The Practices and Perceptions of Religious Health Assets in Lesotho: A Study of Mission Aviation Fellowship

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Declaration

I declare that this dissertation is my own unaided work. All citations, references and borrowed ideas have been duly acknowledged. It is being submitted for the degree of Master of Theology (Theology and Development) in the Faculty of Humanities, Development and Social Science, University of KwaZulu-Natal, Durban, South Africa. None of the present work has been submitted previously for any degree or examination in any other University.

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Abstract

This study was a part of a baseline research within ARHAP on going studies into the relationship between religion and public health. It examined the nature and function of Religious Health Assets that were identified through the activities of Mission Aviation Fellowship- Lesotho; an FBO providing aircraft transport to the Lesotho Flying Doctor Services (LFDS). The basic finding was the critical role FBOs activities play in the provision of health care in Lesotho.

The study drew from 6 open-ended narrative interviews by key informants who contributed to the Home Based Care Project (HBCP) facilitated by MAF and the fieldwork research of 3 one week stays in the remote mountain villages of Lesotho based at different Health Care Centres where MAF has HBCPs over a period of nine months.

The analysis revealed that FBOs occupy a crucial role in the delivery of Health care in Lesotho. The networks that FBOs align themselves with can be trans-national, tapping into RHAs that beneficiaries would otherwise have no access to. The ubiquity of religion in African livelihoods was confirmed to be an important factor in how Basotho engage health provision and seeking strategies. The mobilisation of community members for voluntary participation in maintaining community well being drew the agency of some members which seems to tap into the altruistic values of ‘ubuntu’ and ‘sense of community’. The concepts encompassed in *bophelo* healthworlds offered us insights into the symbiotic strategies necessary to tackle the multi-faceted health challenges facing developing countries. An integrated approach that draws from the holistic constructs offered in indigenous conceptions of being can be utilised to significantly transform our praxis in religion and public health.

The dissertation confirmed ARHAP’s notions that assets and capacities need alignment within and among the different stake holders to harness the various factors for maximum benefit. The development and maintenance of well being in developing countries has been critically deficient in the face of challenges posed by civil wars, bad governance and HIV and AIDS. Health care providers are thus called to not only effectively implement their planned programmes, but to re-visit the structures, policies and ideologies that influence them.

Dedication

I dedicate this dissertation to our three lovely children

Kundai, Tariro and Gwinyai Vera

May this work inspire you and remind you

That with God

You can do much more.

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I would like to acknowledge the following people and organisations, with whose support and encouragement it was possible to achieve this goal.

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CHAPTER I
RESEARCH OVERVIEW

1.1. Thesis Introduction

This thesis is part of a wider research project of the African Religious Health Assets Programme (ARHAP), and in particular a survey into the role that religion plays in health provision in Lesotho. It is a study that examines the activities of Mission Aviation Fellowship (MAF) in Lesotho in terms of the nature and function of Religious Health Assets (RHAs) in Africa. The question that drove the research was two-fold: "What can we learn from an engagement with MAF about (i) the relationship between religion and health in Lesotho in terms of understanding RHAs and (ii) how can this assist us in understanding and encouraging the contribution of Christians to well being?

MAF is an international FBO that provides aircraft transport to the Lesotho Flying Doctor Service (LFDS); a government department that services the remote Health Care Centres (HCCs) by supplying doctors, medicines, and other specialised health care personnel on rotational visits. The Lesotho government has implemented several plans in an attempt to improve the health delivery system of the country. In their ten year reform plan, *Lesotho Health Sector Reforms Plan: March 2000,* the government acknowledged that it is

> "partnered" in the provision of health services by church organisations, non-governmental organisations, UN agencies, and the private sector.[1]

It was this formal partnership that motivated us to explore how the FBOs' contribution to health delivery in Lesotho impacts on the well being of the communities they serve. Even though the Lesotho government recognised this partnership, there seems to be insufficient information on what resources FBOs bring to the health arena because

> The world of religion has been an unacknowledged and often unseen force for many development practitioners in the past.... long traditions of separation of state and religion are deeply engrained[2]

[1] *Lesotho Health Sector Reforms Plan*, Ministry of Health and Social Welfare (March, 2000) p. 40
[2] Kartherine Marshall, *Development and religion: A Different Lens on Development Debates* at http://www.wfdd.org.uk/articles_talks/marshall.pdf

Thus the role and impact of religious assets in health development requires a more systematic and integrated approach if we are to understand its nature and contribution to well being. Since health is a crucial lens to measure development as argued and illustrated by Amartya Sen,[3] it is pertinent that insights into the nature of the contribution different role players bring in pursuit of health is identified and examined, as intended in this study.

1.2. Research Methodology and Findings

In its research, ARHAP makes use of 'Grounded Theory'. What this means is that rather than undertake field work with a well constructed and developed theoretical framework, ARHAP has worked with a series of theoretical hypothesis which it has sought to explore via field work. This means that the theoretical frameworks are developed 'from the ground up'. As part of the wider ARHAP research project this thesis makes a contribution to this development of the theory by exploring experience on the ground to do with the nature of Religious Health Assets.

The study was based on narrative data that was collected from respondents involved in three of the Home Based Care Projects (HBCP) that MAF established in the remote mountain villages of Lesotho which were only accessible by plane, participant observation of MAF's activities during the fieldwork research in the mountains, and the literature review of the reports on MAF activities. This case study approach using narrative analysis was undertaken to provide 'thick' data from one particular project so as to flesh out the theoretical hypotheses of ARHAP, and in particular the meaning of religious health assets.

In its early work, ARHAP had suggested that these assets could be divided into two broad categories, namely tangible and intangible assets, and that they could have both short-term and long-term impact. Field work in Zambia and Lesotho categorised these into three sets of tangible assets, namely, curative interventions, material support and compassionate care, and three sets of intangible assets, namely, spiritual encouragement, moral formation and knowledge giving. Furthermore, in Lesotho, a category of 'relational ambition' that connected both tangible and

[3] Amartya Sen, (1999) *Development as Freedom*, (Anchor Books: New York)

intangible assets was noted.[4] In terms of its findings, this research strengthens this understanding of RHAs.

1.3. Overview of the Thesis.

This first chapter introduces the outline of the thesis, summarising the research motivation and the notion of Religious Health Assets (RHAs); the main focus of the thesis.

The second chapter provides an overview of the research context of Lesotho highlighting several factors that influence the well being of the nation, especially in the remote, rural communities. The socio-economic, cultural-religious and political backgrounds which depicted a profound history of interaction between FBOs and other agencies in health provision introduced the context to our study. *Bophelo,* a holistic concept of well being, is suggested as a significant influence in health perceptions among the Basotho.

Chapter 3 presents the research findings from the fieldwork research of MAF, an international FBO that operates in Lesotho in partnership with the Lesotho government and several NGOs and FBOs. It outlines how the research process proceeded and the findings that came out of the three methodologies applied; namely literature review, organic interviews and participant observation.

In chapter 4, the research findings are analysed in light of our two-fold research question: "What can we learn from an engagement with MAF about (i) the relationship between religion and health in Lesotho in terms of practices, and (ii) How can this assist us in our understanding and encourage Christians' contribution to health?" The second part of the question was further addressed in the theological reflection in the following chapter 5.

In chapter 5 we discussed how the Christian community can enhance their stewardship by embracing a more pragmatic and holistic praxis of the values that promote *shalom*. It noted the need to revisit and evaluate their doctrines so as to reflect the *Missio Ecclesia* where every

[4]African Religious Health Assets Program for the World Health Organization, *Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho.* October 2006

members' agency is valued and applied. The call on the churches was to engage and partner with other stakeholders to promote well being from a holistic perceptive.

Then chapter 6 concluded the thesis by recapping the main points that have come out of the thesis and suggested a way forward that can enhance the nature and use of RHAs in FBOs and health care in general.

Before we proceed with the rest of the thesis, we need to define more clearly the concept of Religious Health Assets that is crucial to this research.

1.4. Religious Health Assets

As noted above, the motivation of this study was the need to identify and understand the nature and application of RHAs within an FBO setting. This interest arose from the several baseline research projects and conceptual papers that have sought to enlighten the religious community and society at large on the resources that religious entities contribute to well being and development at large. This study endeavours to gain deeper understanding of what assets FBOs possess, how these assets function and the insights that can be gained as to their sustainability and reproduction.

Several aspects of the role FBOs play in the health arena motivated us to systematically examine the activities of FBOs in an effort to unpack the nature of the assets employed and the relationships that exist among these assets. Whilst the bio-medical framework sometimes recognises this, it generally focuses on 'tangible' assets. ARHAP argues that this excludes some of the crucial intangible, relational and spiritual assets that FBOs utilise to contribute to the well being of the communities they served. ARHAP's concern, which we adopted, was to identify

> what these religious health assets are, how they work, and what potential exists for strengthening them without undermining the very things they offer or destroying them through inappropriate interventions or engagements.[5]

[5] Steve de Gruchy, "Why Agency.", p. 23

As a first attempt at building a theory that could be tested, ARHAP developed a matrix which identified these assets as *Tangible* and *Intangible*, and as having a *Direct* or *Indirect* outcome on health. For ease of viewing, the matrix is printed below.

This matrix suggests that there are four kinds of Religious Health Assets: a) tangible and direct, b) intangible and direct, c) tangible and indirect and d) intangible and indirect.

Table 1.1. **The Theory Matrix[6].**

Intangible religious assets	*Possible factors include*: **1** • Prayer • Resilience • Health seeking behaviour • Motivation • Responsibility • Commitment/sense of duty • Relationship: care giver and 'patient' • Advocacy/prophetic • Resistance- physical and or structural/political	*Possible factors include:* **2** • Individual (sense of meaning) • Belonging-Human/Divine • Access to power and energy • Trust /distrust • Faith-hope-love • Sacred place in a polluting world • Time • Emplotment (story)
Tangible religious assets	*Possible factors include:* **3** • Infrastructure • Hospitals-Beds etc • Clinics • Dispensaries • Training and Para- Medical • Hospices • Funding/development agencies • Holistic support • Hospital chaplains • Faith healers • Traditional healers • Care Groups • NGO/FBO- "projects"	*Possible factors include:* **4** • Manyano and other fellowships • Choir • Education • Sacraments/rituals • Rites of passage(accompanying) • Funerals • Network/connections • Leadership skills • Presence in the Bundu (on the margins) • Boundaries(Normative)
	Direct health outcome	**Indirect health outcome**

[6] James Cochrane and Barbara Schmid, *ARHAP Tools Workshop Report*. (Cape Town, June 6-8, 2004) Also visit <htpp://www.arhap.uct.ac.za>

a) *Tangible and direct* – these are the concrete assets which are quantifiable that the matrix identifies to have a direct impact on the health outcomes of the community where they are implemented. The assets classified here refer to infrastructure mainly associated with the formal health care systems or those agencies that offer supporting services within the health sector which are termed 'projects'.

b) *Intangible and direct* – the matrix identifies these to be the activities and conditions which are qualitative in nature that directly influence health outcomes.

c) *Tangible and indirect* – associations and activities that are quantifiable but not necessarily identified by the existing formal health system or this matrix as directly contributing to health outcomes.

d) *Intangible and indirect* – assets classified in this category are attributes and characteristics that influence health seeking or provision behaviour. This category needs careful consideration as its boundaries seem fluid and dependent on the dominant influencing healthworlds. Depending on the health need, different assets can be perceived as directly or indirectly impacting on the well being of the individual or community.

It is important to understand that – following the approach of Grounded Theory - this matrix was a hypothesis that needed to be tested by field research.

1.4.1. Tangible and Intangible Assets as Applied in This Research

The hypothesis of tangible and intangible assets was then developed further via ARHAP field work in Zambia and Lesotho. ARHAP had suggested that these assets could be divided into two broad categories, namely tangible and intangible assets, and that they could have both short-term and long-term impact. Field work in Zambia and Lesotho shifted this initial idea, and rather categorised these into three sets of intangible assets, namely:-

i. *Spiritual Encouragement* which encompasses such terms as faith, hope/trust (which is one word in Sesotho - tsepo), prayer and peace (which was expressed as an inner feeling), as well as salvation and baptism. Spiritual encouragement emerged in all the research workshops, with hope/trust and faith being its most important elements. It embodies the religious contribution to resilience, courage and a willingness to continue in times of difficulty, ill health, and misfortune.

ii. *Moral formation* refers to the role religion plays in guiding life choices through values that influence peoples' decision making processes.

iii. *Knowledge giving* points to the role of religion in providing information about health

The three categories for tangible assets were:-

iv. *Compassionate Care*, which includes the factors love and care and refers to the religious willingness to be of assistance to those who are needy, sick or in difficulty; it also concerns itself with holistic health and wellbeing.

v. *Curative interventions* being our term for specific interventions by religious entities to cure people from ill health, sickness or illness - however this is understood; and

vi. *Material support* being the contribution of religion and religious entities to assist the needy with particular material help such as food or clothes and other quantifiable support.[7]

vii. Furthermore, in Lesotho, a category of *Relational Ambition* that connected both tangible and intangible assets was noted.

1.5. Conclusion

This chapter has introduced the thesis, outlining the research question and methodologies that were applied. A summary of the chapters was presented as well as an explanation of the focus of the thesis, that is; religious health assets. The following chapter presents a contextual background of the research by outlining the socio-economic, religious and health contexts of Lesotho that have shaped the delivery of health services within the country.

[7]African Religious Health Assets Program for the World Health Organization, *Appreciating Assets : Mapping, Understanding, Translating and Engaging Religious Health Assets in Zambia and Lesotho.* October 2006

CHAPTER 2

RELIGION AND HEALTH IN LESOTHO

A brief overview of Lesotho's socio-economic and cultural scenario is crucial before we engage with the research. The overview below is not exhaustive of the many factors that affect the religious and health status of the Basotho, but has been selected to offer a background of the factors impacting on health care delivery and health seeking strategies that prevail in Lesotho.

2.1. An Overview of Lesotho

In the overview we outline the physical and historical factors that contribute to the health climate of Lesotho and that have influenced the socio-economic and religious structures that have developed in the small nation. We briefly explore how the accessibility and availability of resources have contributed to the population characteristics, especially in terms of education and human resource development, key factors that contribute to the health climate in Lesotho.

2.1.1. Physical Factors

Lesotho is a small mountain kingdom of 30 335 square kilometres that is totally surrounded by South Africa. It is referred to as the 'Mountain Kingdom in the Sky' or 'Roof of Africa'[8] because most of its land lies above 1500m above sea level. The country has four ecological zones; namely the Lowlands, Foothills, Mountains and Senqu River Valley.

The country is divided into ten administrative districts, with most of the population residing in the Lowlands districts. Maseru is the most populous district with 22% of the population; whereas the mountain district of Qacha's Nek, Makhotlong and Thaba Tseka share only 4% of the

[8] Ministry of Health and Social Welfare (MOHSW) (Lesotho), Bureau of Statistics (BOS) (Lesotho), and ORC Macro. 2005. Lesotho Demographic and Health Survey 2004. Calverton, Maryland: MOH, BOS, and ORC Macro. p. 1

national population[9] as a result of their topography, weather and scarce employment opportunities. Besides this lowland bias, 80% of the population of Lesotho dwell in the rural areas,[10] In other words, most of Lesotho's infrastructure is rural settlement.

2.1.2. Historical Background

Lesotho is a former British colony that gained its independence on 4th October, 1966. It is a monarch under King Letsie III that has a democratically elected parliament. Previous elections were in 1966, 1970, 1993, 1998 and 2007; but the 1970 elections were annulled by a military coup, leading to unconstitutional military rule from 1970 to 1993. The 1998 elections resulted in riots where SADC forces intervened because of civil unrest.

Sesotho and English are the two official languages. The national currency is the Loti (Maloti plural), which is pegged to the value of the South African Rand.

2.1.3. Resources and Production

Since almost 65% of Lesotho is characterised by steep mountains that have fragile soil formation and thus are suitable for moderate animal grazing only, Lesotho imports between 60-65% of its national requirements for maize[11] from South Africa. The 2005 Lesotho Bureau of Statistics (BOS) reported a Gross National Product of 8 832 billion Maluti with an annual growth rate of 3.1%.[12] Water is Lesotho's most crucial and substantial export which it exports to the Free State and Gauteng Provinces in South Africa.

The United Nations report of 2004 on the Common Country Assessment of Lesotho notes that there was a direct correlation

[9] United Nations Systems in Lesotho, (December, 2004) *Common Country Assessment of Lesotho, A Country-Based process for reviewing and analyzing the national development situation and identifying key issues as a basis for advocacy and policy dialogue*, Morija Printing works: Morija, Lesotho p. 9
[10] United Nations Systems in Lesotho, p. 26
[11] United Nations Systems in Lesotho, p. 31
[12] Ministry of Health and Social Welfare (MOHSW) (Lesotho), Bureau of Statistics (BOS) (Lesotho), and ORC Macro. 2005. Lesotho Demographic and Health Survey 2004. Calverton, Maryland: MOH, BOS, and ORC Macro.

between levels of employment and levels of poverty: those with formal sector jobs fare much better than those who depend on subsistence agriculture.[13]

The main occupation in the rural areas is subsistence farming where most of the farmers are women, as the men have either migrated to the urban areas to seek paid employment or are working in South African mines. Subsistence farming in Lesotho is not sufficient for sustaining viable livelihoods and thus renders most women to be continuously poor or economically dependent.[14]

This burden of sustaining households for women is increased by cultural roles of nurturing and housekeeping. Further strain is put on the family when pregnancy and child bearing occurs as this implies neglect of fields and other livelihood duties. Such a scenario is paradoxical in the sense that Basotho women have traditionally an educational advantage over their male counterparts, but this has failed to empower them economically.[15]

2.1.4. Population Characteristics

Lesotho's population is estimated at 2 million[16] and noted to be a very young nation with 36% of the population under 15 years of age.[17] This implies a high age-dependency of 40% in a country where unemployment is on the increase, mainly due to the retrenchment of many migrant miners from the South African mines.[18] Internally there has been no significant development of industry to absorb the young job seekers besides the garment factories.

These above mentioned social factors play a direct or indirect role in the understanding and delivery of health services in Lesotho.

[13] United Nations Systems in Lesotho, p. 63
[14] United Nations Systems in Lesotho, p. 7
[15] United Nations Systems in Lesotho, p. 73
[16] Ministry of Health and Social Welfare Lesotho at file:///ministry%20of%20Health%20and%20Social%20Welfare%20-Referral%20system%23services.htm
[17] United Nations Systems in Lesotho, p. 8
[18] United Nation Systems in Lesotho, p. 13

2.2. A Brief History of the Development of Religion in Lesotho

It is important that we briefly retrace how a range of influential religious worldviews have developed in Lesotho. In this exercise, firstly we hope that it will enlighten us as to the dynamics that have shaped religion and health in Lesotho, and the relationship that has developed between the two. Secondly, we aim to illustrate the context that will assist us in drawing up conclusions when we later theologically reflect on the findings of our research question.

The religious entities we will briefly review include the main missionary initiated churches; namely the Lesotho Evangelical Church, the Roman Catholic Church and the Anglican Church. We will also briefly examine the role of some Independent African Churches (IACs), the emerging Pentecostal/Charismatic churches and the traditional religious institutions or/and associations.

2.2.1. Introduction of the Missionaries

The Basotho nation has been reported as being a 'very religious people'[19] even before their founder, Mosheosheo the Great, formally established the Basotho nation. This was referring mainly to their worship of 'molimo' where

> The ancestor spirits (balimo) of the clan, chieftainship, or extended family could intercede with Molimo in order to provide rain, good harvest, children, health, victory in war,' [20]

It is in this setting that in 1833 Mosheosheo I invited the first missionaries into Lesotho, T. Arbousset, E. Casalis and C. Gossellin who were from the Paris Evangelical Missionary Society (PEMS). He hoped that they would help him further peacefully unite the emerging Basotho nation. These missionaries engaged a developmental approach to evangelise the villagers by also introducing new farming methods, seeds and improved livestock.[21] There was however tension created

[19] Stephen J. Gill, (1997) *A Short History of Lesotho,* (Morija Museum and Archives: Morija) p. 50
[20] Gill, *Short History*, p. 50.
[21] Gill, *Short History*, p. 80.

