, is at the heart of his problem.

Mr RS's reaction to a diagnosis of TB on chest X-Ray evidence should be seen against the nature of TB itself. A handbook on TB lists a number of noticeably vague symptoms - cough, loss of weight, loss of appetite, lethardy, haemoptysis, dyspnoea, pain in the chest, fever, amenorrhoea, hoarse voice (Glatthaar, undated:14). The handbook goes on to say that few TB sufferers present with all ten symptoms; most present with a 'cough plus one or two' (Glatthaar,14). But perhaps most important for the above case is the following observation:

> Because of its (TB) insidious onset and chronicity the symptoms and signs develop slowly and very often the patient ignores certain symptoms or accepts and excuses them as 'overwork', 'not enough sleep', 'smokers cough', etc .... patients often refuse to believe that they suffer from tuberculosis (Glatthaar,14).

Mr RS is clearly one of those patients where the onset of TB was insidious and symptoms were not sufficiently marked for him to feel ill. Nevertheless, at one level he is able to accept the diagnosis which is evident from the fact that he presented himself for treatment at the Qachs's Nek hospital when he was sent home. But, at another level, as Evans-Pritchard (1937) has pointed out, there is also the need to explain events associated with the condition. A belief in witchcraft fulfils this need.

Supernatural causation is not invoked in all cases of TB. The belief in witchcraft is an available resource in a range of customs which may be invoked by the individual at some crisis in life (West,1975:178-179 makes the same point for the performance of ancestral rites). It served this purpose for Mr RS. However, where symptoms are marked (in the case of TB - pain in the chest and blood in the sputum), the seriousness of the condition is soon recognised and therapy is promptly sought. With no accompanying unfortunate circumstances, 'poisoning' is not invoked as the root cause of the problem.

Case 5.2 (see Case 3.12)
This old man lives alone with his son, a shepherd at Peli. They have no fields and sell livestock in order to buy the necessary food and day-to-day needs. For the old man neither jealousy, witchcraft nor ancestor displeasure had anything to do with his TB. He says when the bouts of coughing did not improve (no remedies sought), the pain in his chest increased and he noticed blood in his sputum, he visited the clinic where TB was diagnosed. He had treatment for some time and was eventually cured.

During the course of fieldwork, it became increasing evident that there appears to be a fairly widespread general belief that children and pregnant women are extremely vulnerable to the effects of poisoning. In a country where the infant mortality rate is high the belief is no doubt rooted in personal and family experiences over many generations. This belief functions to ensure a number of protective measures during the most vulnerable years of the child's life (see also Ashton,1952:289).

Mothers' efforts to ensure the 'best' for their children start during pregnancy (see also Maclean,1980:122). They go to great lengths to attend ante-natal clinic, many coming on foot from great distances. Most women also stated that they preferred to deliver at a hospital or clinic rather than in the village. They feel it is safer in case anything should go wrong during labour. Some women who live in the remote outlying areas even come to town a few weeks before the expected delivery date to ensure that they deliver in hospital. This, as was noted in Chapter four (see Case 4.3), is not always as easy as it may seem. For instance a migrant's wife has to make arrangements with kin or neighbours to see to the homestead in her absence.

After delivery there are many customs, ostensibly aimed at protecting against poisoning , but at the same time they also serve (in biomedical terms), to ensure the health of the infants. A neighbour of ours gave birth to a child during my stay. It brought home to me the joy a new child gives to a family and neighbourhood and an insight into the appropriateness of some of the customs associated with birth.

For the first two or three months after the birth of the baby, the mother and infant are confined to the homestead

which is marked with a plaited rope to give notice to the public of the new mother and child (see, also Gay,1980:52). During these few months of relative seclusion female relatives and neighbours take over the homestead tasks and caring for the other children. This allows the mother time with her new child. It keeps both mother and child relatively well protected from the possibility of infection from the wider community. It also allows the mother time to establish her breastfeeing routines. It is biomedically well known that breast milk contains essential antibodies to protect the infant. While this biomedical rationale may not necessarily be widely known among the mothers, they nevertheless take breastfeeding very seriously. Most mothers claim that they continue to breastfeed until the child is about two years old (the number of toddlers I saw being breastfed confirms this. I only saw one infant being bottle-fed and this, according to the mother, was intended to complement her breast milk which she felt was poor in quality as a result of her poor diet during the drought).

After this two-or three-month period the mother and child emerge from the relative seclusion of the homestead (Gay, 1980:53). Patent medicines (which can be bought at a general dealer) are placed on the infant's orifaces and fontanelle as protection against poisoning (see also Ashton,1952:289). One of the first outings is to town. The mother may do some shopping and visit friends and relatives to show her new baby, but her first call is to the clinic (see also Gay,1980:53-54). At this first visit to the clinic after delivery the baby is weighed and checked. The mother also receives her regular post-natal check-up. But, most important, the required course of immunisation against the common diseases of childhood is commenced (see also Gay,1980:53-54). Thus vaccinations against these diseases, which are known to have fatal complications, are viewed as a very important aspect of a range of protective measures.

Evidence of recognition of the importance of vaccinations is seen in the numerous reported instances of enthusiastic popular responses to vaccination campaigns. For example, in 1952 the incidence of diptheria for Lesotho was as high as 428 reported cases (Colonial Annual Report (CAR), 1952:45). In 1956, after the UNICEF sponsored Diptheria and Whooping Cough Vaccination Campaign of 1955 (CAR,1955:63), incidence in Lesotho as a whole was reduced to 58, and no cases were reported for the Qacha's Nek district (CAR,1957:63). Buch also reports a widespread response to some recent mass immunisation campaigns in a black rural area of the North-Eastern Transvaal (1984).

The discussion thus far on supernatural causation points out that examination of incidence of supernatural explanation can identify stress areas in a society (Meyer,1954:14). For the individual, invocation of a supernatural belief such as poisoning , as a cause of disease, serves to explain the inexplicable in extraordinary circumstances (Wilson,1951). At a general level, in a situation where infant mortality is high, the belief in 'poisoning' works to ensure a number of protective measures, which include biomedically approved strategies, during the first years of a child's life. These years are known from extended first-hand experience with infant deaths, to be the time when the child is the most defenceless against the hazards of an impoverished environment.

However,among the villagers, a belief in natural causation of disease predominates. It has been argued that when this becomes an important focus of an ingestigation of peoples' beliefs and practices concerning disease, it becomes extremely difficult to draw rigid distinctions between different medical systems. To move away from an emphasis on differences and to seek the areas of shared understanding about disease has become a concern of this study. To this end the study has not concentrated solely on

specific conditions or episodes of disease, but has sought to investigate a broad spectrum of disease, which introduced some quantitative data on villagers' perceptions of their ailments and their causes. The quantitative data has served the useful purpose of highlighting the rarity of supernatural explanation, which when it is the primary research focus, tends to emphasise differences in disease-related beliefs and practices.

It must also be emphasised that invocation of the supernatural in circumstances associated with disease and misfortune is not specific to the Basotho or African societies. Comaroff makes this point in her study of British parents' responses to leukaemia in their children (1979). The means of explanation may vary from place to place, and among individuals, but the end is the same. Thus, even in the realm of higher level explanation, differences between social groups are not necessarily particularly marked.

Obstacles to Clean Water Systems and Sanitation - An Overview

The villagers stress the importance of the implementation of clean water systems for combating their most prevalent disease and raising the level of health of their communities (46 of the 70 respondents gave clean water in answer to question 10(d) of the question schedule). This view of the importance of clean water systems is shared by other communities in the rural countryside (see 2FYDP:209) and it is also shared with biomedical practitioners at a number of levels.