> because they also tried to undermine the relationships and customs which promoted the personal dependence of Basotho upon their chiefs.[22]

As we discuss the development of religion however, it is crucial that we take cognisance of how the early missionaries' perceptions about religion and 'civilisation' have also influenced the dominant worldview about Christian faith. In Lesotho, research has found that a significant part of

> the religious topography of Lesotho is the continued vitality of Traditional Sesotho religio-cultural forms which operate alongside, beneath, intertwined with, and at times, in competition with the Christian formations which are much more obvious to the Western eye.[23]

2.2.2. Doctrinal Contrasts

As Lesotho progressed as a nation under the visionary Mosheosheo, he accommodated more missionaries from other denominations at a time when tensions between the chieftainship and the PEMS were high. The Roman Catholic Church came and supported the chieftainship which created tension between the two missionary groups that has lasted until today. Gill's studies of this tension[24] noted that it grew into a competitive drive to outdo each other in terms of establishing and successfully run hospitals and schools. Unfortunately for Mosheosheo these new dynamics did not afford him the chance to regain the control over his subordinates he had hoped to. Thus the development of missionary work in Lesotho started on a fragmented and competitive front that divided Basotho communities to align either with the new religious institutions or reject them altogether and remain with their indigenous beliefs.[25]

Besides the antagonism among these missionary developments, Germond and Molapo also cite the conflict that was being created by the then emerging Christian faith which could not accommodate the traditional religions that were in practice at that time. They assert that Christian faith

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[22] Gill, *Short History*, p. 82
[23] ARHAP *Appreciating Assets:* p 93.
[24] Gill, *Short History*, p. 175.
[25] Gill mentions the resistance to the paternalistic approach to the missionaries as having played a role in the development of the Ethiopian movement. See Gill, *Short History*, p. 149.

> became a powerful and enduring element of Basotho agency in the conceptualisation and practice of bophelo,…. Which would radically challenge the hitherto unproblematic world of *borapedi.*[26][27]

In other words, the Christian faith perceptions of health and spirituality influenced the previously implemented practices and conceptualisations on the relationship between spirituality and health in terms of seeking and maintaining well being.

2.2.3. Other Influential Religious Traditions

The antagonistic relationship that prevailed among the carriers of the Gospel created dissatisfaction among the locals. As locals wanted emancipation from the paternalistic mission Christianity, the Ethiopian movement influenced the development of the African Methodist Episcopal Church (AME). Other prominent movements like the Mothers' Union and the Secret Prayer[28] also emerged as the Basotho Christians were seeking religion that would be meaningful and relevant to them.

2.2.4. Religious Entities Shaping Political Governance

The role that the Roman Catholic Church played in the shaping of the political arena during the few years prior to independence is worth noting. This is because this was a period that saw the rapid expansion of the church in terms of infrastructure, membership and personnel. This afforded the church such influence that the colonial rulers of that time wondered

> if the Catholic Church did not want to completely monopolise the social and political life of Lesotho[29]

Gill noted that the Catholic Church was instrumental in the establishment of the Basutoland National Party (BNP) and this intertwining of religious, political and social structures seemed to

[26] *Borapedi* is a Basotho term to represent the spiritual dimension of bophelo (well-being)
[27] Paul Germond and Sephetla Molapo "In search of Bophelo in a Time of AIDS" *Journal of Theology in Southern Africa* vol. 126, 2006 p. 32
[28] For details about these movements refer to Gill *Short History*
[29] Gill, *Short History*, p. 190.

have underpinned Lesotho politics.[30] Whether the church's role was prophetic or pro-establishment[31] would require a separate study. What has been evident though is a continuous spiritual search that has seen a heterogeneous religious climate develop in Lesotho as several other religious bodies have been introduced into Lesotho.

2.2.5. The Current Religious Climate

The current religious climate in Lesotho depicts a marked growth of spiritual movements and smaller churches, especially in the urban areas, since the 1990s.[32] Though most of the smaller Christian communities do not run schools or hospitals, they are regarded as having

> a more dynamic spiritual commitment, a more vibrant community life, and a more wide range of liturgical forms to choose from.[33]

Though the statistics available below depict the Catholic Church as the dominant entity, cognisance has to be given to the reliability and credibility of the different methods applied by the different denominations in arriving at these figures. Table II (over the page) might then be a reflection of a perception within prominent circles that might overlook recent factors influencing denominational identity.

The persistence of traditional religious beliefs however confirms Gill's assertion that they transcend these boundaries as certain religious ceremonies which are contrary to official teachings still play a role in the lives of some Basotho who consider themselves Christian. Gill argues that

> the idioms, the symbolism, the rituals, and the dynamics of the earlier forms of spirituality will not just disappear.[34]

and thus challenge churches to evaluate their doctrines and relevance in light of the indigenous context they find in Lesotho. In Lesotho, research has found that a significant part of

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[30] Gill, *Short History*, p. 211
[31] These concepts of the church being the voice of liberation or working to maintain the status quos are discussed in detail by Gerald West in his article, "Kairos 2000: Moving Beyond Church Theology", *in Journal of Theology for Southern Africa, Vol. 108, Nov. 2000*. p. 55 - 78
[32] Marjorie Froise (1992) (Ed), *Lesotho Christian Handbook 1992/93*, Christian Information: Johannesburg
[33] Gill, *Short history*, p. 231
[34] Gill, *Short History*, p. 231.

the religious topography of Lesotho is the continued vitality of Traditional Sesotho religio-cultural forms which operate alongside, beneath, intertwined with, and at times, in competition with the Christian formations which are much more obvious to the Western eye.[35]

Table 2.1. Religious Climate in Lesotho. *(From ARHAP WHO doc. p. 94)*

Christian	**1,648,622**	**91%**
Roman Catholic Church (RCC)		38%
Lesotho Evangelical Church (LEC)		23%
Anglican Church of Lesotho (ACOL)		5%
Other Christian		25%
(incl Methodist Church, Seventh Day Adventist, Pentecostal Churches, Zionist Churches)		
Traditional Sesotho religio-cultural forms	**161,787**	**8%**
Baha'i	15,915	0.89%
Hindu	1,078	0.06%
Islam	828	0.05%

2.2.6. Faith Based Organisations in Lesotho

Besides the development of churches in Lesotho, Faith Based Organisations (FBOs) in Lesotho have been engaging their religious ethos in developmental activities, including health. This trend is on the increase with the challenges that HIV and AIDS are posing on maintaining well being in particularly developing countries. Some FBOs have been agents or partners in health delivery on a global scale in response to improving livelihoods for communities in general. A considerable number of FBOs in Lesotho are under expatriate administration mainly because of funding relations that have existed within those organisations and the volunteers' sending countries. Agencies like Dorcas Aid, World Vision, Christian Care, Beautiful Gates, Mission Aviation Fellowship and Pregnancy Crisis Centre to mention a few; are manned by expatriate directors whose primary accountability is to their overseas mission office. Though their work

[35] ARHAP *Appreciating Assets:* p 93.

permits are approved by the Lesotho government, the religious climate of their mandate is quite evident in their praxis.

2.3. Health in Lesotho.

Lesotho's health care system involves a multi-sectorial approach to health provision which has the government and Christian Health Association of Lesotho (CHAL) as the main partners. We briefly review how this partnership functions and also identify the role of other stake holders in health provision in the following section.

2.3.1. Formal Health Provision Status in Lesotho

The health care system of Lesotho is implemented in a four tier system which works on a referral system from the simple preventative and promotive structures to the more complicated ones that attend to serious ailments. The first tier comprises of two facilities: firstly there are Health Posts, which are meeting places for mainly voluntary community health workers, traditional birth attendants and community based condom distributors. These posts usually have insufficient infrastructure for a clinic and offer preventative and promotive services at regular intervals to the communities around them. Sometimes Primary Health Care personnel visit these posts to offer immunisation and rehabilitative services.

The second facilities at this tier, the Health Care Centres (HCC), also include curative services and constitute the first formal contact with the formal health system. There are 193 clinics of which 81 are under government and 74 under CHAL management. There are 32 private clinics and six that are run by the Red Cross which all constitute the primary level of formal health care in Lesotho.

As confirmed later through the findings in this research, this state of affairs leaves gaps in the health care provision for marginalised communities who then utilise traditional and religious health care alternatives to maintain their well being.

The secondary level includes the 16 district hospitals that offer similar services at a more comprehensive level. These hospitals refer cases to the three tertiary hospitals: Queen Elisabeth II Hospital, Bots'abelo Leprosy Hospital and Senakatana AIDS Clinic for specialised treatment. Those conditions that these three hospitals cannot cope with are referred to South African hospitals, which is the fourth tier in the health system.

The ministry reports that the referral system faces challenges due to

> poor communication infrastructure, especially at the Health Centre level; ineffective functioning of some facilities because of lack of human resources or bad staff attitudes, out of stock drugs, dysfunctional equipment, poor ambulatory services and other inefficiencies.[36]

2.3.2. Other Stake Holders in Health Provision in Lesotho

The roles of different stake holders in health development, such as the government, FBOs, CBOs, NGOs and the private sectors has been noted. This will assist us in identifying the different internal influences and services that have contributed to the health of the Basotho people. Emphasis will be on accessibility and health delivery approaches that interplay within this multi-sectarian setting.

The early missionary activities formalised health and education and still form a significant part of these services in Lesotho. However, when the government increased its share of responsibility and control over these services, their focus and context became narrower and raised concerns that they had become too academic centred and lost the useful ingredient of shaping and moulding the individual for responsible citizenry they used to have.

Health Services in Lesotho have two distinct categories: the government's horizontal system that involves the health centres and hospitals, then a vertical system that comprises various programmes and task forces.[37] The Christian Health Association of Lesotho (CHAL) is the

[36]Visit Ministry of Health and Social Welfare website at file:///ministry%20of%20Health%20and%20Social%20Welfare%20-Referral%20system%23services.htm for details

[37] Kelello L.M Lerotholi and David Hall, *(2002) Seboche Hospital Strategic Business Plan 2000 – 2002*, Draft paper.

largest of all the non-governmental providers of health care in Lesotho. It is comprised of health facilities that are run by the Roman Catholic Church, the Lesotho Evangelical Church (LEC) and the Anglican Church. The organization provides both preventative and curative services through a network comprised of nine (9) hospitals placed throughout the country. Through this network, the organization provides health care services to approximately 40% of the total population of Lesotho.

Lesotho has been divided into 18 distinct Health Service Areas (HSA's) that have subdivided the 10 administrative districts reflected in the Map 2.1. below.

The table below illustrates the distribution of the facilities in terms of hospitals, clinics and private surgeries in Lesotho. Maseru district has the largest portion of these facilities; having 33% of the hospitals; 25.9% of the clinics and 50% of the private surgeries located in it. As illustrated on the map above, these facilities are concentrated in the urban parts of Maseru district, with a few located in the rural areas. This scenario is more pronounced in the rural

districts like Quthing, which has only 0.04% of the health care facilities located in areas not easily accessible to its population.

TABLE 3.2: Summary of Hospitals and Health Care Centres under Government and CHAL in Lesotho – 2007. (Compiled from Ministry of Health and social Welfare: Health Facilities List: 2007)

	Hospitals	**Proprietor**	**HCCs & other**	**Proprietor**		**Private surgeries**
Maseru	7 1 closed	4 – Gov 1- RC 1- LEC 1- Pvt Closed - MDT	50	14- Gov 1-SDA 2-Rc 1- BC	11- RC 3-AGN 18-Pvt	20
Butha-Buthe	2	1-Gov 1-RC	12	8-Gov 2-Pvt	2-RC	3
Leribe	2	1-Gov 1-RC	27	12-Gov 3-SDA	11-RC 1-Pvt	6
Berea	2	1-Gov 1-SDA	21 & 1 FC	4-Gov 1-SDA	11 RC 6-Pvt	2
Mafeteng	1	Gov	21	8-Gov 2-LEC 1-AGN	6-RC 1-SDA 3-Pvt	5
Mohale's Hoek	1	Gov.	15 1 closed	9-Gov 2-Rc	4-RC 1-RC closed	3
Quthing	1	Gov	9 1 closed	5-Gov 1-Rc	3-RC 1-Gov. closed	0
Qacha's Neck	2	1-Gov 1-LEC	10	5-Gov 1-LEC	3-RC 1-Rc	0
Mokhotlong	1	Gov	11	6-Gov 1-AGN	3-RC 1-Pvt	1
Thaba-Tseka	2	1-Gov 1-AGN	17	10-Gov 1-LEC 1-Pvt	3-RC 2-AGN	0
Totals	**21**		**193**	**81-Gov 32-Pvt**	**74-CHAL 6-Rc**	**40**

Key: Gov. – Government RC- Roman Catholic AGN- Anglican
Rc- Red Cross Pvt – Private MDT - Methodist
LEC- Lesotho Evangelical Church SDA – Seventh Day Adventist

The ninth hospital which was run by the Methodist church was closed in 2006 due to financial constraints.

The imbalance in the distribution and nature of health care facilities left gaps that have been filled by FBOs and other humanitarian organisations like the Red Cross, Dorcas AID, Beautiful Gates and MAF who have partnered with the government. These agencies offer services ranging from relief aid, places of safety; counselling and community based health care projects that contribute to the well being of Lesotho nation.

Most of the FBO agencies were invited into Lesotho by the government in an effort to meet certain health targets that had been set at national or international forums. Lesotho's plight after the 1998 election riots meant that it received a considerable amount of donor aid which translated into the arrival of several donor agencies and humanitarian bodies. Alongside these are humanitarian NGOs and world bodies like the United Nations whose programmes are geared at alleviating poverty, enhancing the delivery of health promoting projects/programmes and complimenting government efforts in development.[38] These agencies, like WHO, UNDP, UNAIDS, UN Peace Corps, usually are tasked to meet certain government targets and work hand in hand with government.

An important part of the landscape are a range of local NGOs and CBOs (Community Based Organisations) that arose especially in response to HIV and AIDS that are also addressing the health needs of their communities. These can be formal organisations as in the case of PLWHA, or be informal associations like care/support groups responding to fill in the health gaps that formal body fell to meet. The Lesotho government, like other countries, has made considerable strides in initiating and formalising these associations as

> capacity within the public sector is decreasing as its employees become infected or affected by HIV/AIDS .[39]

Having explored the health system in Lesotho, it is important to also give some consideration to the way local people conceive of health in Lesotho. This leads us to a consideration of Bophelo.

[38] United Nations Systems in Lesotho, p. 81
[39] United Nations Systems in Lesotho, p. 18

2.4. Health as Bophelo

The early ARHAP research into health and religion in Lesotho discovered that the Sesotho word that is used for health, *Bophelo*, conveys more than the English word, 'health'.[40] This means that we must understand health as perceived by the Basotho, and African societies in general, if we are to understand the assets that religion brings to the health scenario in Africa. The lenses of the modern world are influenced by the Cartesian[41] view of life. This worldview has dominated the western approach to health and disease, shaping us to understand health

> in terms of the biological or technical levels of understanding, rather than in terms of the wider social and economic conditions that promote those diseases.[42]

Against this, the ARHAP research report for the World Health Organisation, noted that in Lesotho

> views of health, its character and the related methods for achieving it that most public health policies and biomedical interventions tend to assume or propagate, are frequently dissonant with Basotho views.[43]

Simply put, *bophelo* is a holistic concept that encompasses the notions of life in relation to self, family, community and the society at large. It resonates the interconnectedness of life that *ubuntu* depicts and thus introduces us to a trajectory that embodies relational values rather than individualistic norms.[44] What this infers is that

> the well-being of a person is fundamentally social, for *motho*[45] cannot exist in isolation, only in relation.[46]

Thus an illustrated view of Bophelo is a set of concentric circles that have the 'motho' at the centre and the wider relationships that surround and affect their health and wellbeing around them. (See figure 2.1. below).

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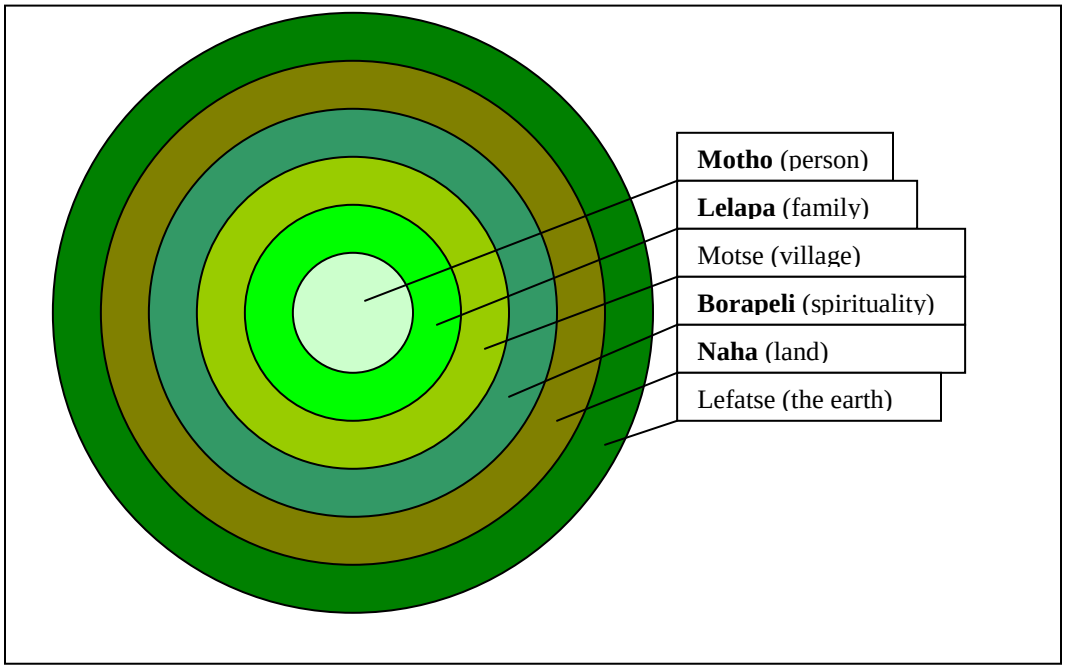
[40] For a detailed explanation bophelo, see Paul Germond and Sepetla Molapo "In Search of Bophelo" p. 27-47
[41] ARHAP *Appreciating Assets* for a fuller explanation of the Cartesian theory. P. 94.
[42] Steven Feireman and John M. Janzen, (Eds) (1992) *The Social Basis of Health and healing in Africa*, (University of California Press: California) p. xvi.
[43] ARHAP *Appreciating Assets* p 94
[44] Germond and Molapo, "In Search of Bophelo" p. 41
[45] Sesotho word for person
[46] Germond and Molapo, "In Search of Bophelo" p. 37

Initially we find that the individual life of every community member is valued and acknowledged as a crucial ingredient to the establishment and well being of the other entities. In other words, the village cannot exist without its members, nor can the members likewise. In the Bophelo healthworlds, meaningful development occurs when members are actively participating in attaining their own family and household sustainable livelihoods whilst also maintaining the corporate livelihoods of the village.

Figure 2.1. *The Socio-spatial configuration of bophelo (adopted from in search of Bophelo in Times of AIDS, p. 37)*



This understanding of Bophelo is an important concept to bear in mind when speaking about religion and health in Lesotho. This leads us to another key word Germond and Molapo[47] discuss in their paper that portrays the development of the relationship between health and religion in Lesotho. The term *borapedi,* that generally refers to spirituality in Basotho cosmology and has been shaped by the different religious influences through the years.

[47] Germond and Molapo, 'In Search of Bophelo," p. 31

Initially, *borapedi* referred to the realm where *badimo* (ancestors) and the families they were to oversee would interact and negotiate their relationships. With the introduction of Christianity however, a new form of spirituality, referred to as *bodumedi,* came to play a contesting role against *borapedi* as it portrayed *modimo* as one triune God with Jesus Christ as the only mediator; displacing the *badimo.* The articulation of bophelo in this new spiritual development with its new identity of *Majakane* (Basotho Christian Identity) challenged the main Sesotho identification process of *Lebollo* (initiation) and relegated traditional Sesotho understanding of spirituality and identity to demonic practices.

The economy of *bophelo* was further reconfigured after Lesotho independence when; though now operating in a climate where the spiritual and the secular accepts of health had been separated, it could not break away from the bio-medical definitions of well being. *Bophelo ba Botle* (good health) was then introduced as a new term to try and signify the goal of health care provision in Lesotho.[48] Nevertheless, the other agencies mentioned earlier and whose work is intertwined with cultural and traditional practices are the traditional healers associations and the office of the chieftainship. These agencies' role in health delivery, though not explicit, is deeply entrenched in the *bophelo* healthworlds and is actively illustrated in the health seeking practices of some Basotho.

2.4.1. Healthworlds in Lesotho

Conscious of the impact of the understanding of 'Bophelo' on local Basotho, Paul Germond and James Cochrane have proposed the notion of a 'healthworld', which is extended from Habermas' concept of lifeworld.[49] The two authors assert that when people seek well-being, they draw from their conscious knowledge which is influenced by a wealth of tacit, unconscious knowledge,[50] In other words, the way culture, socialisation and all other mediums of gaining knowledge and constructing people's understanding of being inform the way they make choices about how to manage their well-being. They also supported this concept by the proposition that people's

[48] Germond and Molapo, "In Search of Bophelo,"
[49] Habermas, J. (1987) *The Theory of Communicative Action Vol. 2: Lifeworld and System: A Critique of Functionalist Reason.* Boston; beacon Press. p. 124
[50] James Cochrane and Paul Germond, *Healthworlds: conceptualizing the Human and Society in the Nexus of Religion and Health.*

healthworlds manifest themselves in differing ways of understanding, as we have seen in our discussion of Bophelo.[51] This being the case, there is need to identify the role of religion in a context where

> the social fields of health and illness in Africa are more complex beyond the capacity of any single view or discipline to comprehend, and they are suffused with a bewildering array of symbolic worlds and the actions taken within them are driven by equally complex sets of motivations.[52]

Using this theoretical framework, Germond and Molapo have identified four healthworlds in Lesotho, namely the Traditional Sesotho Healthworld which they term *Bongaka ba moetlo;* then there is the Christian Healthworld, the Biomedical healthworld and then there are now some Emerging healthworlds. These healthworlds are not exclusive of each other in their influence of health decision-making in health seekers. Rather, as Germond and Molapo[53] suggest, they operate as trajectories; sometimes distinct and in direct conflict with each other; whilst at other times their knowledge and practice can be complimentary and common. Gary Gunderson sums it up when he describes the behaviour of seeking or offering health care as

> complex blends of different ways of knowing and methods of choosing different expressions of agency informed by sources that include conscious accountability to selected portions of science and culture.[54]

2.5. Conclusion.

We have outlined the physical, socio-economic and religious factors that have contributed to the development of health delivery services in Lesotho. The concept of well being that influences Basotho in terms of how they view health has given us insight as to the interaction among providers and seekers as they pursue well being. Chapter 3 now presents MAF , a Christian FBO whose main mission is to provide air transport to the Lesotho Flying Doctor Services (LFDS).

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[51] James Cochrane and Paul Germond, *Healthworlds: conceptualizing the Human and Society in the Nexus of Religion and Health.*
[52] James Cochrane and Paul Germond, *healthworlds, p. 1*
[53] Paul Germond and Sepetla Molapo "In Search of Bophelo in a Time of AIDS: Seeking a Coherence of Economies of Health and Economies of Salvation" *Journal of Theology in Southern Africa* 126 (2006) p. 27-47.
[54] Gary Gunderson "What Do Hospitals Have To Do with health? Exploring the Relationships Among Religious Disease Care systems and Other Types of Religious Health Assets" *ARHAP International Colloquium (2007) Collection of concept papers* (Monkey valley Resort, Cape Town, South Africa. March, 13-16, 2007) p. 5

This is a crucial service as this mountain kingdom where most HCCs are inaccessible by road. We will introduce this organisation and the research findings in the next chapter.

CHAPTER 3:
MISSION AVIATION FELLOWSHIP IN LESOTHO

3.1. Introduction

In chapter 1 we noted that the research that is presented in this thesis is contributing to the development of the ARHAP theoretical frameworks to do with the range of tangible in intangible assets that religion and religious entities have that contribute to health.

This chapter thus presents the research findings from the fieldwork research of MAF, an international FBO that operates in Lesotho in partnership with the Lesotho government and several NGOs and FBOs. It outlines how the research process proceeded and the findings that came out of the three methodologies applied; namely literature review, organic interviews and participant observation. For presentation purpose, the findings are categorised within the six clusters identified in 1.4.1. above that separate the tangible and intangible RHAs; these being spiritual encouragement, knowledge giving and moral formation under the intangible RHAs and the tangible RHAs being compassionate care, material support and curative interventions. Another aspect of RHAs we will consider that ARHAP identified in Lesotho was presented as relational ambition, which referred to the complimentary or symbiotic relationship that was depicted in the application of these RHAs. These categories are also applied in our analysis later in chapter 5.

3. 2. The Research Process

3.2.1. Sampling

The research methodology involved a pre-sample survey among 3 FBOs working in Lesotho, namely, Beautiful Gates, World Vision and Mission Aviation Fellowship (MAF). This was to identify an organisation that would offer a helpful case study that could present us with the data we needed to answer our research question. The literature review and preliminary interviews

indicated that MAF would offer the most suitable ground to carry out the research. The crucial point was the availability and accessibility of that data to the researcher.

The second factor that influenced the sample selection was the language barrier. Having minimal knowledge of Sesotho, it would prove to be a challenge to have meaningful data collection using the narrative methodology because it is less structured in application. There were opportunities for interpretation which were utilised, but a fairly sound use of English by the respondents was necessary to objectively allow the informants to 'tell their story'.[55]

3.2.2. Fieldwork Research

The research findings are presented in two sections: a narrative section that will articulate the research process and how the fieldwork progressed; and the descriptive section that indicates the religious health assets identified that will be categorised in the clusters mentioned earlier. A brief background of MAF is furnished to place the findings in an organisational context. The descriptions then present findings from data collected through the literature review, participant observation and organic interview methodologies.

3.2.2.1. A Brief History of MAF Worldwide[56]

Mission Aviation Fellowship is an international organisation currently operating in 55 countries in the world by primarily providing aircraft transportation for different activities that they or their partner organisations carry out in hard to reach areas. It emerged from a prayer and Bible study meeting of 3 pilots during World War II in 1943. Two years later, Christian Airmen Missionary Fellowship (CAMF); as it was then known, was launched. A 1933 Waco biplane was their first aircraft which Betty Greene piloted to fly Wycliffe workers to Mexico in 1946. To improve communication, shortwave radios were used to keep in touch with the outside world.

[55] Philippe Denis (2003) "Oral History in a Wounded Country", in Draper, ed., *Orality, literacy and Colonialism in Southern Africa*, Pietermaritzburg: Cluster Publications, pp205 - 216
[56] For more information on the history of MAF visit their website at www.maf.org

As the years went by MAF continued to develop and a Piper Pacer that could land on water and on land pioneered MAF work in New Guinea in 1954. These new frontiers were not without sacrifices as in the sad killing of 4 missionaries led by Nate Saint to the Auca Indians in 1956. This tragic event however, resulted in the salvation of 7 of the 9 killers and the availing of thousands of people who wanted to join the mission field in their place.

The following years saw several openings of new mission fields in different parts of the world, like Indonesia, Zaire, Afghanistan, Russia and Ethiopia. Still some missionaries lost their lives in the mission fields but this did not stop the expansion into new territories. By 1998, as they began to conceive of mission in more holistic terms, MAF was making a mark in humanitarian efforts in response to natural disasters, wars and development projects as their means of outreach. Two notable developments in MAF were the research project called 'Operation Access' that surveyed 364 isolated areas in 64 countries and the publishing of the *Bibliologia*; a CD in Russian with 19 Bible translations and 25 Christian books.

3.2.2.2. MAF Objectives

MAF states their 5 main objectives as:-

i. Evangelism and Church Nurture achieved by supplying
    a. Missionaries and local people to bring the gospel to the unreached people.
    b. Indigenous church workers to isolated villages
    c. Theological education by extension
    d. JESUS film presentations
    e. Scripture translation and distribution

ii. Community Development
    a. Christian staff and supplies for health and community improvement projects
    b. Village enhancements, including water wells

iii. Medical Assistance
    a. Medical emergency evacuations

b. Medicines delivered safely
c. Flying-doctor services and other medical transport

iv. Disaster Response
a. Relief supplies and agency personnel to disaster areas
b. Food for the hungry

v. Indigenous Training & Development
a. Distance education and leadership development
b. Technology training

MAF slogan

3.2.2.3. MAF at Global level

Our research into the work of MAF looked at its activities until 2008 in which its annual budget was US$ 38.3 million that comprised of direct and indirect ministry activities, ministry staff expenses and fund raising activities as their expense summary. This budget was met through their field revenues and gifts income which bring in about 36% each of the income needed. About 24% of the budget was met through caring partners, churches, individuals and foundations.[57]

MAF American Headquarters are now in Idaho from where they coordinate the different mission fields. Their guiding vision is

[57] Visit MAF website at www.maf.org

> to see individuals, communities, and nations transformed by the Gospel of Jesus Christ. We promote this transformation by positioning Christ-centred staff in strategic locations worldwide utilizing aviation, communications, learning technologies, other appropriate technologies and related services. In accomplishing our mission, we collaborate with churches, subsidiaries, partners, and networks.[58]

The MAF ministry is an elaborate and personal ministry network that promotes continual communication among all those involved. A Ministry Effectiveness Evaluation System is in place to ensure accountability and proper assessment of the impact of the ministry in the lives of those being ministered to and those ministering.[59] The use of a website is an effective communication tool as it makes it easier for MAF to communicate with a variety and wider network of people and get feedback from the general population. Though sometimes negative criticisms are raised over their ministry, the website seems to be an educational and information tool that MAF can use to further their ministry.

The organisation has expanded to other countries and now has offices in Canada, Europe, Australia and South Africa. It has 52 aircraft in 27 countries in Africa, Asia, Eurasia and Latin America that serve more than 800 Christian and Humanitarian organisations.

3.2.2.4. MAF activities in Lesotho

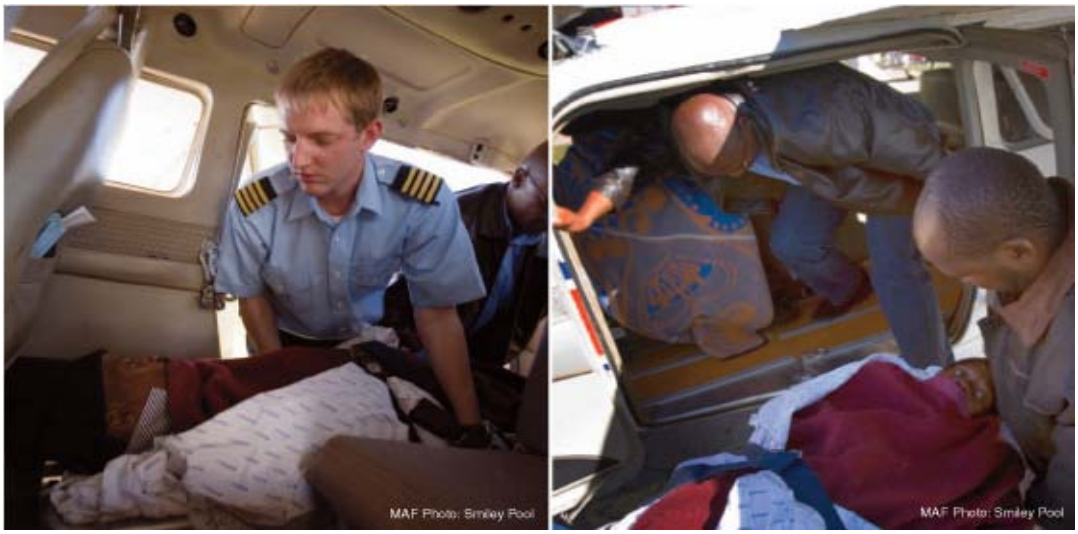
Mission Aviation Fellowship (MAF) has been in Lesotho since 1980. It primarily functions as a flight service for the Lesotho Flying Doctors Services who need to be flown into the rugged, mountainous remote Health Care Centres that are mostly inaccessible by road. The Lesotho Flying Doctor Services serve about 200 000 people in the remote areas of the country. The Lesotho programme has currently 18 expatriate staff that work hand in hand with the locals. The air transport service is critical for the successful operation of 38 partners, including Africa Inland Mission (AIM), Southern Baptist Mission, Catholic Relief Services and Apostolic Faith Mission.

The key project of MAF in Lesotho that was the focus of the research was the development and support of nine Home Based Care groups. MAF embarked on this Home-Based Care project in

[58] See Home-mission Aviation Fellowship.htm, p. 1
[59] For a detailed illustration of this system visit www.maf.org

2003 after having noticed the plight of the mountain people when it came to health care provision.[60] Terminally ill patients were being flown into Maseru, especially those affected by HIV and AIDS, their families hoping that they would get better; but only to die alone in the hospital and far from their loved ones. This seemed to cause a lot of distress as family members would now incur a great expense trying to bring the body back to the village for burial. Besides, the sick people were spending the last days of their lives with strangers and it could take a long time before the families learnt of the death of their loved one. This added stress to the bereaved family.

One of the MAF pilots settling the patient into the plane



The MAF Home-Based Care project thus responded to the scarce availability and accessibility of health care to some of the mountain villages. The present Health Care Centres in the remote rural areas are sparsely located and sometimes inaccessible to their service areas because of the very rugged terrain.[61] These physical impediments have sometimes cost lives as health seekers would die before they could get to a clinic or would not even try to go there because they did not have the required M5.00 to pay or it was too far to walk.[62]

[60] Interview 01, l. 229, p.7
[61] Refer to map of Lesotho, annex 1.
[62] This commercialization of health came up as an impediment to 'bophelo' in the AHRAP –Lesotho research for WHO where people are now forced to resort to self medication. See African Religious Health Assets Programme, "Appreciating Assets: The Contribution of Religion to Universal Access in Africa", Report for the World Health Organization, (Cape Town: ARHAP, October 2006). P. 106

The MAF staff, especially the pilots, who observed this situation when they were called to transport critically patients to Queen Elisabeth II Hospital in Maseru, decided to address minor ailments and empower the community to attend their health needs from within.[63] This led to the engagement of Health Trainers under a project that MAF was carrying out with sponsorship from Bristol - Myers Squibb Foundation (BMS); an American pharmaceutical company. This project was a community based empowerment programme whose objectives were to mobilise and train Village Support Groups that addressed the health needs in their communities.

Table 4.1. Health Centres - Bases for MAF Home-Based Care Project Reflecting Distance from Referral Hospital and The Population Coverage.

District	Health Care Centre	Km from Ref. Hospital (as the crow flies)	Pop. in Catchment	Pop. Covered	% covered
Mohale's Hoek	Ketane/Nohana	8.77km to Butha-Buthe	20 635	5 010	24.3%
	Hloahloeng/Nkau	7.03km to Butha-Buthe	N/A	N/A	N/A
	Kuebunyana	5.05km to Butha-Buthe	16 020	3 609	22.5%
Thaba-Tseka	Methalaneng	4.65km to St. James	27 174	4 635	17.1%
	Semenanyana	9.85km to Mokhotlong	33 012	6 323	19.2%
	Bobete	8.42km to Butha-Buthe	30 709	6 949	22.6%
Qacha's Nek	Lebakeng	9.35km to Butha-Buthe	18 386	5 088	27.7%
	Matebeng	7.34km to Qacha's Nek	21 585	3 190	14.8%
Mokhotlong	Tlhanyaku	15.54km to Butha-Buthe	21 448	10 099	47.1%
TOTALS	**9 HCCs**		**188 972**	**44 903**	**23.8%**

The Bristol-Myers Squibb Foundation sponsored the MAF HBC project under the title, 'Empowerment of family members of HIV/AIDS-infected patients located in nine isolated communities around the Lesotho Flying Doctor Service (LFDS) Clinics in the mountainous areas

[63] See J. Kretzmann and J. McKnight, (1993*), Building Communities from the Inside Out: A Path Towards finding and Mobilizing a Community Asset.* (Chicago, ACAT Publications).

of Lesotho.'[64] They co-funded the project for three years for an amount of US$91,389 together with the Southern African Catholic Bishops' Conference and the Catholic Missions Board. Its main target group were the individuals, families and communities affected by HIV/AIDS in the nine mountain villages that had been identified by MAF. The table above indicates where these centres are, and how far they are from the referral hospital (as the crow flies, which is not always as the Basotho pony walks!).

3.3. The Research Process.

The key research questions were "What can we learn from an engagement with MAF about (i) the relationship between religion and health in Lesotho in terms of practices, and (ii) How can this assist us in our understanding and encourage Christians' contribution to health? Three research methods were used, namely literature review, participant observation and organic interviews. This allowed for a triangulation of results as the data collected through the three research methodologies was also used to cross check the consistency and validity of information.

3.3.1. Literature Review

Literature on MAF structure, mode of operation and activities was accessed from the internet where reports, testimonials and requests for support are posted. This was the simplest way of accessing information, although it did not allow for much probing of the data.

3.3.2. Field work: participant observation and organic interviews.

The fieldwork research was carried out over a period of 9 months. This involved trips by plane for 1 week stays in the mountain villages of Lesotho; namely Nkau – from the 9th to the 16th March, 2004; Methalaneng – 13th to the 19th September 2004; and Matebeng Health Care Centre – 10th to 14th August, 2004. The months of February and October were spent at the MAF head offices, conducting interviews and engaging in participatory observation of the project's daily

[64] Information on Bristol-Myers Squib Foundation sponsorship of MAF project can be obtained from www.trc.org.ls

functions. Interviews were conducted with the 2 Health Care Trainers and the Programme Manager. Interviews with the 2 pilots were unsuccessful as their fight schedules and maintenance duties did not allow them enough time to do so. The researcher was however able to observe them on the flights to the different HCCs.

One trip was rescheduled because the flight booking by the Health Trainers had not specified the number of passengers and the pilots had not reserved a seat for the researcher. The researcher had to revisit Lesotho in December 2007 to finalise and update some data before completing the research for this dissertation. Flights were usually 20 to 35 minutes long, and pilots would have 7 to 12 drops in a day, making Lesotho one of the countries with the most take offs and landings (called 'drops') for a pilot. This poses danger to the pilots as they have to negotiate these take offs and drops onto gravel strips where the wind speeds and direction can change drastically without warning because of the mountainous terrain.

During the mountain stays, we were based at a clinic (Health Care Centre) and moved around on foot with the Health Care Trainers to the different villages in the Health Centre service area. These service areas vary in size, mostly depending on the terrain and infrastructural development of that district.[65] For instance, Matebeng visitations to the different villages were quite challenging in that villages serviced by the MAF projects were about 6 - 10 kilometres from the Health centres in rugged terrain. Besides being unable to hire horses to ride, (I was quite unfamiliar with horse-riding on flat ground!) the villagers did not have horses to hire due to theft and death of animals from poor health. There was one trip which involved crossing the same river 13 times.