The health authorities in Lesotho view the installation of clean water systems as a priority area to reduce the current level of reported diseases in the country (3FYDP:147-148). The Director-General of WHO has recently launched the International Drinking Water Supply and Sanitation Decade 1981-1990 (WHO Chronicle,1981:26). The decade is aimed at

combating some of the 80 percent of disease affecting the inhabitants of the underdeveloped regions of the world. These hitherto neglected areas of infrastructure (largely the legacy of colonialism - see, for example, Van Etten, 1976:18-27), as mentioned above, are recognised to be major contributing factors to the greater percentage of disease in the Third World (see WHO Chronicle,1981:26).

The villagers do not stress the importance of sanitation in the same way as they do clean water systems. Rudimentary pit latrines can be erected relatively inexpensively and with a minimum of technical 'know how'. More and more people appear to be accepting this responsibility as it becomes increasingly difficult, especially in a place such as 'Ngoe, to continue to make use of the 'place of the flat stones' ('dongas' of other similar places which serve as 'natural' lavatories for small communities - see Ashton, 1952:88).

Between March and July 1983, when I returned to Qacha's Nek for my last research visit, I noticed a number of additional pit latrines at 'Ngoe. However, it is extremely difficult for any community to address the expensive and technically complex area of clean water systems without outside assistance. Thus, clean water systems become the priority of the villagers.

Despite widespread recognition of the importance of clean water systems and sanitation, response by the authorities to these areas is slow and often inappropriate. Implementation of clean water systems by the present government of Lesotho is an improvement on the Colonial government's record (see, for example, Table 2.1, page 47), but it continues to be uneven and hampered by a lack of financial resources (3FYDP:148). Between 1970/1971 and 1974/1975 an average

of 20 clean water systems were completed per year (2FYDP:209). Between 1975/1976 and 1980, 16 were completed per year (3FYDP: 148). This was less than half of the 40 per year planned for this period. The reason given for the shortfall is limited financial resources (3FYDP:148).

Plans to improve rural sanitation in Lesotho remain in the pilot phase (see 3FYDP:150-151). This includes some possibly unnecessary and expensive undertakings such as 'environmental laboratories', 'social and medical research' (3FYDP:150-151), and health education programmes (3FYDP:146). As an 'health educator' myself (a post I held shortly before I returned to university), I can vouch that there is little health education can teach people who have coped for generations with a situation such as a rural village devoid of any health amenities. On the contrary, the villagers taught me. The fact that there is not more disease and infant deaths in these living conditions so hazardous to health, is perhaps proof of the villagers' admirable coping strategies which is all too seldom appreciated.

In the face of a poor distribution of clean water systems, and an almost total absence of sanitation in the strict sense of an adequate system, a new hospital was built in Qacha's Nek during 1979-1982. This, despite a report by the then District Medical Officer that a new hospital should not be considered within the next 15 years (Qacha's Nek Hospital Report,1976:5). Circumstances surrounding the construction of the new hospital suggest how the effects of political and economic processes function to serve interests that do not necessarily coincide with the identified needs of a community. In serving these interests, they also serve to ignore and obscure the villagers' very commonsense views on health and disease.

Funds were made available for the building of the hospital through international aid via the United Nations. An emergency fund for Lesotho was set up when, in 1976,

Lesotho, with the rest of the world, refused to recognise the South African Government's newly-created State - the Transkei. In retaliation, the Transkei government closed the Qacha's Nek border post. This effectively cut an important link with Matatiele in South Africa. The hospital was part of the subsequent upgrading of the South Eastern districts for which funding was made available by the United Nations (see Chapter two, page 54).

Lesotho, as one of the poorest nations in the world is the recipient of considerable international aid. In addition, although politically independent, is also heavily dependent on its neighbour the Republic of South Africa, where the majority of the adult male population are employed. The international community is frequently at odds with the Republic, largely on account of its apartheid policy. Consequently the Lesotho government, with loyalties to both parties, finds itself in the precarious and unenviable position of placating its international benefactors on the one hand, and maintaining a semblance of relationship (albeit a guarded one) with its powerful neighbour.

Political and economic considerations can have a powerful effect on health policies. Hayter has argued that international development aid programmes should be seen in the context of the current world recession (1981:12).

> (The Brandt Report) represents the most enlightened expression of establishment thinking about international economic matters, and in particular about the provision of so-called 'aid' to developing countries. But it would be a mistake to think of its authors as primarily or exclusively concerned with the alleviation of poverty in those countries. They are, instead, primarily concerned with the preservation of the existing world economic order (Hayter,1981:9).

For the rich exporting first world countries, Hayter goes on to argue that humanitarian objectives and increased profit margins coincide conveniently (1981:12). But the export objectives of the rich nations (in order to boost their depressed markets) frequently take precedent over the recipient countries' priorities. In this economic climate it takes a brave politician, especially in an extremely poor recipient country such as Lesotho to say -

> that the most important initial steps in health care can be taken without the immediate involvement of any highly qualified and therefore expensive personnel, and do not require substantial investment in building equipment or medicines (Kirsch,1979:164).

But hospital buildings, hospital equipment and medicines are important export commodities for the rich industrialised nations. Moreover, a hospital, particularly one on the border between Transkei, South Africa and Lesotho, unlike sewerage systems in remote mountain villages, is a much more visible symbol of international concern and involvement in Southern Africa.

The building of the new hospital is not a criticism of the hospital as such, or of curative medicine, nor is the 'hospital' versus 'clean water systems' meant as one more argument in the 'curative' versus 'preventative' health-care debate.

Preventative health measures, in the form of Primary Health-Care Programmes, Health-Education Programmes and self-help projects are currently in vogue in many of the Third World countries. This is partly the result of the on-going WHO campaign, 'Health for all by the year 2000' and also an effort to balance, in post-colonial countries, the largely curative bias of many of the pre-independence colonial

health-care programmes. But some preventative health-care programmes, unless appropriately implemented may mean second class health care (see, for example, Jacobs, 1981). Furthermore, in Mozambique, where the post-independence government can claim an admirable record of providing sanitation and clean water systems, the local people are expressing a need for improvements in their curative services (see, for example, Critical Health, 1984:39).

The villagers of 'Ngoe and Peli stated that priority for clean water systems should be seen in the context of relatively adequate curative services, especially near the town of Qacha's Nek. Should their curative services have been poorly supplied, and their social infrastructure adequate, they may have stated a different priority. The solution in providing health care seems to lie first in taking cognisance of the expressed needs of the people, and then (with resources available), to provide a comprehensive service which would encompass both adequate curative and preventative measures.

Lesotho's situation in Southern Africa, politically independent but economically dependant on the Republic of South Africa, also affects implementation of essential health services. As Wilson (1972) has pointed out, a system of migrant labour eventually leads to a settled urbanised workforce. Employers contribute towards the housing needs and, through taxation, to the necessary infrastructure including sanitation and clean piped water, to serve the settled workforce. However, Lesotho's political independence coupled with South Africa's strict immigration (for blacks especially), and influx control laws, removes the responsibility of the health of the workers from South African industry. Urbanisation is curtailed, the system of migrant labour continues and -

> has the effect of hiding behind some mountain in the rural areas the misery which most of the rich and powerful people in society do not see. In other words, were people allowed to come to the cities and did so, to live in shanty-towns, their plight would be visible to all and pressure would be generated for society to do something to help them. As it is, however, people do not know what is happening and so pressures for reform are stifled (Wilson,1972:186).

Notes to Chapter Five

Note 1

It was difficult to obtain exact figures for numbers of, and reasons for hospital consultation, over a period of time. During the time that I worked at the hospital the staff were busy moving from the old to the new hospital and in- and out-patients' records were not available.

Note 2

Mr RS was not a resident of 'Ngoe or Peli. I met him and interviewed him while I worked at the hospital.

Chapter Six: CONFLICT AS A FRAMEWORK FOR THE HEALTH-DISEASE RELATIONSHIP - A PROPOSAL

The medical system (see Chapter one, page 10) is the central theoretical concept of medical anthropology. In line with medical anthropology's primary research interests, the medical system is seen as being predominantly concerned with disease (see, for example, Press,1980). The health system is generally defined as a separate entity (see, for example, Leslie,1978:xii; Janzen,1980:8) - both conceptually and as a separate area of investigation (see, for example, Janzen,1982). However, for reasons stated earlier (see Chapter one, page 8), it is important to recognise the interrelationship of health and disease as two closely related aspects of the single medical domain. Rather than being rigidly dichotomised, health and disease can be viewed as poles on a continuum and the one may be seen in terms of the other. This approach moves away from the disease orientation of medical anthropology (see Janzen, 1981:185) and requires the formulation of some appropriate alternate theoretical ideas. In this chapter some tentative proposals for viewing disease and health as part of a single domain are put forward. It is proposed that some ideas from conflict theorists in anthropology, particularly Turner (1957) and Epstein (1958), provide useful analytical insights for examining disease in its close interrelationship with health. The appropriateness of the conflict analogy and some of its analytical insights are examined in the light of the preceding ethnography.

Simmel uses disease as a metaphor to describe the unifying role of conflict in society (see Levine,1971:70). This suggests that notions of conflict may throw light on the relationship between disease and health. Disease and health

are two interrelated aspects - the 'A and non-A' of the single medical domain (Janzen,1981:185). The 'non-A' disease when it occurs is identified in this close interrelationship because it conflicts with health. It is the 'conflicting' aspect of the medical domain. This theme is borne out in some of the general definitions of health (see Chapter one, page 3). Whether disease be termed the 'abnormal', 'unnatural', or 'dysfunctional', it is identified as that which conflicts with health, be it termed 'normality', 'nature' or 'function' (see Temkin,1973:398; Boorse,1977).

The notion that disease is something that conflicts with health or 'social normality' is also the view implied in sociological studies. Zola, when he describes why people seek medical attention, puts forward a number of non-physiological reasons. These include interpersonal crises, perceived interference with social or personal relations and/or perceived interference with vocational and physical activity (1978:127). In medical anthropology, sickness is generally defined as recognition by members of the social group that a person is unable to carry on the usual social activities (Frankenberg and Leeson,1976:277; Young,1976:6). In other words, people seek therapy, or sickness is recognised when it is seen to 'conflict' with an individual's 'social normality'.

As mentioned above, there are some useful analytical insights to be gained from anthropological scholars of local-level conflict, especially the post-war Manchester School. Interestingly, these post-war scholars claim similar problems to those facing medical anthropology today. Gluckman (see 1969:vii-xx) criticises the pre-war structure-functionalists for their concern with oversystemetisation and a lack of quantitative data (see also Mitchell,1969:17-46 with reference to quantitative data). In medical anthropology today, similar

criticisms of over-systemetisation are levelled at the 'systemisers' (see, for example, comments by Feierman, Helman, Mudimbe in Issues and Findings,1981:433), and generally there tends to be a lack of quantitative data (Frankel,1981:7). Thus, there is a certain aptness in returning to the work of these post-war scholars.

In their desire to move away from an over-emphasis on the regularly recurring aspects of behaviour, some scholars turned their attention to conflict as a part of normal social process. It required a subtle shift in perspective to view conflict, not as an abnormal or irregular aspect of social life, but as an integral part of normal social reality and hence worthy of detailed study. Similarly, much can be gained by considering disease (and disease episodes) as part of an on-going search for health, rather than as something apart from or unrelated to it.

Turner uses the 'social drama' (1972(1957):xvii and 91-93) to analyse conflict as a part of normal social process. In many ways the disease episode (including the therapeutic process) can also be viewed as a 'social drama' in this sense. Turner divides the social drama into four phases - breach, crisis, redressive action and re-integration or recognition of schism (1972(1957):92). The therapeutic process can be said to begin with a recognition by the individual or others that there is a 'breach' with health or there is an inability to carry on normal daily activities (see Zola,1978:127). Therapy may commence with family and neighbours (see, for example, Elliott-Binns,1973), but if the disorder fails to respond or worsens, a 'crisis' demanding 'redressive action' is reached (see, for example, Janzen,1978). The process of 'redressive action' involves the use of healing resources outside the family towards the goal of cure.

Successful cure implies 're-integration' into health or 'normality', while an acceptance that some conditions (such as barrenness) are incurable suggests that there has been a full 'recognition of schism'. Turner also makes the point that not every 'social drama' corresponds to the model be presents. Under varying conditions it may not proceed 'smoothly or inevitably from phase to phase' (1972(1957):92). In the same way, disease episodes, depending on their severity, need not follow the same pattern. For example, not every disease episode necessarily involves a crisis; nor does every therapeutic process result in cure; nor does the disease experience necessarily leave the affected individual unchanged.

One can also see how the disease experience and the therapeutic process may lead to changes in medical ideas. Epstein, when discussing political conflicts and their resolution, sees them as -

> internal inconsistencies (which are) resolved through the operation of the principle of situational selection (1973(1958):xvii).

'Diseases as dramas' are similar to 'internal inconsistencies' which occur in the process of daily social life or health. Some diseases may be cured through 'redressive action' and 'situational selection' of appropriate healing resources, the availability of which will vary over time and in different social and geographic contexts. Thus, through the disease experience, people may use a variety of healing options and through such experience they learn more about the condition, its cause, effects and what is needed for cure. They also learn, through perceived success and failure, which healing resorts they will re-use and which will be discarded.

Of conflict, Epstein has also said that in an open social system -

> fresh sources of conflict are continually generated in the development process itself: here conflict and its resolution provide part of the momentum to further adjustment and change (1973(1958):228).

In the same way diseases, in the context of health, are continually being 'generated' to be 'resolved' and in the therapeutic process of 'resolution provide part of the momentum for further adjustment and change'.

Whether these ideas discussed thus far have a useful application for the study of health and disease needs to be examined in the light of the ethnography presented in the study. There are four main areas arising from the discussion where their usefulness may be 'tested'. First, as a baseline to the argument, one needs to find out whether, in fact, disease and health are closely interrelated at the level of daily life. As mentioned earlier (see Chapter two, page for practical purposes the health and disease ethnography were presented separately. Second, one needs to examine whether disease can be seen to conflict with health or on-going social life. Third, can the notion of the 'social drama' be applied to a disease episode in the context of health? Finally, can it be shown that changes in ideas regarding disease may occur through 'situational selection' of healing resources during the 'redressive' phase of therapy.