Methalaneng trips were most difficult as the villages were not just far spread, but also on very high plains that had very steep slopes that were difficult to negotiate. These experiences were an invaluable learning curve as they demonstrated the physical demands that mountain people adapt to for basic survival. Production strategies in these circumstances were visibly inadequate to sustain viable livelihoods as evidenced by the following observations:-

[65] Obtaining distance figures for all the villages within the service areas was not possible within

i. Very young single or married mothers of 13 – 15 years with malnourished or ill babies seeking health care at the HCC.
ii. Barely clothed or naked children of pre-primary and primary school going age playing sometimes only covered with pieces of blankets during cold August days. (In some places there was still snow on the higher mountain peaks.)
iii. The cold winter months had dried the wild herbs that villagers rely on for relish and there was observed a significant amount of tension among the patients as everyone anticipated receiving the donated food that had been stipulated for malnourished pregnant mothers and children under the age of five.

The physical challenges posed by mountain village life were further exacerbated by the lack of basic infrastructure like roads, proper school buildings and basic amenities like toilets, piped water and electricity.

MAF plane in the mountains with some of the villagers

At each Health Care centre I was able to interview the Nursing Clinician and/or Assistant. They were all agreeable to being recorded by tape except for the one at Nkau (this might have been a lack of proper communication of the need to record as language proficiency was a challenge.) Four group observation meetings with the Support group members were carried out with the help of an interpreter. I also interviewed the Chieftainess of Methalaneng Village who had

participated in constructing an airstrip and the healthcare centre where MAF now launched their HBCP work from. (Sadly she passed away later in 2005).

As noted above, MAF collaborates with 94 villages within nine of the Health Care Centres that are serviced by Lesotho Flying Doctor Services (LFDS).[66] Only about 23% of the population in the service areas had adequate access to the clinics due to the rugged terrain that separates these areas from the Health Care Centres. This leaves the greater majority having to find alternative means of addressing their health problems.[67] Herbal medicines were observed to be the most resorted to alternative, ranging from simple herbal teas from local herbs to those prescribed by *lingaka chitja* (traditional herbal healers). Within the communities, the location of a traditional healer was usually marked by a flag, though not all the time. Since these centres were already located in remote, hard to reach places; it categorised the population groups they served as marginalised, emphasising the ruralness of most of Lesotho's population as mentioned in 2.1.1. So the selection criterion in the case of MAF's project was strongly influenced by the feasibility of effective impact and cooperation from the village chiefs.

Since the home-based care project greatly depended on mobilizing volunteers to address the health needs of their community, the support of the village leadership played a crucial role. In most cases, each visit from the Health Care Trainers commenced with an obligatory visit to greet the village headperson. Where rapport had been established, the village head would be informed of the visit as a formality, though in two cases; Nkau and Matebeng, some of the village heads or their family members were part of the support group.

Besides the intended data collection, invaluable lessons were learnt about the customs and livelihoods of the mountain people of Lesotho through participant observation. Social structural behavioural patterns like the path women take to enter a homestead; where women and men sit within a hut or how you can walk up to greet someone were all valuable insights as to the socialisation and belief systems that govern the villages that one might easily overlook.

[66] Diagrams 2 – 10 illustrates the distances some of the villages are from the health Care Centre
[67] This findings concurs with the assertion that political instability and the struggle for subsistence adhesively affect health in Lesotho. See ARHAP WHO report. p. 106

3. 4. Research Findings

As mentioned above, the description of the findings is presented according to the research methodology utilised to collect the data to assist in presenting a systematic analysis in the following chapter. As pertaining to the interviews, there will be a narrative of each interview and a description of the findings extracted from the interview and findings obtained through participant observation related to that interview.

3.4.1. Tangible RHAs from the Literature Review

In this section we make use of the six-fold distinction of Tangible and Intangible Assets to analyse the information we found via the literature review. We will first look at the Tangible assets that we identified. These fall under the categories of material assistance, curative interventions and compassionate care.

First, in terms of *material support*, MAF saved Christian and humanitarian workers 4,327 days of travel time—or 17.9 work years. In the period under review they increased flight services by 7% to accommodate the growing number of requests from local NGOs who provide AIDS/HIV-related services. In terms of the focus of this research, we can note two things. The MAF worked to accommodate the HBC project within the MAF office space by allocating an office at the hanger furnished with a computer, printer and all the necessary stationery and store cupboard for garden implements and seeds. In the field they empowered the Support Groups and their 'patients' to generate income through vegetable gardens. MAF would supply the seeds, implements and technical know-how while the support groups were to secure a plot from their chief or headman and work the garden. The main focus of the nutrient gardens, as they were called, was to supplement the diet of the patients who might be on ARVs and thus would need nutritious, fresh food. Continuous monitoring and evaluation of the project was undertaken which led to sourcing of a new donor as more input from MAF was still required to further develop the income generating projects.

In terms of *curative interventions*, we note that MAF is itself not directly engaged in curative work, but supports doctors and other health workers in their interventions. In the case of MAF it would therefore seem best to see curative interventions as part of the category of *compassionate care*. In this combined category, MAF sustained the *Lesotho Flying Doctor Service*, providing medical care to some 200,000 people. Here they executed 2,759 flights, transported 6,494 passengers, and delivered 398,251 pounds of cargo in order to provide access to basic services such as health clinics, medical emergency evacuations, and education—services otherwise unavailable in the mountainous regions. In terms of the focus of this research, MAF assisted NGOs and the *Ministry of Health and Social Welfare* in providing proper healthcare and was involved in HIV/AIDS training in very remote areas of Lesotho, through the recruitment, training and establishment of nine support groups within the HCCs areas that are serviced by the LFDS in the remote rural areas.[68]

3.4.2. Intangible RHAs from the Literature Review

The MAF also contributes to health via the three key types of intangible assets, namely *spiritual encouragement, knowledge giving* and *moral formation*. In terms of *spiritual encouragement*, at a very basic level MAF provided safe, efficient aviation services to missionaries reaching mountain villagers with the Gospel. They also facilitated new and ongoing mission endeavours to show the JESUS film in remote villages. They presented the film at a local prison, and it also plays continually in the HCC patient waiting room. A strong reliance on prayer and 'the word of God' for guidance in MAF activities as depicted in one of the testimonials where they request for

> prayer for the safety and health of his family in Lesotho, for the doctors and nurses in the mountains treating the patients who are mostly affected by HIV and AIDS.[69]

In terms of *knowledge giving*, MAF clearly combines this with *spiritual encouragement* by supporting an evangelistic, home-based, patient care project, teaching families to care for their critically ill relatives infected with HIV/AIDS. They distributed Bibles to patients and their families.

[68] See Lesotho-Mission Aviation Fellowship.htm
[69] Visit www.maf.org/vennel for the full testimonial

It is interesting to note that *Moral formation* is promoted mainly through setting a good example. At MAF there is a high level of sense of duty among expatriate missionary staff as they leave their homelands to provide services in remote areas, and a commitment to vocation and response to the call to witness to the unreached. The testimonials of staff display faith and dependence in divine protection in the face of danger or uncertainty.[70] We also see accountable stewardship in the annual, quarterly and monthly reports.

In summary, the literature review suggests that the key tangible assets that MAF embodies are *material support* and *compassionate care*, and the key intangible asset is *spiritual encouragement*. We shall note if this is borne out through an analysis of the field work.

3.4.3. Findings from Organic Interviews and Participant Observation

3.4.3.1. Interview 01 – MAF Programme Manager - 2004

The respondent of this interview was the Programme Manager for MAF . He was the one who gave approval for the researcher to carry out the research. As mentioned earlier in the selection of sample agencies, it was the relational associations that assisted in the securing of the research project. He had understood the language barrier that the researcher had and felt that his organisation would offer a suitable ground in which credible data could be obtained.

The interview was carried out on the 26th June 2004 at the hanger around noon in the manager's office. It was a very interesting interview as the respondent was readily responsive to the promptings and offered valuable information.

The MAF Programme Manager is an American male, aged between 41 and 45. He is married with three children. His formal training was as an Aircraft Engine Fitter, and after feeling called by God into mission work he had a year of Bible School training as preparation for working with MAF. He worked for MAF in Lesotho since 1996. His formal responsibilities were to supply air transport to the Lesotho Flying Doctor Service and to initiate Support Groups and self help projects among the mountain peoples served by LFDS. He was overall in charge of the whole

[70] Visit www.maf.org/vennel for the full testimonial

programme to ensure that planes were flying and being maintained properly and that the MAF personnel were motivated to keep working. Alongside this, his own personal involvement in church work saw him help out at an orphanage with maintenance and fund raising activities, and teaching in Sunday School at Maseru United Church, an international and interdenominational independent church.

In analysing the interview in terms of tangible and intangible assets the respondent pointed to the following in terms of MAF's contribution to *material support*. MAF is involved in providing flights to LFDS in order for them to serve inaccessible Health Centres in the mountain villages, as well as providing flights to other partnering FBOs and NGOs who work within the mountain communities. MAF ensures the safety of pilots and passengers by maintaining the aircrafts, and secures qualified committed experts to render flight services for LFDS and ensure quality service delivery within MAF. (These experts are called volunteers as they raise their own support overseas and are not supported by the benefiting country.) MAF also offers technical support at the Health Care Centres in fixing equipment like radios and pipes which would retard or hamper service provision because of delayed government's response.

In terms of *curative interventions* and *compassionate care* the respondent noted MAF's contribution through flying critical patients to Maseru Queen Elisabeth II Hospital, and through mobilising mountain communities to start home-based care projects that stress the importance of terminal patients to "die at home with their family and people around them who love and care for them".[71]

In terms of *spiritual encouragement* and *moral formation* the respondent spoke of incorporating Christian values in their home-based care programme as they encouraged people how to change their hearts and attitudes. Furthermore, he portrayed the role of faith in his personal work in MAF by strong association of his decisions to the guidance of the Holy Spirit or God. Besides the daily commitment of each day to the Lord through devotions at the hanger, he pointed to the role his faith plays in his choices and decisions in various ways.

[71] L. 232 – Interview 01

In terms of *knowledge giving*, the respondent, noted that MAF is involved in teaching rural communities how to prevent transmission of HIV and AIDS when tending to ill relatives or patients.

Other important information that came out of this interview included the fact that the respondent portrayed a holistic view of health by defining it as "more than just the physical well-being of a person. It also deals with your emotional and spiritual well being".[72] This means that for him Christian health providers must also share love and not just attend to the physical needs of their patients. It was interesting that he held the view that Traditional Healers have no power to positively address spiritual needs, and may jeopardize people's health. When responding as to whether his local church was giving him any tools or support to be able to live a health life or help others live a healthy life, the informant stated that it had recently started to happen. He felt more should be done to open up congregants to discuss issues that affect them, especially for the children. The government initiated teachings on HIV and AIDS were regarded as having gone stale and no longer interesting for the children.

3.4.3.2. Interview 02 – Home-Based Care Trainer I

The first Health Care Trainer interviewed was a female Mosotho of around 25 to 30 years old. She had been employed by MAF since 2002 and had been trained as a Peer Educator and Youth Trainer in Life Skills by the Ministry of Agriculture. She was still single and chose this career after hearing of the vacancy from a friend.

This interview proved to be very informative as the respondent became the subject of her story. Some of the details furnished emphasised what Philippe Denis[73] alluded to when highlighting the therapeutic aspect of being allowed to express your experiences, especially ones you regard to have been challenging. The interview took almost two hours, with the respondent relating in detail the experiences that are meaningful to her, letting her voice be heard.

[72] L.188 – Interview 01
[73] Philippe Denis, 'Oral History in a Wounded Country,' in J. Draper (Ed) (2003) *Orality, Literacy Colonialism in Southern Africa*, Cluster Publications: Pietermaritzburg.

However, because the respondent had so much to relate, some memories are juggled up or incomplete, possibly revealing that those details were not what she wanted to recall. The interview process itself became an enlightening exercise as to the need for silent voices to be offered the opportunity to be heard, identifying richness and positive assets that the community otherwise was unaware of.

In analysing the interview, this respondent noted that in terms of *material support*, MAF assisted the Support Groups to become self reliant by supplying seeds and implements to develop gardening projects that would avail nutritious and fresh vegetables and legumes in the second phase. MAF promoted health in the patients by encouraging them to use fresh vegetable from the gardens and boost the health status of the villagers by encouraging sells of these vegetables to the rest of the villagers.

In terms of *compassionate care*, the respondent felt that MAF was involved in ensuring that established Support Groups took care of members in their communities whose health had been compromised, especially by HIV and AIDS. This included the orphaned children that would be left behind by the death of their parents. Furthermore there was an emphasis on building a harmonious relationship between health providers and the community members by going the extra mile and have an open clinic within the village to attend to the sick who could not get to the clinic. She also reported that the communities were becoming more receptive to health education, even evidenced by children taking regular baths and more hygienic conditions around the homestead. The identification of poor homestead planning brought an inter-departmental intervention as the Environmental department brought in cement and bricks and engaged in a toilet-building project. This was evident in Matebeng as most homesteads had either a stone and mortar or brick toilet. This was resulting in improved health and a gradual change in sanitary habits within the mountain village.

The following factors arose from the respondent's narration of the changes she perceived to have resulted from mobilising and educating the community on health issues that they can participate in to improve their communities' health. Some factors were observations that she noticed that were contributing to an improvement in health provision that other agencies were engaged in.

Possibly in terms of her role as a Home Based Care Trainer, this respondent saw a very strong contribution in terms of *knowledge giving*, which echoed her own strong contribution to the project. MAF mobilised the mountain villagers located where LFDS ran Health Care Centres to participate in the three phases of the Home Based Care project, mobilised community members through their chiefs to volunteer to be in a Support Group that they would then train in home-based care, and carried out an assessment and evaluation of the project for further recommendation to the donors in the third phase.

The participation of *Lingaka* (traditional healers) in the Health Care Trainers' workshops was viewed as a success as these practitioners were reported to be crucial in health provision in the mountains as clinics were sparse and not readily accessible and because of the R5.00 fee. *Lingaka* were reported to be generally cooperative except that they were reluctant to share their medicinal knowledge because they were worried that, 'now that you've brought the western thing – medicine and all – now you are taking away our clients'.[74] Traditional herbal knowledge was passed on to the Health Care Trainers through discussions with the village elders, with some interesting prescriptions for diarrhoea and vomiting like fresh cow dung in half a cup of milk in AIDS patients. Some bitter herbs like *moseresere* and *piso* were reported to be effective for coughs and fever. The respondent was open to try the herbal treatment on herself and her family. She also researched from some herbal literature which confirmed some of the medicinal values of culinary herbs like thyme and rosemary.

The respondent's approach to implementing her role in knowledge giving was influenced by her perceptions of the context of the communities she was serving as evidenced by the following definitions and observations. When asked to define a healthy person the respondent stated that her perception of a healthy person was one who eats nutritious food to be physically healthy. Personal hygiene and mental health were also important for someone to be healthy. (This was witnessed by the researcher on the trips where the respondent would not rest until she was satisfied that the sleeping quarters offering were hygienically acceptable.) A positive attitude to life and hope were mentioned as critical to maintaining mental health, especially in challenging circumstances like those of the mountain communities were basic needs are a struggle to obtain.

[74] L. 392 – Interview 02 – Health Care Trainer

Lastly she cited spiritual health to be more that just attending a religious gathering, but living the principles that show that, 'I know what Jesus can do for me'.[75]

The respondent also identified health in terms of the mountain community people of Lesotho as being full of hope and belief because of their attitude to life. This was despite the fact that many of them might not be exposed to churches as their might be very distant, but still suggesting to her a spiritual sense of hope. In responding to whether there is a relationship between spiritual health and physical health, she noted that you have to believe that the medicine was going to help you get well if want to get well thus emphasising the need to activate your faith in the process of seeking health. She noted that the use of prayer in seeking health was crucial, especially where medical assistance is delayed. She stated that, 'you can see that prayer or faith or hope is medicine by itself.[76]

The respondent further mention the cultural differences in sexual behaviour as a critical challenge to health provision between the isolated mountain villagers and the rest of the Lesotho communities. Noting that having multiple sexual partners was an acceptable practice within some mountain communities, she expressed the difference as ignorance of the mountain people as to the dangers of multiple partner relationships that are acceptable within these societies. Another area of concern was the unsafe exposure to blood when attending to the injured that some villagers were oblivious to. The respondent felt that health education was critical to conscientise the villagers of the prevailing health challenges.

Another practice that the respondent referred to in responding to the question of a healthy community was the ignorance around basic homestead planning where some villagers were reported to relieve themselves upstream whilst collecting water for home use downstream, exposing themselves to water-borne infections.

Spiritual encouragement was also noted a strong part of her contribution to the work of MAF. She reported that her faith has assisted her in being less judgemental about people's role in

[75] L. 213 – Interview 02 – Health Care Trainer
[76] L. 272 –Interview 02 – Health Care Trainer

unpleasant circumstances. It enabled her to empathise and tolerate other people's weaknesses as she believed God was teaching her to, 'be in their shoes and you walk; talk the way they talk; …then they will open more to you and you can convince them to change'.[77]Positive affirmation within MAF and follow up encouraged her to feel secure and that she was an important team member as it informed her that others were noticing her vital inputs in the project. Affirmation also came from the nurses at the Health Care Centres. The respondent expressed that she withdraws to herself and tries to find solutions by herself when dealing with personal stress. So prayer was again her source of support in such situations. It was clear from this interview that the respondents own key strengths – *knowledge giving, compassionate care* and *spiritual encouragemen*t – were seen to be the contribution of MAF to health care in the project.

3.4.3.3. Interview 03 – Health Care Trainer II

The interview was carried out on the 28th July 2004 at the MAF hanger at round nine-thirty in the morning. It was interrupted as some other workers were curious to know what it was about. This seemed to have affected the respondent to freely reflect on his experiences as he also showed uneasiness in a common office that we were using for the interview. However, as the interview progressed, he became more articulate and more confident to narrate his story.

The Health Care Trainer II was a male Mosotho respondent of between thirty-one and thirty-five years old. He was married with two daughters and at the time of the interview he was living in a village called Bopopo in Leribe, a town in the north-west border of Lesotho. He introduced himself as a born-again Christian, not just a Christian. He had been employed by MAF since 2002 after having being trained as an agricultural extension worker with the Ministry of Agriculture.

In his response, he saw a strong role in MAF in the area of *knowledge giving*, particularly around what does and does not contribute to health. The respondent noted the use of traditional herbs in the remote rural communities. He attributed this to the fewer health promoting alternatives in the mountain villages as other health providers were absent or difficult to access. Thus the

[77] L. 507 – Interview 02 – Health Care Provider

availability of the traditional medicinal herbs and the knowledge of the *Lingaka chitja*, together with some village elders, played a prominent part in the health seeking strategies within the community.

There was caution on the use of traditional herbs, though usually safe to use when tried and tested for a long time, some herbs were noted to be dangerous as their dosages and prolonged usage were not well documented and verified. As the respondent was mostly in charge of training in establishing self-help projects and maintaining accountability of the project among the groups, he saw a key role of MAF to mobilise and train people to form Support Groups within the mountain villages around the LFDS Health care centres. Key to this was his work in educating the community he served on how to best take care of their sick and also maintain their well-being in the process.

This respondent saw a strong part of the work of MAF to be *spiritual encouragement*, possible due to his own strong and vibrant faith. God was seen to be central to the well-being of individuals, the community and the nation; central to living a life that is meaningful. He saw people needing to consciously seek to build a relationship with God; know more about God as that illuminated the purpose for one's life; in other words – one's vocation. Spiritual health within the family was reported as crucial to developing a healthy family. This was achieved through reading the Bible and encouraging the children to memorise verses. Within the community they serve, spiritual counselling was used to 'equip' the community members so as not to 'lack knowledge'.[78]Furthermore, practical illustrations about life like marriage and proper behaviour were used as vehicles to convey the Christian values when working with the community. The respondent saw a strong connection between physical and spiritual health as a balance was needed as then, 'I'll know what I should do. I'll be able to think'.[79]

[78] This was in reference to Hosea 4:6 which relates that people are destroyed because of ignorance, the equipping is in the Biblical context.
[79] L. 239 – Interview 04 – Health Care Trainer II

3.4.3.4. Interview 04 – Methalaneng Nurse Assistant

Methalaneng Health Care Centre was reopened in 2000 after having been closed due to theft. It is a strategic HCC because whilst the area is accessible by road, it is isolated by the very rugged and steep terrain. At the time of the research visit, the area had evidence of infrastructural development within the community in terms of a toilet-building project which was attractive as some villagers were using dressed stone.