The baseline to this argument is perhape best illustrated by the fact that the understanding of the individual's disease experience is enhanced by examining it against the background of a household's health or survival strategies. For instance, in large materially advantaged households with access to more than one cash wage income, disease is

easily legitimated and there is a choice of therapy (see, for example, Case 4.1). Access to material wealth may seem, on first analysis, to be the most obvious reason why individuals in these households have the cash resources to afford a number of therapeutic options. However, on closer examination, it appears that it is size and composition of the household that play equally important roles. These households, being large and multigenerational, comprise a number of adults who are not only the primary legitimators of disease, they are also able to assume responsibility for the household tasks of an afflicted member during time of sickness. But response to disease in these households is also related to the household health strategy. Large multigenerational materially advantaged households with more than one cash wage income are health strategies in themselves. They aid the broader survival process of redistributing scarce resources for providing food and shelter amongst a wide range of people.

A background of health also partly demonstrates why kin are available to assist with therapy management (see, for example, Janzen, 1978) in some cases but not in others. In Case 4.4, the mother-in-law gave advice and financial assistance when her daughter-in-law's child was ill. Both women are part of a co-operative network of female relatives who live in the same village. The co-operation between members of this network is an essential part of their physical survival strategies (see, for example, Case 3.7). Clearly, this co-operation in ensuring health also extends to assisting each other in the event of disease. On the other hand, women who are the sole resident de facto adults in a household and who do not have a supportive network of female relatives living in the same village (for instance some of the young women living at 'Ngoe), to provide financial and other support, find it difficult to adopt the sick role.

Finally, health and disease are also closely interrelated amongst the most impoverished members of the village. When illness is seen to threaten the continuation of a health strategy (see, for example, Case 4.5 and the market women of 'Ngoe), it is suppressed. Individuals cannot afford to adopt the sick role if this means foregoing a survival strategy - for themselves or for their dependants.

Taking up the second point listed above, there are a number of examples from the ethnography which illustrate that disease may be viewed as that which conflicts with health. For instance, some pain and discomfort may be part of a chronic ailment, but when the pain reaches a level that interferes with daily activities, it is recognised as an episode warranting therapy (see Case 4.1). In a child the progress of diarrhoea to the more serious symptoms of fever is recognised because these conflict, or are contrary to, the normal process of diarrhoea, which usually resolves itself under treatment with a home remedy (see Case 4.6 and Case 4.7 in contrast with Case 4.2),

Infertility may conflict with the normal transition of a female from girlhood to womanhood. It may conflict with the usual process of marriage, interfering with bridewealth payments (see Gay,1980:107). Conflict may occur between intermarrying households as a result of a woman's inability to bear children. Furthermore, a lack of offspring may jeopardise security of shelter and sustenance in old age (see, for example, Case 3.13). Similarly, the responsibilities of a household may conflict with continued therapy (see, for example, Case 4.3).

Finally, the most impoverished members of the community are faced with the conflicting situation of frequently experiencing the symptoms of illness, but at the same time having to

maintain their physical survival (see, for example, Case 4.5).

In this conflicting relationship with health, a disease episode can be analysed as a 'social drama' (Turner,1972: 91-93). The majority of cases in the ethnography illustrate that the point of conflict at which disease is recognised, is the 'breach' with social normality. It may be pain, as mentioned above, or a breach with normal bowel habits, as in diarrhoea. Turner also makes the point that not every 'social drama' necessarily follows exactly the same pattern (1972(1957):92). In the same way not every disease experience is the same, but this need not detract from the usefulness of the concept in examining an episode of disease in the context of health. I give some examples.

In Case 4.4,the child's fever marked the original 'breach'. This motivated some initial 'redressive action' (the clinic was visited). However, when the child failed to respond a 'crisis' developed. The child's grandmother made a diagnosis and suggested the next phase in the 'redressive action' (the indigenous healer), which, as far as the people involved were concerned, resulted in a 'reintegration' or cure.

In cases of infertility, recognition of the 'breach' with normality may be slow. There may be, for example, a series of consecutive miscarriages before a woman comes to realise that she is unable to carry a pregnancy to term. At the same time as the 'breach' with normality (other women carrying pregnancies to term) is being recognised, a 'crisis' is also slowly developing which eventually demands 'redressive action' or the exploitation of a variety of healing resources towards the goal of 'reintegration' of cure. Barrenness and

infertility, as mentioned earlier, may be resolved either in the biological sense, in that the woman conceives and delivers a healthy infant, or in the social sense in that she fosters the child of a relative.

One can also apply the concept of the four phases of the drama to a chronic ailment. There are two possible ways to approach a chronic complaint (see Case 4.1). Having experienced similar episodes at other times in his life, a chronically ill individual may not necessarily wait for a 'crisis' to develop. Instead, he may immediately seek 'redressive action' at the point where the pain breaches normal activity. On the other hand, one can suggest that the 'breach' occurs when the disease is first recognised and diagnosed. Thereafter, he may experience a number of 'crises' which are recognised when the chronic pain threshold is breached and causes interference with daily activities. Re-integration in a chronic condition does not necessarily imply a complete cure, but only a relief of symptoms.

Poverty may curtail the disease experience. Individuals may experience the symptoms of illness and within themselves recognise a 'breach' with normality. But if disease threatens a health strategy, the situation may remain in conflict or be resolved by ignoring the signs of illness (Stiano,1981:329 - see Case 4.5).

While there are general examples from the ethnography which point to the similarities between the disease experience and Turner's 'social drama' (1957), the usefulness of the concept is perhaps best illustrated by examining a case study.

Case 6.1
Mrs Z, in her early twenties and her two small children (aged 3 and 1 year) live in a sparsely furnished single-roomed dwelling at 'Ngoe. Her husband is a poorly paid migrant worker and his remittances are meagre and infrequent. They have neither livestock nor fields. Unlike the majority of one wage-dependent households at 'Ngoe, Mrs Z does not have cash to spare to buy the ingredients to make 'joale' (home brewed beer). Instead, as an alternative, to supplement her food supplies, Mrs Z maintains a link with her natal village where she 'helps in the field' in return for which she receives food (her 'health' strategy).

About two years ago her child was taken ill. The child developed diarrhoea and later fever. When the child failed to improve she took him to her mother's village. At her mother's home the child's condition continued to deteriorate and they consulted an indigenous healer, but the child failed to respond to the treatment. Eventually Mrs Z and her mother went to the government hospital at Qacha's Nek where, despite receiving treatment, the child died. The doctor, according to Mrs Z gave the cause of the child's death to be kwashiorkor and diarrhoea. He also suggested at the time, that she deliver her next child at the hospital, which she duly did.

The onset of the physical symptoms marks the 'breach' with normality. As the physical symptoms deteriorate a 'crisis' develops which demands 'redressive action'. Redressive action includes selection of a number of available healing resources (the mother, the indigenous healer and the hospital). Cure or re-integration into health was not attained, the child died and 'schism' is recognised.

Mrs Z's first therapeutic action, to seek her mother's help even though the hospital is in relatively easy walking distance of 'Ngoe, can best be understood by looking at her overall health strategy. For some of her health needs Mrs Z maintains a link with her mother's village by helping in the fields in return for food. When disease occurs she follows a similar route. It can also be understood by the fact that she had had little experience with biomedical services. Prior to visiting the government hospital with this child she had never attended a clinic, nor had she

delivered any of her children in hospital. Mrs Z's maternal relatives also have a history of motheketheke which may also explain why she first sought her mother's help and then the indigenous healer.