The Nurse Assistant at Methalaneng HCC was a female Mosotho of between fifty-one and fifty-five years who was a single parent living with her grand-daughter. She had been working for the LFDS at Methalaneng since 2001 after having been trained at Maluti Adventist Hospital. The respondent chose nursing as a career because she enjoyed helping people in need. Her decision to apply to a government clinic was because the salary at the Mission hospital was low and, 'they are treating us as voluntary work….as an African child, I wanted not to be voluntary – to be earning, because there are needs at home for my family'.[80]

When explaining her job responsibilities she pointed out that she worked under the supervision of the Nurse Clinician who ran the clinic. Her duties included recording the daily attendance of patients, ensuring proper hygienic conditions and orderliness within the clinic and dispensing medicines prescribed by the Nurse Clinician. However, because of the remoteness of the clinics, the respondent reported that they engaged a more holistic approach. There are times she also did deliveries, or phoned for a plane if they are emergencies and so she has gained experience in sorting out transfers and others duties she would not do at departmentalised hospital.

Because of her work in a remote area, the respondent saw a strong contribution from MAF to *material support* and *compassionate care*. She noted that MAF was using the clinics as distribution points for food packages from other organisations like World Vision or Dorcas Aid to address the nutrition challenges which were sometimes delivered through MAF aircrafts. She was herself involved in managing logistical challenges as the aid distribution service was mostly

[80] L. 69 – Interview 03 – Nurse Assistant. (The research understood the term 'African child' can be viewed as a literal translation which normally refers to the cultural expectations of an extended family on one who is working to support others in the family).

left to the already short-staffed Health Care Centre personnel who were already struggling to cope with their nursing duties. This meant she spent time managing disputes within the community of who is entitled to receive the hand outs as some patients would complain to the Health Care Trainers that they were being left out as some community members had believed that just being a patient should have entitled them to food aid. The food supplements were only for pregnant mothers, under-weight babies, TB, and HIV and AIDS patients.

Alongside this role of managing the *material support* and *compassionate care* her role as a nurse meant she saw MAF making a strong contribution to *knowledge giving* in the community through various training and educational interventions. According to her assessment, among the mountain villagers illness was caused mainly by 'lack of knowledge'.[81] The mountain villagers had no access to health education and this had made them ignorant of basic hygiene and dietary requirements. Ignorance as to the proper nutritional value of the agricultural products they farmed contributed to poor nutrition which resulted in ill health. She also promoted personal hygiene and cleanliness by encouraging using covered, clean water, using the toilet and following a balanced diet were stated as crucial elements of maintaining health. These could be maintained if the health seeker has access to and applied the knowledge on how to maintain good health.

Of particular concern to her was *knowledge giving* in the area of sexuality. She reported that the cultural practice of marrying too young; at 12 years in some cases for girls, or being sexually active at a very early age was noted as a contributory factor to sexually transmitted diseases at an early age. She sought to counter balance this through knowledge giving. Workshops on sexuality and STDs were conducted with the different groups in the communities like, 'the youth, the adults, and the witch doctors who were responsible for circumcision.[82] These had a positive impact as she reported that some community members had made further private enquiries for clarity on some issues. They followed up the workshops with counselling, encouraging treatment of couples and issuing condoms. Clarifying benefits of preventative measures was critical because though how to use a condom was common knowledge even

[81] L. 123 – Interview 03 - Nurse Assistant
[82] L. 167 - Ibid

among the shepherd boys, the problem arose as to understanding the benefits of using one and the availability of the condoms in the remote areas.

In terms of *spiritual encouragement*, the respondent concluded that religious values humanise us and are beneficial to the wider community's health. As a health provider she has counselled patients who were stressed or suicidal because of life's challenges. Bringing hope and promoting harmony in any situation was seen as critical to assist patients overcome life's challenges. In her response as to where she felt she found her source of strength to do the work she did in difficult circumstances, she stated that she had a mentor who assisted her and encouraged her to read the Bible. This had led her to deepen her understanding and knowledge of God's purpose in her life. Her understanding of death had been redefined from a spiritual perspective.

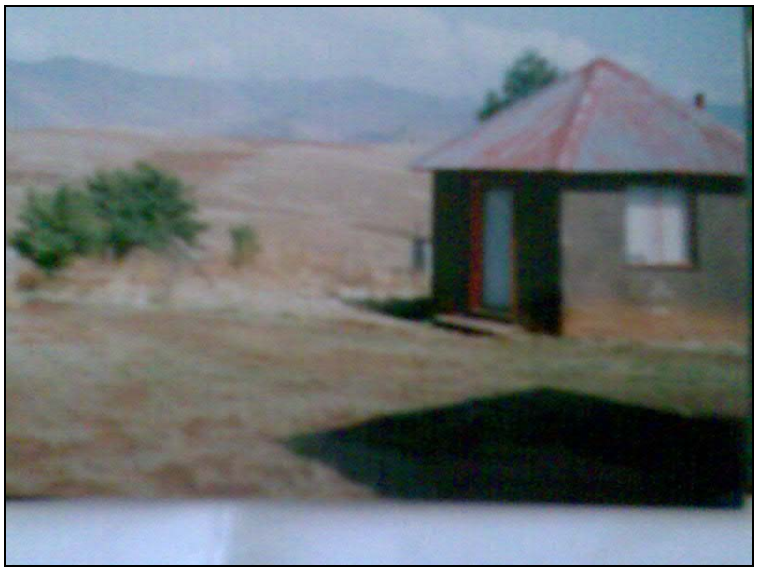
3.4.3.5. Interview 05 – Nurse Assistant – Matebeng Health Centre

Matebeng HCC site was on a highland plain which steeply drops into a scenic river valley that was bordered by majestic stratified yellow limestone boulders, similar to those in the 'Golden Gate' route in South Africa. The villages around the HCC were fairly developed with sanitary facilities reasonably visible on most homesteads around the plains closer to the centre. However, the more sparsely located villages further from the HCC comprise mostly of mud and dagga huts that vary in habitable standards. Dotted among these were houses built from concrete blocks which normally belonged to a retired miner or some other migrant worker.

The researcher had the privilege of meeting one of the traditional musicians who was playing his traditional two stringed harp. (see photograph below) and also spent her resting time making beadwork necklaces for the villagers.

The HCC itself had three buildings and our team had to use the clinic's two-bed ward for accommodation. Our male team member had to share a hut with the security guard. The general condition of the clinic was fair, except for the neglected unhygienic condition of the ward we used as our sleeping quarters.

One of the views from Matebeng HCC with the guard's hut in view,
showing the distance the team had to walk to the mountains in the background.



The researcher with the Traditional Musician at Matebeng HCC

The researcher later found that the responsible authorities for repairs, supplies and general logistical support were very unreliable, as evident in the absence of any medication (which the Nurse Assistant had to collect from the hospital at her expense to be reimbursed later). This posed a difficulty for the researcher to create a positive atmosphere conducive for a resourceful interview. Thus this case study did not offer as much in-depth data as it was difficult to motivate

the respondent to tell her story. Answers seem to be 'press reviewed'[83] and brief, limiting the scope of data for analysis.

The Matebeng Nurse Assistant was a female Mosotho of between forty-one to forty-five years old. She had been posted to Matebeng on a rotational basis for an original six month period but had been at this post for one year and two months at the time of the interview. The respondent was a single parent of two boys who resided in Maseru as she felt there was better schooling there. She held a certificate as a Nurse Assistant from Thaba-Tseka (Paray) Hospital which is under the Roman Catholic Church.

The respondent was clear of the contribution of MAF to *curative interventions* and *material support*. She noted that the HCC was in dire need of repairs and medical supplies so that it would render a meaningful service to the community. The clinic did not have any medication at all at the time of the interview. It was reported that in order to get any medication, the nurse needed to close the clinic for a day so as to travel the four hours by bus to Matebeng. Furthermore, there was an inefficient administrative set up between the Health Centre and the District Hospital which was causing a lot of stress for the personnel at the Health Centre. The introduction of the MAF initiated Support Groups was reported to have been a very positive and helpful move. There was reported harmonious working conditions as the Health Centre would assist the Support Group members with any information about treatment and replenish the kits if need be. (Though noticing the run down state of the clinic itself, it was difficult to ascertain how successful this was).

The respondent had little to say about intangible assets. Even though she used to talk to patients about God during treatment, she had stopped doing so. She attributed this to the heavy work load as she was running a clinic without the Nurse Clinician. On top of this, morale for the staff was very low and it was difficult to maintain acceptable hygienic conditions as workers seemed not motivated to work. There was also no *spiritual support* as the respondent reported that there was

[83] Press Reviewed is a term that Philippe Denis uses to describe answers that respondents give to please the interviewer, or which are safe enough to release, without threatening the comfort zone of the respondent.

no church nearby by to attend. The church assembly that was present in the village seemed to comprise of members of different denominations which the respondent did not attend.

The respondent was operating a Health Centre under very trying conditions. These conditions affirmed the sentiments of some villagers that the government had forgotten them. The research team had to use the maternity ward and entrance to the clinic as living quarters. The atmosphere seemed to be one of resignation, but one which the villagers still flocked to every morning hoping to get treatment. These circumstances had not deterred the villagers, even when having to cross a river thirteen times to get there; that was persistence displayed in face of adversity. In this case the simple presence of the centre supported by MAF in such a marginal out-of-the-way place is a key asset.

3.4.3.6. Interview 06 – Methalaneng Chieftainess

This interview was included to assess the interaction between MAF activities and the local leadership, namely the chiefs. As already mentioned, the chiefs are an essential part of the initiation and continuation of the HBC projects as they facilitate for the introduction, recruitment and training of their community members in palliative care for the ill members within the community. The interview was of the Chieftainess of Methalaneng and Mantsonyane, which comprised of 22 villages. At the time of the interview the respondent was seventy-five years old, very eloquent in English and eager to tell her story. She had been the Chieftainess since 1968, two years after her husband's death on the 22nd July, 1966. The Chieftainess' memory was impressive and she became the subject of her story. Some of the facts were difficult to verify though some DFID personnel confirmed coming across the records of road-making in Methalaneng. The role of individuals was portrayed from the Chieftainess' perspective and the physical evidence collaborated the facts of how infrastructural development began in Methalaneng.

The interview was administered over two days, the 9th and 10th of September 2004 because there were frequent disruptions to the interview process due to visitors to the Chieftainess. Also being

a diabetic patient, the respondent expressed fatigue and needed to break to prepare her food early as she was hungry.

In terms of tangible assets, the Chieftainess spoke of the importance of MAF in terms of the remoteness of the villages. Several infrastructural development projects that she initiated opened up the surrounding villages to economic and social development. She reported that she mobilised villagers to work on road construction to use for the transportation of the sick and dead, since the terrain is very rugged and would only be covered on horseback. The government then introduced food for work, and money for work, which only motivated the people when it was available. The road was never completed in other sections because the finances had stopped, but the one to the District hospital in Mantsonyane was later connected under government initiative. She oversaw the building of the clinic, and the clearing and construction of the air strip, which she reported was a very challenging task, since many members of the community, 'Say what I am doing – it's because I am mad'.[84] The villagers did join in later to help construct the air strip. The air-strip was seen as crucial because of the support from MAF to the community.

The Chieftainess saw the importance of *knowledge giving*, *moral formation* and *spiritual support* for health care, but did not report of much contribution from MAF in this regard. The cause of disease was attributed to God by her; it was a way to remind people to pray and not forget God. Sickness was sometimes God's way of testing our love and commitment, healing us when we respond positively. God's role was perceived as the tester and healer. HIV and AIDS were perceived to be God's attempt to deter people from adultery, whilst the introduction of condoms was not discouraging the young generation from being promiscuous, but teaching them to 'do it with condoms'.[85] Of interest was the Chieftainess' comment on the health promoting strategies was that she felt helpless in maintaining traditional values in face of the new health promoting strategies. She was disappointed that modern teachings were ignoring the values that Basotho used to adhere to. There was no longer the community spirit that used to govern the people to uphold common values and build up the pride of being a Mosotho. How this interfaced with MAF and some of the ideas of the MAF workers would be an interesting challenge for the future.

[84] L. 9 – Interview 06 – Methalaneng Chieftainess
[85] L. 170 – Interview 06 – Methalaneng Chieftainess

3.4.4. Findings from the Participant Observation in Group Sessions

There were four Support Groups that met with the researcher during their report meetings with the Health Care Trainers. The researcher was then given time to conduct group interviews with the Support Group members.

These group sessions were intended to initially follow some guiding questions in order to extract the information pertinent to the research question. This became unfruitful due to the language barrier and as a result most responses were simply affirmations to the questions posed. The researcher then decided to allow the group members to share with her how they were finding the work that they were doing and be a participant observer of the report sessions. The findings thus reflect the different issues that were specific to the different groups and their situations.

i. The commitment of the Health Care Trainers to monitor and develop the support groups to be more effective in the palliative care and income generating projects by patiently assisting and encouraging them during the visits.
ii. The rapport observed between the nurses at the HCCs and the Health Care Trainers as they expressed a moral duty to serve the mountain communities during informal discussions enhanced the HBC effectiveness within the community as there was coordinated efforts to maintain health.

3.4.4.1. Group Session with the Nkau Support Group Members

The group session meeting at Nkau was held on the 24th May 2004 in one of the support group member's house. This group session was an important learning lesson about crucial aspects of the dynamics of the narrative methodology referred to by Chase and Colleen S. Bell when they say,

> When we treat those we study as subjects – we open ourselves to interaction, to intersubjectivity, to other's understandings of and relations to us as researchers.[86]

[86] Chase and Colleen S. Bell, 'Interpreting the Complexity of Women's Subjectivity,' in Evan McMahan and Kim Lacy Rogers (eds), *Interactive Oral History Interviewing*, Hillside, New Jersey: Lawrence Earlbaum Associates, 1994, p. 64

In this case, the researcher had to adjust the methodology to create a more culturally conducive climate that could allow the respondents to feel safe to share their experiences with a 'stranger' in this rural setting.

The key asset that emerged from this discussion was *compassionate care*. The members were grateful to be able to assist the critically ill members of their community, but felt that they needed more information and training from the Health Care Trainers to be able to confidently do it. One of the support group members had previous training and experience in home based care as she has been recruited to be a Village Counsellor (VC) by the Ministry of Agriculture in a programme they had run before. She would assist the other members when in doubt of the correct care to administer to their patients. The group reported that they had no problems from their families or the community about their work, people were grateful that they had offered themselves.

The experiences of the group session developed an appreciation of the need to cultivate trust, a relationship between the researcher and the respondent that affirms the respondent whilst allowing the researcher to get information through the shared experiences.[87] The asset of trust echoed by Gary Gunderson[88] and Cochrane and Germond[89] when discussing the dynamics of relational experiences was affirmed by the process of the group session of the Nkau support group.

3.4.4.2. Group Session with Matebeng Support Group

The trip to this village was challenging as we were tired and blistered from the previous day's trip in search of another Support Group that had been given gardening implements and seeds and was supposed to have been running a vegetable garden. We left the clinic the morning of 15th of

[87] Philippe Denis explains how context affects methodology in , 'Oral History in a wounded country,' p. 205 216.
[88] Gary Gunderson, 'What have Hospitals Have To Do with Health' Exploring the Relationships among Religious Disease Care Systems' in ARHAP International Colloquium (2007) *Collection of Papers* (Monkey Valley Resort, Cape Town, South Africa. March, 13 – 16, 2007), p. 3
[89] Cochrane, James and Paul Germond, 'Healthworlds: Conceptualizing the human and Society in Nexus of Religion and Health.' Unpublished paper.

October 2004 at about 8 in the morning. After a very steep descent from the clinic plateau we walked along the river valley, crossing the river thirteen times before we climbed up two adjacent mountain to reach the village, about 3½ hours later. Evident along the river bed were huge dongas where the soil had been eroded after the rainy season. Deforestation had reduced the mountain slopes to mainly stony landscape dotted with shrubs. Some villagers could be observed gathering the small scrubs for firewood, as there were scarcely any trees around.

The village was quite isolated from others and had new district boundary demarcation problems as they were now falling under Matebeng clinic, which was further away than their previous HCC. The only domestic animals observed were a few chickens and a pig that was not penned, but left to roam the yards for food. The cattle and sheep were with the herd boys further out in the mountains, where it was reported they could be for days or weeks at a time. After being introduced as a pastor's wife to the group and given a Sotho name, Tsepo (which means Hope, the researcher's middle name), the researcher was requested to open the meeting in prayer.

3.4.4.2.1. Findings from the Support Group in Matebeng Village A

The researcher observed conflicting aspects of *compassionate care* and *spiritual encouragement* in the following findings: The headman of the village had been ill for a while and needed medical attention but it was reported that there was no horse to transport him to the clinic as their last three horses had been stolen. There was a cloud of suspicion around the headman's illness as some of the Support Group members felt that it was punishment for his ill treatment of his late mother. He had forbidden the support group to attend to her as he had accused her of witchcraft. The group was visibly upset over the headman's illness as they did not know how to respond to the situation. The Health Care Trainers listened to the issue, but left the decision in the hands of the support group. (We later learned that the situation was tense because one of the support group members was the headman's wife.)

Palliative Care issues like checking on patients and feeding some of them were reported to be intense on participating members as other members were not attending the duties because of early summer field preparations. The support group member who was responsible for the

medical kit was questioned about the alleged personal use of the contents that had upset some of the members and the community. The issue was not resolved as the kit was not there for inspection. It was however reported that the kit needed more Vaseline and pain relief tablets.

The group was friendly and tried to communicate with the researcher. It was a warm atmosphere even though there were serious issues under discussion. It was clear that the key asset that such a group offered was compassionate care and some material assistance, through their links to MAF.

3.4.4.3. Group Session with Methalaneng Support Group I

Methalaneng HCC is situated on a plateau amidst pronounced deep valleys and high mountains that separate the sparse located villages mainly near the tops of the lee side of the mountains. Access to the villages north of the clinic involved descending about 300m on a very steep slope that would almost amount to 700m as one would move zigzag to maintain balance.

The first support group session in Methalaneng was in a village about three hours from the clinic on foot, using the shorter way. This though was very treacherous as it involved navigating your way upon a half meter wide path on a cliff edge. (We opted for the longer trip back.) A guide came to assist us get to the village on the morning of 8th September 2004 and took us to the headman's homestead. On departing we were shown the hut used as the post office and magistrate's court. We were informed that the court is held once a month and cases that the headman and chief could not resolve were brought before the magistrate who would come from Maseru.

We also visited a client of the support group who was very old and critically ill. She had no food and besides the support group member who lived some distance from her, there was no one to care for her except for a old man who was her neighbour. When we met her we noticed that the old man was trying to cook some crushed mealies using pine leaves as there was no firewood. It was a very moving sight as one could notice the dire situation the woman was in. The support group member tried to assist in the cooking but we had to move on as the headman was waiting for us. (We were informed after two days that the woman had passed away that same evening).

On arrival at the headman's place we were informed that the headman was absent and had to wait for him for about 30 minutes. He had to follow up a case of cattle theft, which was becoming a problem in the area. The village homesteads around showed signs of pride in their ethnicity as some houses traditional decorations with red mud and paint. When the headman arrived we were introduced and then he took us to another village where the meeting of the support group members was to be held. The researcher was introduced by the headman who informed them that they were free to go about their business as I was to observe.