The indigenous healer was also the next most accessible therapeutic option after Mrs Z had arrived at her mother's home with a desperately ill child. In an emergency people tend to resort to the nearest source of therapy even if it is not perceived to be the most appropriate (see, for example, Case 4.7). No mention was made of what was perceived to be the cause of the condition. It may have been perceived to be 'poisoning' which may also have led to her consulting the indigenous healer. But again it has been shown (see Case 4.7), that when a child's life is in imminent danger, seeking cause and explanation become unimportant.

Her eventual contact with the staff at the government hospital, (although the circumstances were most unfortunate), led to some changes in Mrs Z's medical ideas. She attended ante-natal clinic during her next pregnancy and she delivered her youngest child at the hospital. In the same way as Epstein has argued that through conflict change is generated, one can also argue that through the disease experience, which includes the use of new healing resources, changes in medical beliefs and practices occur.

The model put forward to explain change in disease-related beliefs and practices may suggest that change is least likely to occur among the most impoverished members of a community. They can seldom adopt the sick role and therefore may be said to experience the least amount of disease. In addition, through poverty they have the least recourse to therapy. But, it must be remembered that the vast majority of disease experience and therapy occurs in the popular domain,

which is largely invisible, especially to the outside observer. The fact that all disease experience cannot be observed, does not mean that much exchange of ideas regarding disease is not occurring at the level of day-to-day interaction, or in the sphere of the popular domain. The perception of 'kwashiorkor' as the commonest disease of the village, by one of the most impoverished villagers of Peli, is a good example (see Table 5.1).

An elderly, childless and poverty-stricken widow at Peli (see Case 3.13) listed kwashiorkor among adults as the commonest disease in the village. She describes the symptoms of changes in complexion and swollen and cracked lips which are symptomatic of an avitaminosis. Although her terminology is not strictly speaking biomedically correct (kwashiorkor is a protein deficiency found mainly among children), she is not far wrong in describing the effects of a diet of 'gifts of joale'. Through her own experience and interaction with others in a similar plight, she has come to know the effects of malnutrition in adults.

In line with Janzen's suggestions to medical anthropologists to broaden their research focus (1981), this study has endeavoured to include, in addition to disease, the dimension of health. It has put forward some proposals for viewing this broader dimension. A review of the ethnography in the light of these proposals suggests that the conflict analogy, and some insights from scholars on conflict, notably Turner and Epstein, could be a useful approach in the investigation of disease in its relationship with health.

Chapter Seven: CONCLUSION

This study has taken up Murray's challenge to anthropologists working in South Africa, to document and 'integrate the experience of individual families with an appreciation of trends at the macro level' (1980:3). The macro trends for health and disease - the 'experience' on which this study has selected to focus - are indicated by the mortality and disease profiles for Lesotho. The study has endeavoured to provide a qualitative perspective on the health and disease-coping strategies of the families in two villages in the south-eastern district of Lesotho. Their coping strategies have been examined in a situation of generalised poverty, where resources for maintaining health and coping with disease are severely limited, largely as a result of historical and on-going political and economic processes.

Within the framework of this main thrust, the study also addressed the specific nature of the relationships between health and disease and natural and supernatural causation. It has been argued that by utilising definitions which emphasise the interrelationships between such concepts (see Temkin,1973:398; King,1975:13), one can overcome the difficulties of excessive dichotomisation. Such an approach also provides a more representative baseline for the investigation of a society's practices and beliefs regarding these areas of social life. In this way, the study has endeavoured to move away from an emphasis on the lengthy, and often more unusual disease episodes, where supernatural explanation is invoked, to include a focus upon health and natural causation which have generally been underplayed in medical anthropology (Janzen,1981).

Broadening the research focus of medical anthropology is not necessarily to criticise or deny the value of investigation of unusual disease, or the value of detailed examinations of

disease episodes where supernatural explanation is invoked. However, the impression created for the reader by this focus which underplays or assumes an understanding of the additional aspects of the larger medical domain - naturally caused disease and health - tends to be one of enormous differences between social groups. While this is perhaps not very serious in other parts of the world, it is particularly problematic in the South African situation, where there is already excessive and unnecessary stress on differences between social groups - usually described in 'cultural' terms to disguise the political motives underscoring the inequalities based on 'culture/skin colour' differences. Thus, there is a certain urgency in this country to seek out those areas for investigation which direct attention away from the esoteric (no matter how interesting), to the practicalities and hardship of life in the rural areas (often hidden from those in the cities), created to a large extent by political and economic factors beyond the control of the local people. There is also a pressing need, on this sub-continent, to seek out those areas for investigation which stress the common humanity of all its people. Including health and naturally caused disease, in addition to incidents where supernatural explanation is invoked, is directed at drawing attention to some of these wider issues.

The reason for selecting Lesotho as the geographical area for the investigation rests on a number of factors. There is a large body of data available on this country which is always useful background for any new study. The work on Lesotho also includes some studies on traditional 'Sotho' medical systems (see, for example, Hazam,1983), However, there are few anthropoligical investigations which approach health and disease along the more practical lines of this thesis. One hopes, therefore, that the study can make a contribution (albeit a small one), both to health care and

to the works available on Lesotho. The interest created by colleagues who have worked in Lesotho, and their knowledge of the country (as is no doubt the case in other departments of anthropology), are also factors which determined the choice of geographical area. But, more important, Lesotho is historically and economically very much part of Southern Africa. Consequently, it is reasonably representative of other parts of Southern Africa. Moreover, being politically independent, the anthropologist is not subject to the constraints imposed on participant observation by Group Areas legislation, which is the case in the Republic of South Africa.

In planning the study 'health' proved to be a particularly difficult area to operationalise, but I have tried to adopt a 'practical' approach which focussed on the way in which people strategise in order to maintain health. This inevitably led to a focus on the social relationships which exist between people and which are mobilised in a very overt way during the processes of maintaining health and treating disease.

In order to circumscribe health, I have selected certain key characteristics of the social conditions, viz. inadequate clean piped water, sanitation, food, shelter and income - all of which are associated with high infant mortality rates, low life expectancy and generally undesirable disease profiles such as those reported for Lesotho (see Table 1.1). Clean water systems and sanitation - matters of infrastructure - directed attention to political and economic factors in the wider social context which hamper the upgrading of social services and which may, if implemented, reduce infant mortality and the incidence of the diseases which presently plague the local population.

Food, shelter and income were used as departure points for the investigation of household health. It was argued that

cash is the essential item for survival in Lesotho - food and shelter both being cash-dependent. But while cash remains the central resource for the maintenance of survival and health, food provides a pointer to day-to-day strategies and shelter (or the building of the homestead) to those over time.

The nature of health strategies in both villages is portrayed as an egalitarian one. Various mechanisms, such as 'large households', 'large families', 'fostering' and 'visiting' serve to redistribute scarce resources amongst a wide range of individuals. Similar health strategies were observed at both villages, but at 'Ngoe there are also a number of noticeable variations. For example, in addition to some households having 'large families'(see Case 3.16), there are also those choosing to limit the number of offspring (see Case 3.20).

The similarities, plus the differences in health strategies at 'Ngoe, in comparison with Peli, suggest that a village close to an urban area offers a wider range of options for maintaining survival. This is borne out by the fact that 'Ngoe supports a much larger percentage of landless wageless households (35 percent at 'Ngoe; 13,3 percent at Peli).

The fact that a large proportion of impoverished people near an urban centre are maintaining at least a semblance of survival reflects findings elsewhere. Various researchers point out that chances for survival are greatest near the cities because -

> ... there is money floating around the edges and there are ways and means for the poor to make ends meet as they often simply cannot do in the rural areas (Wilson, cited by Streek, Cape Times,26.1.1984).

Unfortunately, the Basotho's chances of reaping the full benefits of migration to the industrial cities of South Africa - their traditional workplace - are curtailed by the Republic's stringent immigration (influx control)laws. The laws may serve South Africa's interests and limit the settlement of blacks in the industrial cities, but they do not stem the broader rural to urban drift which is the natural process in a situation of migrant labour (see Wilson,1982:144-152).

What appears to occur in a situation where the process of urbanisation is limited by legislation is an accumulation of impoverished households on the outskirts of district towns such as Qacha's Nek, as is evident from the larger proportion of impoverished households at 'Ngoe in contrast with Peli. Whether these district towns and others like them in South Africa, which are grossly inadequate to provide for a growing population, will be able to support a probable increase in impoverished persons and how these people will cope in these circumstances, are areas for further investigation.

The question of the effects of rising poverty, associated with increasing material differentiation, that has been predicted for the 1980's has been raised (see, for example, Spiegel,1980). At the time that this study was carried our (the early part of the 1980's), a household's access to greater material wealth appears to make little difference to the observable levels of health of the dependants. In response to poverty, via a number of social relationships aimed at providing food and shelter for a wide range of individuals, the effects of differential material wealth are levelled out. However, as some sectors of the population become richer - through, for instance, access to secure employment -

and an increasing proportion face poverty through unemployment, one can anticipate that marked differences between the levels of health of the rich and poor might emerge.

A materially based reciprocity appears to underscore many of the social relationships directed at maintaining health. For instance, the possibility of acquiring arable land in the future may be the factor which attracts cash remittances from a working migrant dependant of a large landholding household (see, for example, Case 3.1). Large landholding households may also provide food and shelter for the young wives and children of a working male migrant dependant in return for these regular cash payments (see Case 3.2), Adult dependants, such as unmarried or divorced female relatives may earn their keep by contributing to the running of the household (see, for example, Case 3.19; Case 3.23). Fostering of young children may also be said to be partly directed at securing future wage earners for a childless couple (Case 3.10). However, a notion of reciprocity with a material base is not entirely adequate to explain all the social relationships directed at providing food and shelter.

A notion of reciprocity rooted in materialism cannot explain the care extended to the frail elderly (see Case 3.18), or retarded and deformed children (see Case 3.6) or impoverished neighbours (see Case 3.13). All of these individuals have no means of reciprocating either in cash or in kind the food and shelter with which they are provided. A materialist analysis also fails to explain adequately what must be a complex set of human resources, or 'resilience', underpinning survival amongst those with minimal or no material assets.

This directs attention to issues such as the morality of kinship which Fortes has emphasised (Bloch,1973). Bloch points out that few aspects of Fortes' views on kinship

have been criticised as often as his insistence that individuals are willing to forsake political and economic considerations, at the level of personal social relationships, for the sake of good. But findings from this study indicate support for Fortes' notion. There appears to be very little in the way of materially-based political and economic considerations in the care extended to the frail elderly and retarded and deformed children. Clearly, whether one calls it morality or not, other factors not as easily observable perhaps as the material, but nevertheless equally important, need to be examined if we are to understand more fully that which determines social relationships between people. Findings also suggest that these factors relate not only to kinship obligations but have a wider application in the community at large (see, for example, Case 3.13).

Some quantitative data on the villagers' perceptions of their disease experience (see, for example, Lewis,1975; Frankel,1981) has proved useful. It brings to light what the villagers, and not the observer, deem important. Consequently, an ordinary ailment such as diarrhoea, which the villagers see as their most common problem, receives considerable attention in this study and an unusual disease such as motheketheke (see Chapter four, page 144), which was reported only once, plays a very small role.

Invocation of the supernatural (poisoning) as a cause of disease tends to be rare. When invoked at the level of the individual disease episode, it provides a rational means of explanation, especially in unfortunate and apparently inexplicable circumstances (see, for example, Evans-Pritchard, 1937; Case 5.1). The belief that infants and pregnant mothers are particularly vulnerable to the threat of poisoning does not emerge from data gathered at the interview, but from informal discussion during the course of fieldwork. The

belief is easily understood in a situation of high infant mortality and is certainly no obstacle to a number of biomedically sound strategies during pregnancy and early childhood.

A high frequency of ordinary ailments and a predominant belief in natural causation of disease suggests a broadly based commonsense approach to disease. There are few people who would disagree with the villagers that 'dirty water' is closely associated with diarrhoea. This suggests that there is considerable overlap among people generally in their notions of disease and its causation. To make this point, in the absence of an easily accessible body of data on general popular views on ordinary ailments, and to emphasise the point, the villagers' views were contrasted with those of biomedicine which is often presented as typifying 'Western scientific' views on disease (see, for example, Cheetham and Griffiths, 1982).

And even at this level of what is considered to be scientific thinking, the villagers' views and those of the practitioners of biomedicine are found to be remarkably similar. It is therefore difficult, on the basis of these findings, to specify a distinctly traditional 'Sotho' medical system that differs markedly from a 'Western' biomedical system. Or, if these disease findings are taken to a cultural conclusion, to identify a distinctly 'Sotho' or 'Western' culture.

Besides pointing out that a belief in natural causation predominates and invocation of the supernatural is rare, the quantitative disease data also reveal a high proportion of 'don't know' (the causation) replies. Last (1891) has pointed out that these replies should not be overlooked since they point to factors other than perceived causation and explanation which may play a role in recognition of disease and choice of therapy.

The findings have indeed shown that a number of factors such as size and composition of household, availability of healing resources in a geographical area, perceived severity, cost and expectations of quality of service, do indeed play a role. In fact, these factors are so numerous that it is difficult to make generalisations. However, there appears to be a belief that all disease should be curable and it is merely a matter of exploiting the appropriate healing resources (see Last,1981:289). This idea is not necessarily specific to the villagers of 'Ngoe and Peli and is probably a strong determinant of therapeutic action in most societies. But, it takes on an added impetus in conditions of poverty where survival demands resuming personal and social identity (or cure in Stiano's terms - see 1981:331), as soon as possible.

The broad base of this investigation has also served to identify how the extremely poor, the least visible members of a society (Hill,1972:148), cope with disease. They suppress the signs of illness in order to survive. Being biomedically trained I find this particularly disturbing, especially regarding serious conditions such as TB where onset is insidious and symptoms often so vague that they are easily suppressed. These people, comprising a considerable percentage of the population of both villages (35 percent at 'Ngoe and 13,3 percent at Peli) are the most vulnerable to disease, but their disease is effectively hidden from biomedical personnel. Consequently, those who need it most in a population itself largely defenceless against disease, are the least likely to receive adequate health care.

One further point of particular biomedical interest is the role of political and economic factors in the provision of health services. Guided by the notion of scientific neutrality of biomedicine (see Mishler,1981:15), the role of

the political economy on the health of a population, or on biomedicine itself, tends to be played down, or ignored altogether by the majority of the profession, (though there are some notable exceptions: see, for example, Jacobs,1981; Kirsch,1979). Yet, findings in this study suggest that political and economic process has a powerful effect on health-care policy, and at the same time, by concealing the villagers very sensible views on health and disease, which they share with biomedicine, block useful channels for communication.