There were thirteen members from three different support groups present. There was a strong focus on intangible assets, particularly *knowledge giving* and *spiritual encouragement*. Group members were requesting better direction from the Health Care Trainers as different approaches to their task was bringing confusion in the groups. The headman requested more regular visits from the Trainers as it motivated the members and affirmed their status as legitimate within the communities. The female members were quite vocal on this issue, reporting that some of their members had dropped out after being accused of being Satanists tying to hunt down their dying victims. The headman and trainers encouraged the members to resist these accusations, rendering them to be petty jealousy ploys by trouble makers. Of interest was the fact that the presence of a visitor (the researcher) was regarded as a welcome affirmation of their valuable work and the 'visitor' was requested to bless the meeting in a closing prayer.

In terms of tangible assets, the clinic's delay in replenishing their kits was an obstacle to their progress as most of the kits now had only some few bandages and no methylated spirits, gloves or ointments. The members seemed eager to be empowered to do their work skilfully. Though they had some challenges from some members of the community, those present seemed determined to carry on. The visit from the Trainers had boosted their morale and all the members cheerfully walked the visiting team up to the end of the village before turning to go to their own homes.

3.4.4.4. Group session with Matebeng Support Group II

On the 14th October, 2004 we left the clinic just after seven to visit several groups and monitor their progress. We only found two members of the first group we visited who reported that the other members were busy in their fields. The Trainers then requested to get an update of the progress on the gardening project but the members were reluctant to take us to the plot of land, explaining that they had not cleared the land yet as they were busy preparing for the coming planting season. The Trainers cautioned the members of not keeping to their promises and warned them not to misuse the seeds and implements they were given. The headman of the village assured the Trainers that he would encourage the women to work on the garden and there would be a better report next time.

We then processed to the village that the trainers had supposed was just beyond the next mountain but which turned out to be almost 3 kilometres from our first stop. We met the members of this group who had been waiting for us by midday and the meeting was convened.

These support group members saw the MAF project contributing a lot in terms of *material support.* This included the provision of fresh and nutritious vegetables for the clients the support group attended to, which provided the support group members and their families a source for nutritious diet. This also provided a source of income for the support group through the sales of products to the other community members, and created a fund that the members could draw from to assist some of their clients and each other with finances from time to time.

There was a long discussion about finance, and allegations of mismanagement. The session revealed some of the challenges and expectations that were required from the support group which were sometimes not their expressed needs. It highlighted how 'expert' induced programmes can complicate rather than resolve problems; reducing the community members to be clients rather than agents of their own destiny.[90] The focus and energies of the support group were being spent on secondary issues which seemed to be affecting relations in the group and

[90] The concept of agency is illustrated in the book and Kretzmann, P. John and McKnight, L. John (1993) *Building Communities from the Inside Out: A Path Toward Finding and Mobilizing Community Assets.* Evaston, Illinois: centre for Urban Affairs and Policy Research.

between the group and the community. The palliative care activities were not referred to at all in the meeting.

This focus group session revealed the complicated nature that HBCP members have to sometimes negotiate when executing their duties. The voluntary nature of such activities portrayed the need to holistically conceptualise the dynamics of the relations and health provision strategies that need to be employed in such set ups.

3.5. Conclusion

We have reported on the interviews and group discussions. The next chapter will now analyse this data in view of the two-fold research question: "What can we learn from an engagement with MAF about (i) the relationship between religion and health in Lesotho in terms of practices and (ii) How can this assist us in our understanding and encourage Christians' contribution to health?

CHAPTER 4

ANALYSIS OF THE PRACTICES OF RELIGION AND HEALTH IN MAF LESOTHO

4.1. Introduction

In chapter 3 we presented the data that emerged from the literature review, participant observation and organic interviews. We are now going to analyse these findings in light of our two-fold research question: "What can we learn from an engagement with MAF about (i) the relationship between religion and health in Lesotho in terms of practices, and (ii) How can this assist us in our understanding and encourage Christians' contribution to health? This current chapter deals with the first part of the question, and the next chapter deals with the second part of the question.

For presentation purpose, the analysis articulates the findings as they are categorised within the six clusters identified in 1.4.1. above that separate the tangible and intangible RHAs; these being spiritual encouragement, knowledge giving and moral formation under the intangible RHAs and the tangible RHAs being compassionate care, material support and curative interventions. Another aspect of RHAs we will consider is that ARHAP identified in Lesotho was presented as relational ambition, which referred to the complimentary or symbiotic relationship that was depicted in the application of these RHAs. It is within these categories that we attempt to answer our research questions outlined above.

Our findings are summarised as follows:

1) The work of MAF is driven by compassionate care, which is experienced in tangible ways by the people served by the HBCP programme
2) Compassionate care leads MAF to offer material support and the possibility of curative intervention through specialised and deliberate aircraft transport to otherwise inaccessible rural communities
3) Spiritual encouragement is crucial for MAF, and this assists in the building of trust between MAF and local Basotho.

4) MAF uses its assets in relationship to many other agencies, and these networks are themselves an important asset, highlighting the importance of relational ambition.

We will now examine each one in turn.

4.2. Finding 1: The work of MAF is driven by compassionate care, which is experienced in tangible ways by the people served by the HBCP programme.

MAF's HCBP grew out of the compassion of the pilots who had to ferry critical patients to the hospital where most of them would die in an alien environment.[91] This compassion was translated into action through the establishment of the HBCP that then tapped into the agency of the local leadership and ordinary community members. ARHAP's report for the WHO reported that compassion, this characteristic of religious entities, is critical in facing the health challenges posed the HIV and AIDS as it affords communities to build up their capacities to solve their own problems.

Gary Gunderson elaborates on these relational virtues above by noting that

> These virtues do not compete with technical and scientific competences. ...we are beginning to see that relational virtues make the technical virtues accessible to the human networks in which technique must eventually find value.[92]

FBOs that are pioneering agencies have the ability to adapt to situations quicker than established bureaucratic institutions because they can approach their target communities with an attitude of discovery and flexibility. Kreztmann and McKnight emphasise the need for agencies to be flexible and innovative in their approach to development.[93] This is a crucial aspect of development since perceptions about challenges can be better informed through practical engagement with the existing environments than by mere external observation.

Flexibility is also noted in the personnel delivering the services, as is illustrated by the pilots who would assist in deliveries or emergency health needs as there were transporting patients to

[91] Interview 1, l.
[92] Gunderson, 'What Do Hospitals Have To Do With Health? p. 4.
[93] Kreztmann and McKnight, *Building Communities from the Inside Out*

hospitals. Support group members also displayed this versatility by being teachable and willing to learn new skills to help their community members. Skills for palliative care and entrepreneurial skills did not only benefit the community, but enriched the individuals involved to enhance their agency within their communities and in their own lives.

4.3. Finding 2: Compassionate care leads MAF to offer material support and the possibility of curative intervention through specialised and deliberate aircraft transport to otherwise inaccessible rural communities

The supply of volunteer pilots, engineers and planes to countries with hard to reach areas makes it possible for health personnel, missionaries and local communities to partner together in providing and enhancing health care strategies in remote communities. This creates a rich intercultural and dynamic interaction that promotes the inclusivity of marginalised communities into the wider society. MAF material support assets thus illustrate how specialised services delivered through such FBOs can enhance well being in otherwise remote communities.

MAF's nature of transport put them in a critical position when it came to response to natural, civil and other emergencies or in situations where other modes of access were remote or nil. Such specialised and focused response in agencies is life-saving in countries where the infrastructural, socio-economic or environmental challenges surpass the governments' capacities to offer adequate response. Even where governments are equipped to deal with such emergencies, the bureaucratic nature of their services often delays or curtails the response; and in turn endangers or marginalises the communities that are in need of such services.

Another crucial asset presented in the rapid response of aircraft transport by MAF is that it is specific and targeted to the location in need. This is possible because of their versatile and small planes that can land on gravel or water. Besides the prompt supply of materials or personnel, the targeted response of such organisations can minimise potentially catastrophic results or loss of lives. MAF's response to the *tsunami* and earthquake survivors[94] are some of the examples of the specific and targeted response possible for MAF.

[94] Visit MAF website at www.maf.org for details on their dictator response activities.

The nature of tangible RHAs employed by MAF indicate a gap filling approach that is vital to the delivery of health care to the marginalised communities in Lesotho. Besides the formal relationship that exists between MAF and the LFDS, MAF has also responded to other health needs that the government has limited resources to address by establishing the HBC programme. They have engaged the community at a local level, thus tapping into the communities' assets and capacities to improve their own well being.

We can assert that RHAs, besides those that are applied within the formal health system in Lesotho, such as the outworking of compassionate care, can make a crucial contribution to well being when they are harnessed and focused such as in the activities of MAF. This added role that FBOs can contribute to the delivery of healthcare in a context where they are already playing a significant role alongside government efforts in the formal health system underpins the relevance of religious entities in maintaining well being.

The ability to respond rapidly to needs due to aircraft transport also enabled MAF partners to effectively carry out their programmes without wasting time in travel. Critical patients are air lifted to Queen II hospital where imminent death would have prevailed as specialised services are not available in the HCCs. In a country challenged by a 23.2% prevalence of HIV and AIDS for adults between 15 and 49 years of age[95] and the opportunistic illnesses associated with it, MAF's contribution to the well being of Lesotho mountain communities affirm Amartya Sen's[96] argument that healthy conditions are central to measuring the success of development.

One eminent technical asset that MAF uses in Lesotho is the GIS tracking system for their flight patterns: a very useful resource in the rugged terrain of Lesotho that they have shared with the national military air force at several occasions. This technology illustrates how FBOs can contribute to national development through introducing technological assets that are at their disposal through their networks. Local personnel are exposed to such resources and can gain skills that are necessary to stay abreast with global trends.

[95] UNDP,(2007) *Lesotho National Human Development Report 2006: The Challenges of HIV and AIDS, Poverty and Food Insecurity*, (Morija Printing Works; Morija)
[96] Amartya Sen, (1999) *Development as Freedom* (Anchor Books: New York)

4.4. Finding 3: Spiritual encouragement is crucial for MAF, and this assists in the building of trust between MAF and local Basotho.

Spiritual encouragement is evidenced by the whole praxis of MAF; based on the conviction that the activities they engage in are fulfilling God's purpose in their lives and the lives of the communities they partner with. In the religious context of Lesotho, this builds a strong element of trust between all the role players. When an FBO displays interest in the welfare of the community that is convincing, there seems to be a reciprocal response to enhance such efforts and in turn build the capacities of the local community members. Community members' agency in promoting well being is displayed in their willingness to assist each other in maintaining a healthy community. The crucial religious asset of trust was cited in several ARHAP research reports and papers as a fundamental asset that is

> responsible for the life of the asset, its reliance, effectiveness and positive role in the lives of its patients and communities.[97]

Trust is also portrayed as a motivation to engage in the sometimes unpredictable and foreign missions that some of the expatriate staff carry out. In this instance, it is directed to God, whom they trust to protect and empower them to reach out to the communities they are serving. Gunderson explains these motivations as

> part of a system of healing and hope in which standards of care that God has made possible are not experienced unless some group of humans make it so.[98]

The assets analysed above illustrate how the sense of mission played a significant role in motivating MAF to engage in the activities that they do. The decisions of the expatriates to venture into sometimes unknown, volatile situations illustrated a deeper conviction of a calling that was meaningful to them.[99] Thus spiritual encouragement was not just something that MAF offered to others, it was very much part of the 'driver' of their own agency.

[97] Gary Gunderson, 'What Do Hospitals Have To Do With Health? p. 3
[98] Gary Gunderson, "What Do Hospitals Have To Do with Health?' p. 6
[99] Amartya Sen advocates that people want to live lives that are meaningful to them to achieve personal or community health.

4.5. Finding 4: MAF uses its assets in relationship to many other agencies, and these networks are themselves an important asset, highlighting the importance of relational ambition**.**

MAF Lesotho is part of an international organisation whose elaborate infrastructure of both tangible and intangible assets positions it to render crucial services in the countries that it operates. The elaborate networking system developed by MAF enhances its agency as it draws from several assets and the agency of the Christian community that identifies and responses to its vision and mission. Several religious assets interplay in this network, such as the role of *identity* with the Christian faith spurring individuals and communities to engage in the MAF activities, either directly by offering their expertise; or through the prayers, financial contributions or other logistical support some which are outlined above[100].

Furthermore, MAF's response is usually married to the governments' efforts or pleas when addressing challenges to a nation's welfare or stability. This deliberate approach to partner or support government service delivery enhances the agency of local institutions and exposes them to experiences that may improve their skills level. Thus the symbiotic relationship illustrates synergies that empower the partners involved, confirming the notion of *relational ambition* and empowering relationships advocated for in community development.[101]

Emanating from this network of assets is MAF's effective management of the different aspects that are connected to it that makes it effective in the implementation of its programmes. The relationship among these assets is symbiotic in its function; each asset would have minimal functional use in the local environment of function if it did not feed from the support or function of the others. In other words, the expertise of the pilots or the willingness to financially support missions would not impact the rural Mosotho if the two assets were not connected by a common, stated vision. Such an illustration of motivation to engage in community development concretise the intangible RHAs that religious entities possess, as affirmed by Gary Gunderson when he remarked that

[100] See point 2.7.1.2. in chapter II on the summary of the activities of MAF or visit www.maf.org
[101] Steve de Gruchy, Notes on ABCD.

> religion is an organisational asset that contributes to the capacity of the living web ….. to find connection, coherence, agency, blessing and hope with the larger life of the systems.[102]

The partnering of MAF with other missionary organisations, FBOs, NGOs and government departments to deliver services to the rural communities further enhances MAF's role in national development in Lesotho. It is however important to cautiously plan for such partnerships as they can spread the limited resources too thinly to have a significant impact on the target group. As noted in chapter II, Lesotho has 40% dependency burden in a population where 80% are rural settlement depending on farming on fragile soil. This underpins the need to harness and manage available resources that are accessible to the remote communities.

MAF tactfully avoided this trap by sourcing a different donor and recruiting more local personnel to address the health care needs of the communities through the Home Based Care Project (HBCP). They also enhanced the agency of other FBOs by partnering with them to contribute other needed resources like food parcels and evangelistic outreaches by offering transportations to the inaccessible areas.

All these efforts need the involvement of the national government and ownership by the local community if they are to be sustainable. The HBC support group demonstrate such a step by MAF as they are now involved in income generating projects to create wealth from within the community[103]. MAF hopes that these activities and many by other agencies will be translated into infrastructural development that can lessen the country's dependence on aircraft transport as the rural areas become accessible by road, this still has to be seen; an attitude essential for an effective approach to sustainable development.

MAF requires its volunteer missionaries to spend a year personally visiting congregations and individuals and requesting their financial and spiritual support in order for them to be able to be sent out into the mission field. This tactful approach of allowing a relationship to be formed between the volunteers and their sponsors develops a bond and commitment that can foster

[102]Gary Gunderson, "What do Hospitals Have To Do with Health"…p. 4
[103] Kreztmann and McKnight, *Building Communities From the Inside Out...*

accountability and loyalty. This asset builds on the common faith and outreach spirit that FBOs and churches advocate amongst their members[104].

4.6. Conclusions: Lessons about Religious Health Assets.

The relationship between religion and health as illustrated in the activities of MAF illustrate a positive engagement that has enhanced well being in the mountain communities of Lesotho. It has motivated the agency of MAF, its health partners and the local mountain communities to address health challenges, especially those posed by HIV and AIDS in a coordinated effort. This has also illustrated how FBOs can contribute significant to the well being of communities they serve if they apply their assets in collaboration with other role players of health care provision.

Our focus has been on how the practices of MAF inform us in terms of the ARHAP hypothesis on the nature and function of RHAs. The services of MAF in the remote areas of Lesotho illustrate the critical role that FBOs are playing in the delivery of health, especially within the marginalised communities of the countries they operate in; thus confirming ARHAP's notion of tangible and intangible RHAs contributing to well being. Their holistic approach to well being enables them to address several health needs as they utilise tangible and intangible RHAs that enhance each other. This comprehensive use of RHAs however, poses a challenge to the AHRAP matrix categories of direct and indirect assets, as the impact of qualitative assets like faith or prayer becomes complex and difficult to categorise in cases where people believe that their healing was a direct result of prayer and faith.

We see in the Lesotho multidisciplinary approach to health care provision, a wealth of assets that are interacting and developing through time. A number of FBOs have impacted upon remote, marginalised communities whose well being is challenged by natural, socio-cultural, religious and economic forces. The tangible and intangible RHAs create a strong base for the enhancement and tapping of the agency of the communities that MAF serves and partner with.

[104] Galatians 6:10

The relationships that the health care strategies MAF have employed have enabled it to spread its influence and effectiveness as it is motivated by Christian ethos of love and outreach.

CHAPTER 5

THEOLOGICAL REFLECTION ON APPROACH TO HEALTH: FORGING A HOLISTIC PATH IN THE PLURAL HEALTHWORLDS

5.1. Introduction

In the previous chapter we engaged the findings of our research by analysing the nature and function of the RHAs presented in chapters 3. We confirmed the critical role that FBOs can assume in health delivery when they align their assets to address community health needs in partnership with other role players.

Now in this chapter we address the theological insights that we can draw from this analysis. We examine how the insights gained in this research can inform and deepen our understanding and practice of theology as the church or faith community by suggesting the following two factors that need the faith communities' attention: (i) Stewardship of religious assets in mission, and (ii) Developing dialogical structures with other health partners.

These issues will be discussed with the goal of reflecting on the second part of our two fold question; that is ii) How our knowledge about the nature and function of RHAs can assist us in our understanding and encourage Christians' contribution to health? We will also consider the prevailing context of HIV and AIDS; a challenge that has demanded FBOs, communities and other socio-economic structures to re-evaluate their approach on health provision strategies and well being. Our point of departure will be Perry Yoder's[105] reflections on *shalom*, the Hebrew word which Nicholas Walterstorff defines as

> more than an ethical community…. (*but*)[106] the responsible community in which God's laws for the multifaceted existence of his creatures are obeyed.[107]

We will now discuss these in detail.

[105][105] Perry Yoder (1987) *Shalom*, Holder and Stoughton Publishers, London
[106] Word in italics mine
[107] Nicholas Walterstorff, (1983) *Until Justice and Peace Embrace*, Grand Rapids; Eerdmanns, p. 71

5.2. Stewardship of Religious Health Assets

5.2.1. Employ a Pragmatic Engagement of Religious Assets

Our analysis revealed a rich presence of religious assets that are available for churches and faith communities to draw from and impact on the communities that they serve. The spiritual energy that religious entities bring to the health arena needs a conscious and pragmatic approach that demystifies its nature and makes it accessible to the ordinary health seeker or provider. Faith communities need to appreciate and utilise the synergies created by intangible religious assets by ensuring that their approach to health enhances those values of humanity they hold valuable to portray the attributes and image of God. Faith communities need to promote the agency of their members by embracing the diverse assets that they bring to the organisations that can be utilised to participate in *Shalom* making.

5.2.2. Enhance Stewardship by Promoting Inclusivity

Stewardship of the assets that God has availed to the church also needs proper management for them to achieve meaningful development. Even in cases where doctrines fully portray the *Shalom* love, FBO praxis has been insufficient to fully embrace those who are seeking well being. Faith communities should draw from

> an understanding of life as an interconnected whole, the ultimate well-being of the individual can hardly be disentangled from the well-being of the others.[108]

MAF activities portray how religious convictions can be translated into pragmatic programmes that enhance the quality of life and incarnate what Jesus promises to usher to humanity; life in abundance.[109] When religious entities highlight the innate value of human life and the capacities that are invested in it, they can not only humanise the marginalised, but also stimulate their agency. This would translate such values as human worthiness, dignity and portray the love of God for all human kind in a more pragmatic way.

[108] Munyaradzi Felix Murove, "The Convergence of Ethical Concerns" 25
[109] John 10:10

5.2.3. Broadening the Perception of *Missio Ecclesia*

The acknowledgement by the leaders of faith communities of the resourcefulness of every member in the communities' development and mandate sets the stage for focused interventions to solve local challenges. MAF portrays how religious entities can choose to have focused impact that taps on the human resources available and fulfil their mission to reach out to the world with the love of God. This approach recognises that religious entities can participate in efforts to maintain well being amongst their communities by bringing scarce skills and resources that would otherwise not have been at the localities' disposal.