To provide a model for examining disease in its relationship with health, I have put forward some ideas from scholars of local conflict, viz Turner (1957) and Epstein (1958). A review of the ethnography in the light of these proposals suggests that they could provide a useful means of viewing disease in its relationship with health. The notion of the 'social drama' (Turner,1972(1957):91-91) seems particularly suitable for examining the disease process from the point of recognition of disease through therapeutic action to cure, or recognition of schism (death or the incurable nature of some conditions). The model of disease as a 'social drama' could have a wider application, for instance, in the examination of the individual case study.

The question arises as to whether the broad findings of this study can be generalised to other rural situations in black Southern Africa. It is always difficult to make generalisations as people tend to respond in various ways in different social situations, subject to particular and on-going political and economic processes (Comaroff,1982). However, one can suggest on the basis of a common health index (high infant mortality, low life expectancy and a high incidence of infectious fevers and diseases of poverty) and similar historical and contemporary neglect of essential services

in other parts of black rural Southern Africa, that limited resources for maintaining health is widespread. Furthermore, like the majority of the Basotho, a major proportion of Southern Africa's rural black population are dependent on migrant labour and confined to underdeveloped labour reserves. Thus, it can be proposed that the limitations imposed on the rural blacks of Southern Adrica, and consequently the demands for securing survival, are the same. Therefore, similar health strategies will be evident elsewhere.

A comparison of the disease findings of this study with medical anthropological studies elsewhere in Southern Africa is difficult. Few studies have examined responses to a whole range of disease which a given population perceives as its disease experience. Some have focussed on a specific condition, such as 'intwaso' (see, for example, Mills,1983). But, without quantitative disease data, one cannot say how representative these studies are of the communities' disease experience or of their disease-related beliefs and practices. However, with a wider quantitative baseline for the villagers' disease burden which correlates significantly with the macro disease profile for Lesotho, one can argue that the findings of this study are probably more representative of disease-related beliefs and practices elsewhere in Southerh Africa.

In the concluding chapter of this thesis, I have carried out what is customary - I have reviewed the findings and suggested areas for further research. But, during the course of fieldwork I have been continuously plagued by the question - what do the people who take part in studies of this nature get out of the research? True, one has documented a fragment of their history, which may be of interest to some of the present residents of the two villages, or to future generations. By making use of numerous case studies one hopes

that the villagers' role in the documentation of their experiences will surface. One also hopes that the very realistic pleas they make for improvements in their health status will not go unheard.

> In the face of the continued threat from communicable diseases and the danger to children both in rural villages and the new urban slums, political and public health action must clearly concentrate upon reducing their devastation .... Proper sanitation, clean piped water supply and adequate food are the basic essentials ... (MacLean,1980:125).

APPENDIX A QUESTION SCHEDULE

1 Identify Household:

a) Name of head of household
b) Place of res/occ of household head
c) Name of respondent
d) No. of interview
e) Date of interview

2 Household composition:

a) List of household members/occupants of the dwelling
b) Marital status
c) Respective relationship to household head
d) Year of birth
e) Place of birth
f) Years of schooling
g) Present occupation
h) Place of occupation
i) Religious affiliation
j) Clan membership
k) For wage earners:
    1) How much does he or she send or bring home?
    2) How often?
    3) When was the last time you received remittance?
    4) How much?

3 Stock Holding:

How many of the following animals do you have?

1) Out on loan 2) Up at the posts 3) At home

a) cattle
b) sheep
c) goats
d) horses
e) donkeys
f) pigs
g) fowls
h) young animals
i) 1) Have you sold any animals since January 1982?
    2) What animals have you sold?
    3) What amount did you get for each?

3 Stock Holding (continued)

j) 1) Have you bought any animals since January 1982?
2) Where did you buy each of them?
3) How much did you pay for each?

k) 1) Have you received any animals any other way since January 1982?
2) Bridewealth - how much and what kind?
3) On loan or mafisa - how many and what kind?

k) 1) Have you sold any wool or mohair since January 1982?
2) How much did you receive for it?

4 Land Holding:

a) How many fields do you have (masimo)?
b) How many plots (dirapana) do you have?
c) Do you have a garden (jarete)?
d) When did you acquire each of these?
e) How did you acquire each of these?
f) Do you have the use of any fields or plots or gardens which are not yours?

g) Last Season - what did you plant in each

field? plot? garden?

(maize, sorghum, wheat, peas, beans, potatoes, pumpkins, other)

h) What did you get from each

field? plot? garden?

i) 1) Did you sell any of what you got from each

field? plot? garden?

2) What did you sell?
3) How much did you get for it?

5 Working in the fields:

a) How did you work on each of your fields/plot/garden?
b) Who did the ploughing of each - how much paid?
c) Who did the planting of each - how much paid?
d) Did you seed - how much paid?
e) Did you use fertiliser - how much spent?
f) Did you do sharecropping on any of your fields?
g) Did you do sharecropping on anyone else's fields?
h) Who helps you in your fields?
1) with weeding - what did you give/pay?
2) with harvesting - what did you give/pay?
i) Did you help others in their fields with:

1) weeding - what did you receive from them?
2) harvesting - what did you receive from them?

6 Other sources of household income:

a) Do you sell anything to get money or payment in kind?
(eggs, sheep's heads, meat, vetkoek, bread, reed mats, clay pots, milk, vegetables, joale, other)

b) Do you do anything for other people to get money or payment in kind?
(fetch firewood, draw water, herding, helping in other people's houses, washing clothes, looking after new mothers, mending (e.g. primus stoves)

7 Household Maintenance:

Who in the household does the following tasks?

fetching firewood
fetching water
plastering/smearing floors and walls
collecting dung and mud for plastering
sweeping the house
washing clothes
cooking food
herding animals
feeding livestock
shopping for food and fuel
shopping for durables
working in the vegetable garden
building
making bricks
nuilding walls
roofing the house
collecting the building material

8 For every adult woman:

a) how many pregnancies have you had?
b) how many children have you born, names of each?
c) where was each child born?

1 name of village
2 home/hospital/clinic

d) why did you choose home/hospital/clinic?
e) if the child was born in the village, by whom?
f) did any of the children die?
g) if this happened, at what age?
h) what do you think was the cause?
i) did you take the child to a ngakga/hospital/clinic before he/she died?
j) for widows/widowers - cause of spouse's death?

1 if on mine, any compensation?
2 if other, any compensation?

9 Sickness:

a) Have any members of the household been sick during the last ±6 months?
b) What was the name of the sickness?
c) What caused the sickness?
d) How did you know you were sick?
e) What did you do to get better?

1 treat yourself?
2 get help from a member of the family?
3 get help from a neighbour/friend
4 visit the ngake/chemist - his name - his place?
5 why?
6 clinic - name - place?
7 why?
8 hospital - name - place?
9 why?

f) Did you get better?
g) What do you think made you better?
h) Do you know anybody with motheketheke or tuberculosis?
i) Is witchcraft a cause of disease?

10 a) What kinds of illness are most common in the village?
b) What are the causes?
c) Do you think there is more sickness than previously?
d) What do you think would improve the health and reduce the sickness?