When religious entities affirm the holistic nature of *bophelo,* it is pertinent that they start by evaluating whether the structures and doctrines that they adhere to are enhancing meaningful livelihoods of their members and the communities they are in. Yoder argues that

> If the coming of shalom demands a transformation, should not the church be leading the way in dismantling the structures of oppression and death wherever they are found so that shalom, God's will, may be done on earth as it is in heaven?[110]

The challenge is initially to reflect on the perceptions and ideologies that have shaped our conceptualization of being and the images that this has created about the Christian community; both within and without. Several theologians have engaged this debate from different angles, but women and African theologians can offer useful insights into the humanizing theologies that encompass a

> comprehensive and inclusive theological language which enables the ecumenical church … to continue with its important earlier challenges to poverty and injustice[111]

The call is for the Christian community to realign its assets to address the challenges facing its members; both within the church and in their communities. As the church has a rich and varied resource of human capital, tapping into the different capacities and skills to tackle challenges of poverty and injustice has been evident in some of its history; but so has oppression and segregation also been entrenched in some of its praxis.

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[110] Perry Yoder, (1987) *Shalom,* (Faith and Life Press: London.) 23

[111] Annalet van Schalkwyk, 'Women, Ecofeminist Theology and Sustainability in a Post-Apartheid South Africa,' in *Journal of Theology for Southern Africa,* 130 March 2008, p. 7

5.3. Developing Dialogical Structures with Other Health Partners

5.3.1 Promoting Dialogue for the Common Good

The realigning of the theological framework within faith communities is insufficient to position them favourably within the health care arena. De Gruchy[112] suggests that all players in public health care need to develop dialogue that creates common knowledge and appreciation for the assets and roles players occupy in providing health care. We suggest that here it could be pertinent to broaden *bophelo* as a tool to articulate livelihoods strategies that can promote this dialogue.

The networking suggested here challenges religious entities to reach out to other health partners and develop symbiotic relationships that are targetted at enhancing well being in their communites; to move out of comfort zones and enter into

> suffering love because it is a love manifested in struggle and opposition; it is embodied in conflict with the forces which hold people in bondage[113]

The dialogue should develop structures that can sustain communities' well being in a more holistic praxis; addressing issues that have hindered *Shalom* in the lives of members because of their social status, gender or religious affiliation.

5.3.2. Tapping into Common Goal to Maintain Well Being

The ability FBOs have to draw from the faith community and other philanthropic members of society is evident in the networks that MAF taps into in carrying out its activities.[114] Whereas Lesotho as a nation might not have solicited the support of many Christians overseas to reach out to its remote communities, MAF developed this network through sharing a *Shalom* vision that motivated the support of many who identified with reaching out to the marginalised communities

[112] Steve de Gruchy, Taking Religion Seriously, p. 9
[113] Perry Yoder, *Shalom*, p. 146
[114] Visit MAF website for details at www.maf.org

around the world. Such an asset becomes a considerable opportunity to portray *bophelo* at the global village level, even transcending cultures.

This role that religious entities can occupy in service delivery is essential and significant. It however needs to be carefully articulated and managed for local communities to be the primary beneficiaries. We are referring to FBOs realising that their activities are a vehicle to participate in the *missio ecclesia* and maintaining integrity and accountability within themselves and to the communities they serve. Germond suggests that

> for the church to engage effectively in issues of development it has to be aware of the power that it wields as a religious institution as well as of the networks of power operative in the context in which it is to exercise that power[115]

Firstly, the recognition of this power has to be in the context of relationships[116] if it is to positively impact the communities in its application. Here we refer to some of the negative sentiments that have shrouded FBOs in terms of accountability[117] that have led to other health care agencies not taking them seriously. Such perceptions underpin the necessity of FBOs and other faith related agencies to communicate with other partners in health care provision as they all develop an appreciation of the power collaboration would bring to their efforts.

Secondly, it has to be in relation to the plural healthworlds that prevail in our African health context that is enshrined in health systems that have fallen short in comprehensively addressing the health needs of their communities. The general criticism levelled against health care strategies has been that they

> tend to slip back into pragmatic interventions that are largely biomedical, health sector and behavioural (and thus psycho-social) in nature, with minimal impact mitigation. The challenge --- is --- to shift and deepen the conceptual understanding underpinning the national response to a comprehensive understanding and, secondly, to reflect this conceptual shift in--- related programmes and interventions.[118]

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[115] Paul Germond, 'Theology, Development and Power', p. 22
[116] Donal Dorr (1990) *Integral Spirituality,* Maryknoll: Orbis,
[117] Barbara Schmid, 'What Value Does Religion Add to Health Services,' in ARHAP *international Colloquium,: Collection of Concept Papers,* Monkey Valley resort, Cape town, South Africa, March 13-16, 2007.
[118] UNAIDS (2003) *Turning a crisis into an Opportunity: Strategies for Scaling Up the National Response to the HIV/AIDS Pandemic in Lesotho.* The partnership of The Government of the Kingdom of Lesotho and The Expanded theme Group on HIV/AIDS, p. 34

5.3.3. Expand Symbiotic Relationships with Other Interest Partners

FBOs need to appreciate that the '*Missio Ecclesia'* encompasses participation in all aspects of life where the messianic kingdom; the kingdom where *Shalom* reigns, is being translated and inaugurated by human activity.[119] MAF portray this networking in the HBCP where local trainers are engaged as the 'boundary leaders';[120] a strategy that points out several pertinent issues that FBOs and the faith communities need to align in their programmes and praxis.

Firstly, when mobilising communities to participate in their own development, an inclusive approach that is sensitive to the cultural and linguistic context of the communities seems to enhance the agency of the local community members. This approach should be from an attitude of appreciation of the context; not demeaning the identities of the community because they have different worldviews. Germond et el argue that this has been the approach of the western healthworlds which excluded traditional and religious health care practices as inferior and thus unprofessional.[121]

5.3.4. Engaging Traditional Leadership in Health Care Provision

As mentioned earlier, traditional structures have been previously unacknowledged within the formal or recognised health care programmes mainly because of the dominance of the bio-medical approach that many governments adopted. This meant that a wealth of knowledge and their agency was not being formally utilised for the well being of community members who would often feel alienated from their familiar healthworlds environments. I concur with the UN advocating for greater involvement of traditional leaders as they

> are spread out among the people throughout the country and usually live among them. They know the needs of the people, their 'language', and are thus best placed not only to play an effective awareness-rising role towards HIV/AIDS competence, but to also offer their people counselling on the need to go for testing, treatment, care and support.[122]

[119] Perry Yoder, *Shalom*,
[120] Gary Gunderson, 'what Do Hospitals Have To Do with Health?'
[121]Germond, Molapo and Reilly, "The Singular Health System and the plurality of Healthworlds," p. 53
[122] UNAIDS (2003) *Turning a Crisis into an Opportunity:*

By developing dialogue and engaging traditional structures, FBOs can network to 'forge common solidarity' and enhance

> the capacity of the next generation of leaders in religion, (*traditional structures*)* and public health, so that they can enter this dialogue with knowledge and confidence.[123]

This engagement has to be cautiously tackled and could identify common grounds like home based care strategies employed by the different stake holders as starting points to share knowledge and experiences. These workshops could be used to gather information on the skills and experiences that traditional religious leaders and Churches utilise in addressing health challenges within their communities.

5.3.5. Aligning Development with the *Shalom* Worldview

Yoder defines *Shalom* salvation as liberation of the whole being from anything that might cause them to be oppressed both materially and spiritually.[124] Such salvation should create

> 'a society worthy of human beings', a 'humanised' society in which human dignity and the economic and social well being of the individual and the whole society are adequately promoted.[125]

Churches whose doctrines and praxis reflect this perception should demonstrate a deeper involvement of their members in participating in the *Missio Dei.* This holistic view of salvation is echoed in African spirituality as affirmed by John Mbiti assertion that in African communities,

> religion is the strongest element in traditional background, and exerts probably the greatest influence upon the thinking and living of the people concerned.[126]

The challenge is for faith communities to review doctrines that fail to tap into the dynamic impact that could come from holistically interpreting life as being religiously based.[127] If *Shalom* making is to take meaning within members of FBOs and the wider society, then there is crucial need for a marriage of the values and principals FBOs promote with public health care praxis. Development needs sustainable praxis that is inclusive and caters for all members of the society,

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[123] Steve de Gruchy, "Taking Religious Seriously," p. 10 * words in italics, mine
[124] Yoder, *Shalom*, p. 49
[125] José Míguez Bonino, (1983) *Towards a Christian Political Ethics*, Fortress Press: Philadelphia, p. 30
[126] John S. Mbiti (1969) *African Religions and Philosophy*, EAEP: Nairobi, p. 1
[127] Gary Gunderson, What Do Hospital have to do with Health?

an approach that seems to be beginning to take shape among some stake holders in the health sector, as portrayed by our research findings.

5.4. Conclusion

Whereas chapter four examined the findings of the research in terms of ARHAP's concerns about the relationship between religion and health in Lesotho, this chapter has drawn out some implications for the churches and the faith-based community. We have noted the following 2 factors that need the faith communities' attention: i) Stewardship of religious assets in mission, and ii) Developing dialogical structures with other health partners.

Thus in summarising the answers to our two research questions on the relationship between religion and health, we can conclude that MAF activities have afforded us to appreciate the ubiquity of religion in health delivery in African communities.[128] An organised mobilisation of RHAs where partnerships and dialogue are encouraged can align these RHAs to benefit and motivate communities to engage their health challenges with better results. In a conference of the United Nations, the challenge was stated as

> to broaden the impact of the dynamically growing sectors of the economy, while deepening their linkages with other sectors.[129]

This is an approach that ARHAP has been seeking to concretise through the various researches and papers it has under discussion.

[128] De Gruchy, "Taking Religion Seriously"…
[129] United Nations Conference on Trade and Development (Geneva) *The Least Developed Countries Report 2006: Developing Productive Capacities* (UN: New York and Geneva, 2006)

CHAPTER 6
CONCLUSION

This thesis is a report of a study that examined the contribution that the practices of health care by Mission Aviation Fellowship (MAF) in Lesotho made to the understanding of the nature and function of Religious Health Assets (RHAs) in Africa. The aim of the study was to gain insight into the nature and function of RHAs in the provision of health care in Lesotho in a faith based setting. The question that drove the research was two-fold: "What can we learn from an engagement with MAF about (i) the relationship between religion and health in Lesotho in terms of both practices, and (ii) How can this assist us in our understanding and encourage Christians' contribution to health?

6.1. Findings Presented through this Research

The research was undertaken as part of the ARHAP studies seeking to gain insights and deepen our knowledge about RHAs and how this can inform our praxis in health care delivery and theology and health per say. It made use of 'Grounded Theory', seeking to test some initial hypotheses through field work on the ground. Two hypotheses were tested, one to do with practices and one to do with ubiquity of religion in the seeking and maintenance of health in African communities. In terms of practices, ARHAP has hypothesized that religion and religious entities have a series of 'assets' that contribute to public health care. In terms of the ubiquity of religion, ARHAP has suggested that religion plays a significant, though sometimes imperceptible role in the holistic construction of well being that prevail in African communities.

In terms of the practices around the religious contribution to health we noted the following:

1) The work of MAF is driven by compassionate care, which is experienced in tangible ways by the people served by the HBCP programme
2) Compassionate care leads MAF to offer material support and the possibility of curative intervention through specialised and deliberate aircraft transport to otherwise inaccessible rural communities

3) Spiritual encouragement is crucial for MAF, and this assists in the building of trust between MAF and local Basotho.
4) MAF uses its assets in relationship to many other agencies, and these networks are themselves an important asset, highlighting the importance of relational ambition.

Two important lessons were drawn from these findings about practices to contribute to ARHAP theory. The services of MAF in the remote areas of Lesotho confirm ARHAP's notion of tangible and intangible assets contributing to well being. The interconnectedness of the RHAs confirmed the relational ambition that promotes the effectiveness of holistic attitudes in applying assets and creating agency. However, it was felt that the fixed categories RHAs in the ARHAP matrix (see *Table1.1.*) do not capture the complexity of the assets themselves. The holistic climate within the African healthworlds needs more comprehensive tools to unpack the interconnectedness of RHAs that are mobilised to address health issues within such communities as those served by MAF.

In terms of the ubiquity of religion in African healthworlds, the research confirmed ARHAP'S hypothesis of the holistic construction of healthworlds in African perceptions has significant underlying religious influences in health. This underlying religious influence needs to be acknowledged and understood as to its nature and function in order for it to be effectively applied. This implies that the traditional separation between secular and spiritual aspects of our lives limits our understanding of the intertwined and complicated nature RHAs that are critical in seeking and maintaining well being in African healthworlds. *Relational ambition* is a critical component of RHAs that underpins the impact of health care praxis in African communities. Applying the lessons from the discussion on *bophelo* is critical to deepen our understanding of decision making processes that affect the health behaviours of individuals and communities.

We have seen that well being in African communities is a communal responsibility that encompasses the spiritual, physical, emotional and environmental consciousness in which individuals are a part of the whole. This suggests that African agency in the maintenance of well being should be best promoted from a perspective of the common good. We have also noted that these holistic perceptions of well being bring with them complex dynamics and interactions that

need stake holders to appreciate and find common ground that they can work from. Collaboration more than conflict can be forged if communal well being is the focus of health provision rather than the different means and attitudes that presently hamper cooperation and understanding among health providers.

6.2. Theological Reflection

The research then reflected on the insights that were drawn out of the findings, highlighting the need for faith communities to appreciate their role as stewards to the assets entrusted to them. A need to engage a more holistic praxis and conceptualisation of health provision was noted. The language and ideologies influencing the praxis of religious entities has been influenced by the secular modern outlook which separated life experiences into secular and religious; a construct that ARHAP proponents argued to be insufficient to interpret African conceptualisations of well being[130].

Furthermore, in the final chapter we have argued that we need to inform and deepen our understanding and practice of theology as the church or faith community by undertaking two tasks: i) Stewardship of religious assets in mission, and ii) Developing dialogical structures with other health partners. In this way, we argue that the Churches and faith communities can best use their assets to contribute to the wellbeing of the people of Africa to bring meaningful and sustainable development that is appreciated by the communities they partner with.

[130] Germond and Molapo, 'In Search for Bophelo,

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Appendix I: Information Form for Key Informants

ARHAP Lesotho Study

Health Care Providers

Fieldwork Cover Sheet

Archive Code:

INTERVIEW DETAILS

Interviewee:
Healthcare centre:
Description:
Position:
Phone number:
Email address:
Address:

Date:
Place:
Time:

DEMOGRAPHIC INFORMATION

Age:
Nationality:
Race:
Gender:
Marital Status:
Children:
Religious Affiliation:
Education (Western):
Education (Cultural):
Time in position:
Length of contract:
Time in Lesotho:

COMMENTS ON INTERVIEW

Appendix II: Sample Interview Transcript – Health Care Trainer

INTERVIEW TRANSCRIPT

CODE: **EV HP 01 FB**
INTERVIEWER: **Evelyn Hope Chipo Vera**
INTERVIEWEE: **Noma Betty (Not Real Name) – Mission Aviation Fellowship**
DATE: **28/07/04**

Transcript:

E: This is the interview of Noma Betty by Evelyn Vera on the 28th of July 2004. Right Noma, if you can just start basically by giving your background; where you were born. --- a brief history of you.

N: I was born here in Maseru, Queen II. I don't know whether it was night or day. (both laugh). The fourth of July, 1979. My mother had just arrived from Kimberley where she was married. So – then I grew up, in fact I grew up in Qwaling where I stayed with my uncle from – Vereeniging – the one who died and we had to buy a land, build a house. Then we moved to our own ------. Then I went to school Hoohlo Primary School near the border. We used to live in Maseru West, for sometime – I think for five years. She was working at the American Embassy.

E: O. K. she was working as what?

N: As a cook actually - as a chef sort of. Then I went to Itekeng Secondary School. Form one up to Form three. Then I had to leave the secondary I had to go a high school – I had to go a high school – (Admin Reed) High School –near – it was a hill near – the Teachers Training College. And then after that I had to stay home because when I wrote, I didn't pass maths and I didn't have – my English was good but not that good – you know the English you pass but the symbol but --. And then I had to stay home – I *stayed* home. And then –

E: How long is, 'I *stayed* home?'

N: Uhmm, I think for two years, doing *nothing*. Then I had about this Lesotho Youth Anti AIDS Movement for the youth who were doing nothing who wanted to be counsellors, peer educators. Learn more about life skills and all that and be trainers of trainers. Then I went there and I was trained 1998. And then I came in 19 – in 1998 I was trained as a Youth Peer Educator, then in`99 was trained as a Youth Counsellor and then –

E: Who was doing all this --?

N: It was the Ministry of Health, under Health Education. Then I want to – Allais François to do french – *I don't know how to speak French*. I went there for nine months. And then my money ran out. Then I have to go to the computers – we didn't have them that much in those days. Then I do computers and then I got my certificate, I passed. And then *in 2000*, I was still with the youth organisation, I met Mrs Majara. At that time she was a Personnel of Agriculture with the Ministry of Agric. And then she had just opened a Youth HIV/AIDS unit – because the government said every – department or whatever government thing should have a 2% aside for the AIDS activities. So she wanted some youth to help her with the AIDS issues because they needed the young farmers or whatever who were still there at the college. And then we were appointed me and my

other friend – she's now with the CIDs. And then we worked from 2001 to 2002, and then in December 2002 –

E: What were you working as?

N: We were Peer Educators and Youth Trainers in Life Skills.

E: O. K. What does that involve?

N: It involves something like self-esteem; you know youth should have confidence in themselves. Really they should not let anything happen to them saying that, 'I'm useless and all that.' We had to encourage youth and then we had to teach them about HIV and AIDS. They didn't know anything. It wasn't our fault anyway – we thought that it was only the Ministry of Health that had to do that, but in which case it was wrong – so we really spoke about HIV and AIDS – how it's affecting the youth and the numbers that were increasing. And these youths projects that were teen pregnancy and the marital status and so – in fact that's what we did.

E: How was that experience – having to speak --?

N: *Aiya ya*! It was hell you know – you could stand up in front of all those youth – you look at them and they are so big. And you say, 'ah - ah - I'm so young and these people are so big' but you know - it's the same. The age difference ---

E: How old were you then?

N: I was something like twenty. You know, it was really scary because some of them –*eh! had lived.* Before they wanted to change - their behavioural changes, they had lived. You tell them, 'abstain from sex,' and they ask you, 'what do we do when we abstain?' so I didn't have anything. Now I thought, 'Why don't we start a youth group or something?' that's when the idea came and she said, 'Oh ya, you should start a youth group and call it a youth group – or support group or something like that.' So in different areas that we go to – different districts we went to they used to choose which name they want and then we start the youth group. We went to Mokhotlong, TY, Leribe, Mohele's Hoek, Quthing and Qacha's Nek. These are the places we went to - most of them. – some of them. And the FTC – Farmers' Training Centres ---- so we trained them. Really it was nice but. At other places you find that this youth you can see that she is sick or what - but they don't want to talk – it's very frightening. That's when my counselling skills came – ya – I had to talk to them for so long – that, 'you know, once you know that you are positive or what, it doesn't mean that you are going to die. Because the thing that they went with – the mind that they went with when they went to test – mean while they go with, ' I know I'm negative.' Only to find that they are positive – so that made them really low. So you – find that they are always afraid of other people – they just lock themselves.

E: So did you have to counsel those people who had tested positive after they've got the results?