APPENDIX B FOOD DIARIES

Examples of food diaries from a sample of households in the various categories of material differentiation, Peli

1 Example of food consumption of large male-headed wage-dependent landholding household with three wage incomes

	Morning	Midday	Evening
Mon	maize porridge & wild spinach	maize porridge & wild spinach	maize porridge & wild spinach
Tues	maize porridge & wild spinach	maize porridge and cabbage	maize porridge and cabbage
Wed	maize porridge and cabbage	maize porridge and cabbage	maize porridge and cabbage
Thurs	'Zoop' *	'Zoop' *	'Zoop' *
Fri	maize porridge	maize porridge	maize porridge
Sat	not recorded		
Sun	not recorded		

* 'Zoop' is a meat powder which can be made into soup and is also used to flavour the cabbage

2 Example of food consumption of large male-headed wage-dependent landholding household with two incomes

	Morning	Midday	Evening
Mon	maize porridge and milk	-	-
Tues	maize porridge and cabbage	-	maize porridge and meat
Wed	maize porridge and milk	bread	bread and tea
Thurs	bread	tea	bread and tea
Fri	maize porridge and milk	bread	bread and meat
Sat	bread and milk	soft porridge	
Sun	soft porridge	-	bread and tea

3 Example of food consumption of large male-headed landholding one-wage-dependent household, Peli

	Morning	Midday	Evening
Mon	maize porridge and cabbage	maize porridge and cabbage	maize porridge and cabbage
Tues	bread	-	maize porridge and cabbage
Wed	maize porridge and potatoes	maize porridge and milk	-
Thurs	maize porridge and meat	maize porridge and meat	maize porridge and potatoes
Fri	maize porridge and peas	maize porridge and peas	maize porridge and cabbage
Sat	maize porridge and potatoes	maize porridge and cabbage	maize porridge and cabbage
Sun	Bread and tea	bread and milk	bread and potatoes

4 Example of food consumption of a large female-headed landholding one-wage-dependent household, Peli

	Morning	Midday	Evening
Mon	bread	soft porridge	bread
Tues	maize porridge and cabbage	soft porridge	bread
Wed	bread	-	bread
Thurs	maize porridge	-	maize porridge and cabbage
Fri	maize porridge and cabbage	samp	maize porridge
Sat	maize porridge	-	-
Sun	bread	soft porridge	bread

5 Example of food consumption of a large male-headed one-wage-dependent household, Peli

	Morning	Midday	Evening
Mon	soft porridge	soft porridge	maize porridge and milk
Tues	Tea	maize porridge and potatoes	-
Wed	Tea	-	maize porridge and milk
Thurs	-	maize porridge and cabbage	soft porridge
Fri	maize porridge and cabbage	'Sesotho' home-beer made from hops	bread and potatoes
Sat	not recorded		
Sun	not recorded		

6 Example of food consumption of a small male-headed one-wage-dependent household, Peli

	Morning	Midday	Evening
Mon	maize porridge and cabbage	-	maize porridge and peas
Tues	-	maize porridge and cabbage	-
Wed	-	maize porridge and cabbage	-
Thurs	-	maize porridge and cabbage	-
Fri	maize porridge	-	-
Sat	-	soft porridge	-
Sun	maize porridge	sour porridge	-

7 Example of food consumption of small male-headed wageless landholding household, Peli

	Morning	Midday	Evening
Mon	-	maize porridge	-
Tues	-	sour porridge	-
Wed	-	Maize porridge and cabbage	-
Thurs	-	Bread and tea	-
Fri	-	samp	potatoes
Sat	-	Maize porridge	-
Sun	-	maize porridge and milk	-

8 Example of food consumption of small female-headed wageless landless household, Peli

	Morning	Midday	Evening
Mon	-	maize porridge and potatoes	-
Tues	Maize porridge and peas	-	maize porridge
Wed	-	sour porridge	-
Thurs	-	-	-
Friday	Not recorded		
Sat	Not recorded		
Sun	Not recorded		

Examples of food diaries from a sample of households in the various categories and of material differentiation, 'Ngoe

9 Example of food consumption of large male-headed wage-dependent household with two incomes, Ngoe

	Morning	Midday	Evening
Mon	maize porridge and cooked cabbage	soft maize porridge	maize porridge and cooked cabbage
Tues	maize porridge and tea	cabbage	soft maize porridge
Wed	Maize porridge	bread and tea	maize porridge
Thurs	bread and eggs	soft porridge	bread
Fri	maize porridge	-	-
Sat	meat and maize porridge	soft porridge	samp
Sun	tomatoes	soft porridge	maize porridge

10 Example of food consumption of large male-headed one-wage-dependent household, Ngoe

	Morning	Midday	Evening
Mon	bread and tea	maize porridge and cabbage	maize porridge and cabbage
Tues	bread and tea	maize porridge and cabbage	maize porridge and cabbage
Wed	bread and tea	maize porridge and cabbage	maize porridge and cabbage
Thurs	bread and tea	maize porridge and cabbage	maize porridge and cabbage
Fri	bread and tea	maize porridge and cabbage	maize porridge and cabbage
Sat	bread and tea	maize porridge and cabbage	maize porridge and cabbage
Sun	bread and tea	maize porridge and cabbage	maize porridge and cabbage

11 Example of food consumption of small male-headed one-wage-dependent household, 'Ngoe

	Morning	Midday	Evening
Mon	samp	-	meat and peas
Tues	maize porridge and milk	-	meat porridge and milk
Wed	bread and tea	-	samp
Thurs	bread and tea	oros	maize porridge
Fri	-	pumpkin beans and tea	-
Sat	tea	-	maize porridge and cabbage
Sun	tea	beans	potatoes

12 Example of food consumption of a large female-headed one-wage-dependent household, 'Ngoe

	Morning	Midday	Evening
Mon	maize porridge and cabbage	soft porridge	soft porridge
Tues	maize porridge and cabbage	maize porridge and cabbage	maize porridge and cabbage
Wed	maize porridge and cabbage	maize porridge and tea	maize porridge and cabbage
Thurs	maize porridge and cabbage	maize porridge and cabbage	maize porridge and cabbage
Fri	maize porridge and tea	maize porridge and meat	soft porridge
Sat	maize porridge and eggs	maize porridge and cabbage	samp
Sun	maize porridge and cabbage	maize porridge and cabbage	soft porridge

13 Example of food consumption of large male-headed wageless landless household, 'Ngoe

	Morning	Midday	Evening
Mon	maize porridge with milk	maize porridge and cabbage	maize porridge with potatoes
Tues	bread and tea	soft porridge	maize porridge with water
Wed	maize porridge with milk	soft porridge	maize porridge with water
Thurs	maize porridge and cabbate	maize porridge with milk	maize porridge with water
Fri	maize porridge with milk	soft porridge	maize porridge with water
Sat	soft porridge	maize porridge	soft porridge
Sun	soft porridge	-	maize porridge

14 Example of food consumption of small male-headed landless wageless household, 'Ngoe

	Morning	Midday	Evening
Mon	maize porridge and cabbage	-	-
Tues	-	soft porridge	-
Wed	-	maize porridge and cabbage	-
Thurs	maize porridge and cabbage	-	-
Fri	soft porridge	-	-
Sat	-	maize porridge and cabbage	-
Sun	-	cooked mealies	

15 Example of food consumption of large female-headed landless wageless household, 'Ngoe

	Morning	Midday	Evening
Mon	maize porridge and cabbage	maize porridge and tea	maize porridge and cabbage
Tues	maize porridge and milk	tea	maize porridge
Wed	maize porridge and cabbage	maize porridge and cabbage	maize porridge and cabbage
Thurs	maize porridge	tea	tea
Fri	maize porridge and tea	tea	maize porridge and tea
Sat	maize porridge and tea	tea	maize porridge
Sun	maize porridge	maize porridge	tea

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