N: I didn't *really have to*, I could talk to them after they have learned but at the clinic, at the hospitals – they were counsellors – the nurses. So we – we just advised them, 'you can go and talk. If you feel that you are seeing this and this – have you tested?' – but you don't have to push them. It has to be their own will and all that – really they would just go and come and tell you, 'I went and the counsellor was nice or the counsellor was this' – I remember I had this one friend - he died. Ya, we worked with him actually. So he said - he found out that he was positive when he was in the --- in Durban. He was sort of an Indian. He wanted to go to Saudi Arabia. He got a scholarship and then they said, 'Saudi – Saudi people you can't go there unless you have tested negative.' So when he found out

that it was late. But when he got to the hospital, there the nurse said, 'here are your results –you are positive, now go and live your life.' You know – it was very bad and he was always depressed. So we always had to be with him; talk to him; encourage him until he came out of his shell and talked ---. And then he always wanted to talk – advise the youth – how to handle everything and it was O. K. – and really - it was – I learnt a lot from him – a lot. But then he died in 2002 – in September.

E: What kind of things do you feel you learnt?

N: Oh, a lot. You have to accept yourself no matter – how people treat you – as you are when you are positive. And talking, is the medicine – is the cure. He always told me – he told me – you know, I was always telling people we should talk. Then they would laugh – but I didn't know – when they were others – how they were feeling, until he told me, 'You know, when you are in a position that you are positive, *really*, talking is the best medicine ever.' So really, I learnt that communicating and talking more is more better than just keeping quiet and --. And then, he liked talking to people, meeting people – you shouldn't always be alone. He said, 'Whenever I am alone, I feel like now my everything is coming back to me. But when I'm with people, it's much better that way. I can just – not be depressed. So really – that was my. And then, from the Ministry of Agric I had to leave because now the lady – the project was cancelled—it was a project actually. It was funded by the GTZ.

E: What is GTZ?

N: The German –I don't know

E: O. K.

N: But it's like – because they were the ones who was giving the anti-retro viral drugs. When it was supplying some of the clinics and hospitals in the country. So when the project was through and the money was out, she couldn't keep us any longer. We were volunteers actually, we were not being paid, but she used to give us some compensation or something. So afterwards, I think, I didn't even stay at home because I heard about this job here. MAF was looking for - actually it was four people who would be working. So 2002 I applied – after a week staying at home, then I got the reply then I came to –

E: What did they say when they were adverting the job?

N: It wasn't advertised actually—

E: It wasn't advertised?

N: I heard through somebody who worked here. I used to have a friend here he told me, 'Hey I know you are a Youth Peer Educator and all that – why don't you apply at MAF where I work. There are looking for some people and all that. And then I said, 'Oh, that's it.' And then I wrote and then I came here – and then I found, 'Ha! People I know who go to church with me.' Then I saw Ntate Rick, he was still the Manager at that time. Then I applied. *After a week* they told me, 'You've got the job.'

E: What did they say they needed?

N: *They didn't know*. (whispering)

E: They didn't know?

N: When I came here,

E: (Laugh) O. K.

N: The response – really. We had to do this. We had to go to the mountains actually – training people. And it was my first time to train all the people. I was always training my youth or those young people who had just got married. Not women – *older people* – the

adults and all that. Hey! And I was told I had to talk to the chiefs of ---- I said, 'Ayee!' I think now I am the PS (Permanent Secretary) or something. It was such a hassle. But then I just found out that we really have. It was basically a certain part of what I had been really doing all along. Just that it is different; this time you have to really support those people because they are looking up to - *you are from town*. You know everything; you've got money and all that. We had to support groups and those people that wanted – we had to go – there is no cars – there are no roads or anything – nothing. There's no transport there. You are either on a horseback or you are walking. So we went there. The first time I went there I was with the guy I used to work with. He knew everything because he used to work at the Ministry of Agric. So he was something like a Coordinator. So he knew a lot of people already. So he just told them, 'No, I've just changed the work, now I'm doing this. Come together as a community. He called some gathering – the chief and we talked to them – told them what we wanted. We wanted one person who had been trained previously by anybody. It didn't matter which department they were trained by. And two—

E: Trained in what?

N: In home-based care. They know about HIV and AIDS. And they know about a little bit of counselling. Actually counselling ---counsellors need. Counselling you know how counselling somebody is – in our African community – dies, women come. They talk to this person about – whatever would be the case. So they knew what they were doing. And also we had those Village Health Workers, you know, long time ago that the government had trained and all that. So we found them and we told them that's what we want to do. We want to form support groups for people who are HIV positive; critically ill and disadvantaged and children like orphans and those who ---. We didn't care type of community – we wanted everybody to be there. And the chiefs there were really cooperative – though some of them would tell you, 'What is AIDS? --You people, you are bringing your AIDS here, go back! I don't want to hear anything.' So we – *but not a lot of problem*. Then the people came. We had to choose the new ones who didn't know anything. They should be volunteers. They shouldn't be chosen. They should have the calling in themselves that, 'I want to do it - I want to help people.' Because if you have problem; as time goes on you get tied they say, 'Ah! I'm not even getting paid you know. So why should I do it.' So we wanted somebody who really wanted to do it. And it would be a woman and a man. *Men*; they don't want to be involved in community work. But once they are sick, now they want to be taken care of. So we thought that if they are taken care of by a woman, it will be a – they won't be relaxed and all as if it's a man. So we told them, we want it to be a man because when another man is sick, it would be much easier for them to communicate – to talk; otherwise if it's the opposite sex it wouldn't be easy really. So the women came. We had our workshop. Actually our workshop - we didn't want a huge thing. We wanted only about twenty people, not more than thirty. And then we trained them – in the first year. Because the project the three categories; the first year would be training in home-based care, HIV and AIDS and everything that involves taking care of patients, looking after --. Then the second year which is now we are doing it - -which is training in self-reliance projects and income generating. We shouldn't always be looking for the government for donations and – sometime they will come to an end and what will the people do. So we thought we would do that. And then the third phase which is the last one will be evaluation made by outside people; like people from

CHAL, Ministry of Health and other organisations; even from South Africa. See how the project has gone and all that. So that now we are in the process of self help projects and it's coming. But a lot of people think, 'Ah! If those people are getting those seeds free, I should be there.

E: O. K.

N: Not looking back that they have been working all the year round. Taking nothing and not been paid. Now everybody wants to come in. they think it's a government donation for those people. They don't understand. But that's a problem.

E: So you have been trained home-based care when you were still a peer trainer?

N: Yes.

E: O. K. so now you are working as a Health-care Trainer?

N: Yes. That's what they call us.

E: So how are you finding – when you say, 'Health-care Trainer' –when you think of health in your own mind, how do you define a healthy person?

N: I think --- naturally I like to define it in three or more categories. I think to be healthy physically; the way you eat – you eat nutritious food and all that. Cleanliness – I think you should be healthy physically and clean; even if you don't have much clothes, they have to be clean. And then they should be healthy mentally. People shouldn't be having problems of always thinking of problems – they should be thinking positively; even if they don't have anything – but a person should have a mind of always hoping, knowing that one day things will change. Especially for those that – who are in the mountains, everything is happening here, but in the mountains, there is nothing! Like I said, no roads, no tap water. They have to go to the well – sometimes it's just dark, you know, there wouldn't even be soap. People should be healthy mentally by not thinking about those things they should be provided with material things – everything. And then lastly, spiritually – healthy spiritually. In our country most people say it's a Christian country but I don't think so. Most of the people are non-believers – ya they are church goes but they are non-believers. They just go to church on a Sunday and then they come back, 'What did the Pastor say?' 'Ha! He talked.' 'What did he say?' 'Ah! I'm telling you, he talked.' But they don't know nothing. So healthy – I think a person should be mentally healthy, physically healthy and spiritually healthy.

E: So a spiritually healthy person according to you is a person who is what?

N: *Rooted* in Christ. Not really saying that person does show that results consistently. When you say. 'I know what Jesus can do for me.' You mean it and say it and believe it and show what He really done for you really. And I find that it is very much – I don't know - surprising, because those people up there; although most of them don't go to church, but they have such hope, they have such belief. We here we go to church – uhm – but then up there, not many receive – there are not many churches – you have to go a long way to a Roman Catholic Church or an LEC church or an Anglican church anyway but they have such belief. Even those who haven't set foot in church, they tell you, 'One day I hope will make me feel better.' They keep hoping. If maybe you can see – very deep – if you sit down and look at this person – the thing you get there – you feel like, 'haa, this person is really hoping for something and believing.' So you can see that although some of them don't go ….but really they know that there is somebody. A mighty power – a higher power than the one that they can see here. So really, I think that's why – what we chose …

E: O. K, that's quite interesting actually. So, in other words what you are saying is - it might not be exposure to the church but something from within the person.

N: Uhm.

E: O. K. Alright. Now, when you have explained what you think is a spiritually healthy person, a physically healthy person and a mentally healthy person; do you see any relationship between spiritual health and physical health? Do you see any relationship …..?

N: I see the relationship because – you know there was this lady in Matebeng – Matebeng village – it's a small clinic. And then *the nurse there* – I didn't know – I didn't mind at that time – it didn't click in my mind – that when she was giving the medicine to this old lady – she was actually suffering from TB. And then she said, 'you know, you might not have food, you might not have anybody to care for you, but as long as you believe that one day you are going to be well. And if you put your trust in this medicine and you drink it and you use it as I have instructed you; I'm telling you, you are going to be well in no time. Then I saw, 'O. K. so which means,' – we also encourage our people to pray in our workshops and all that. We do the spiritual part also in our workshops- so I thought, 'This means that although the health issues –you know science – or something like that - it's also related to religion - as Christians.' So afterwards I asked her, 'why did you say that?' then she said, 'ah, you know these people how they are, if you tell them they should believe and they should pray; they will pray even when they are taking the medicine – she'll pray and she'll throw the pills inside and she'll feel better in no time.' There was this lady also who came – the baby was very sick and -- Ntate I work with – she just told – she asked the woman that, 'Do you think your child could be healed or could be well the minute you leave the clinic when you get the medicine?' she said, ' I already believe that she's O. K. when I'm here in this house, because I'm here and I know she's going to be O. K.' so you can see that really health-wise and religious life – people – I think they come together because you can go to the hospital but still don't believe that those medicines are going to make you well – you will never be well.

<u>(End of side one of tape)</u>

<u>Side II</u>

E: Side two of the interview with Nthabeleng. Now let's just continue; you were talking about how you see the relationship between spirituality and health – and religion and health. Now, about these relationships; what relationships do you think are important for a person to be healthy?

N: Firstly I think people should – when a person is not healthy or not feeling well. Let's say I'm not feeling well and I need some help; sometimes you find that help comes a little bit later. What do you do in the meantime when you are waiting for help to come? Most people pray. That's what I've seen and that's what I encourage them to do that - even if you don't have medicine– like the home-based kits we're giving them, there's not much things inside them. There's a little bit of that, a little bit of that so you can see to those people who are critically ill or that need to be taken. So in the meantime people – I ask them actually and say, 'what were you doing before the kit came or the medicine or help comes?' they tell me, 'I prayed so much. I prayed that I'll get well. I won't die before people can see that I'm low – anything.' So I think that when somebody is sick or anything while still looking for help – health-wise, they are praying that maybe – you can see that prayer or faith or hope is medicine by itself.

E: O. K. Well, that's quite interesting. O. K. The communities that you serve, how can you describe them; what type of communities do you go to? I know you did say disadvantaged but can you describe more the type of communities that you (*visit*)?

N: You know it was hard choosing because once you leave Maseru, everyone is disadvantaged. So the communities that we look for are those that the government or other agencies haven't been able to reach them coz our advantage is that we have planes to take us even into the deep, deep, deep areas where – nobody even motorcar or anything can't reach. So first we – *(select)* the place. And then when we get there, we find that some people are able to get medicine and all that. Then we look for those places that are inner, inner, inner and they don't know anything. There is no radio. When you come with a bucket like that one (pointing) it's something that is a jewellery – something that is a luxury. So we actually look for – I can say primitive villages – that's in a simpler way. Primitive villages that are very very – *(remote)* - you know – government – some even government officers when you go to them to ask for some help they will even ask us, 'Is that place in Lesotho or even outside?' they don't even know that the place exists. And people there – there is other time we went to – there's this place – Halibete. It's in Matebeng village next to Mokhotlong. It's so far – that is in Qacha's Nek. When we got there – and I was wearing my glasses they said, 'What are those?' the small children – I said, 'My eyes – I can't see well.' I say – it's my first hearing – the parents said, 'It's their first time to see them.' And then in Kuebunyane – some kids – they haven't seen a car in their life. Those are the kind of villages we go to - they only know a plane; 'O. K. it's coming.' – There are lot of people that when they see a car – they run. Even some villages like that – that are very backward. And then we get there – still we have to choose. There are those people who are very poor. There are those people who are poor but you know that they can afford. Then they are those people – patients who are very sick and have been sick a long time. So we look who people are very poor and then we look for people who have been sick for a long time and then we look for orphans. And then we take the whole community and educate them on HIV and AIDS – which way they should live now – change the way their life – behavioural change - the way they have been living and all that. Those are the people that we help.

E: So when you say they should change the way they were living – do they tell you how they were living before?

N: Uhur!

E; And what do they say? How was their life ---?

N: The common thing is having more than one partner when you are married. And it's not something that you can be surprised of – it's a common thing there. They tell you that, 'Here, if you have a boyfriend – besides your husband – it's O. K. – nobody cares.' So I was very amazed I said that, 'Ha! I come from the city and you have to go like hide, when you have somebody and here they don't mind.' Even the husband can come here and see you with a boyfriend – he wouldn't say anything. You know what they said; 'As long as he's taking care of my kids when I'm away, it's O. K.' They don't mind. So really we had to tell them that, 'This is wrong.' You say you're Christians – some of them even have this small tickets for church thing – membership or whatever and then they are still doing it. We said, 'you say you're a Christian but the Bible doesn't say this, it says that.' And then they see – and then we tell them – health-wise it's not good also. So you find that there is no protection – they don't know anything that's called family

planning or safe sex or whatever. They are old people – they live the old ways. We tell them there are lots of diseases nowadays, you know. So how do you settle that? They say that, 'Oh! We have medicine – we have herbs.' They have the traditional medicine – they have herbs. They think they cure it, but it just goes for a while and then it comes back. Again another thing, blood – they are not afraid of touching one another's blood. When a person is sick, they just change – they don't mind handling with their bare hands. They don't know what's getting into them. So those kind of things – we tell them, 'You should change the way you live – the way you look at things. Now is the day – not like before. So you should change the life really. You don't have to live in grass and all that and teach them really. And again – the food they eat; sometimes you find that they eat – the meat is not that well cooked, and it makes them sick. You find that where they go to the toilet and all that – you find that it's up there and the water supply they get from the well it's down here. It rains and it flows and diarrhoea comes and all that. You really have to change the whole thing and tell them how to live.

E: And how are these received?

N: Oh! Well received. Very well received. Because the office – the environmental office also pitched in they brought cement and they brought bricks and all that - corrugated sheets to cover the well and build you know – cover it nicely – it was taken very well. And then the issue of far away clinics was another thing. And then I was very impressed – another clinic – the nurse there – she takes her time off – during the weekends, on Sundays and Saturdays; there is this open clinic in the village. Then she can help those who couldn't go to the clinic. And sometimes you find that she pays from her own pocket. It's five rand – it's very cheap for a person to go there, but you find that there are those who can't afford, most of them. So it's very nice. And so the medicine – you find that it's the problem. Well I don't know what the ministry – what it's --- about that. But really ---.

E: So I'm quite interested in what you've saying just now – so how do you see the sense of community?

N: I – it's very –I don't know – they feel like now – it's opening up. It's just that they were in the dark – now somebody just opened the door and they are in the light. They are very recipient – now they are starting to see things in different ways. Some of them will just say, 'Oh, we have been neglected for so long we don't mind. The government doesn't care about us.' And now that things are happening, they are starting to realise, 'Oh, thank God.'

E: So how would you say your view of a community's health – the health of a community in the communities that you serve – how would you see it?

N: It's changed a lot. When we used to visit the villages you would find that the children were dirty and all that. Now when you they know we're coming – *not even when we are coming*. You know in the morning you have to bath the baby. You have to clean the house. You know how those people are – they just throw the food and go to the field; that was their main problem. Come back – it's late – the house - the windows is very small – you can't even see very well. So when we told them that, 'Hey! The house should be clean. They should be air enough – light and everything.' They are changing – you find a lot of change. Now children are not as sick as before. And the well is nearer to the village and the outside, you know – everything is changing a lot. A lot of it changed.

E: Now, if you are saying that there are not many churches and the churches are far away; and even other services are taken to like clinics or even roads are not so prevalent – what do you think in your own view, has managed to make them survive?

N: You know these people, as I said before hope and – I don't know how they learnt it, but they said it's been like this for such a long time, why should it change now?' So people really they say, 'We'll live this way and we'll adapt.' The other thing is adapting – those people have really adapted things to their situation.

E: So you mean they have some survival strategies that---?

N: Uhm! Really.

E: Are there any that you have noticed that – this is the way they have managed to survive?

N: You know like roads – roads are a problem. The way they do it it's like– they say, 'since we don't have roads – there must be an advantage on the other side – river.' So they don't have roads, but they've got rivers. Why don't they use small boats – something like a canoe? So they use that. So they said, 'well we don't have roads, but we've got mountains, valleys and all that. We have animals.' They use horses. And then again they say, 'we don't have roads but we have huge piece of land and vast land.' So they said, 'if we don't have roads then we can use the land as our means of living.' Then they would plough the land – they are farmers those people. But as for clinics and all that – they are still very depended on their traditional healers.

E: Oh! So do you communicate with the traditional healers?

N: We do. We do. And they even come to our workshops. But they are very reluctant to share their knowledge of the medicine and all that. And then the only problem we got from most of them to the places that we went – the traditional healers were saying, 'now that you've brought the western thing –medicine and all – now you are taking away our clients.

E: Oh!

N: Ya, that was the only problem. But apart form that, they were very co-operative. He even told us, 'Ah! If you have diarrhoea or something you drink it with this – and I even tasted it and my diarrhoea went away – because I couldn't adjust to the water.

E: So have you leant about some herbs?

N: Ya! I know a lot! Hey, I'm a songoma now. (Both laugh) I know a lot of herbs I've learnt. And I even tasted them myself. I always want to taste something – I'm somebody. I tasted them and I saw that it really works – it really helps. I don't know the names but I know when I see them.

E: Which cures which ---?

N: Like when you are burnt, there is this herb that you can use. You can actually boil it with, when it's warm you mix it with Vaseline, and then you put it on the wound. Then just press it nicely. Tomorrow I tell the wound will be - the wound would be a little bit closed. Partially closed and you wont be bleeding or –

E: Do you know the Sesotho name for that?

N: That herb? That is the one that I don't know. But there is this other one – it is *'Piso'* – it's for chest pains. If you use it only like that. And it's also for cleaning ---.

E: How do you prepare it?

N: You put it in boiling water – the green leaves, not the roots. The green leaves – you put it in boiling water for some time, and then when it is a little bit greenish – the water – then you drink it. It's very bitter. But then if you put *moseresere* with *piso* and then you put it

with *pathinyangaka*, that's the medicine for cough and fever. Those three one – you still have to boil and then you drink. It's very bitter those two combinations. And then there is this other one – I don't know the name – it's very good for when an AIDS patient has diarrhoea or vomiting; just give them that – they drink only half a cup – not a lot – half a cup. And then the thing stops immediately. Well, the recent one that I learnt is that you take fresh cow dung, mix it with milk for an AIDS patient, and drink it. I'm telling you, that vomiting and diarrhoea stops immediately.

E: *Is that so!*

N: Yes, it does. I have seen it with my own eyes. I tried it on this patient, she was *weak,* you know. She couldn't put anything or swallow anything – it would just come out. I gave her that – it was fresh and just put a little bit of milk and gave her. It stopped.

E: Well, that is very amazing! I'm thinking -----.-(laugh)

N: Well, it's ----- but it's very, very good. And you know there are others that I know and I have a book on them – about - eer – like menstruation pains and period pains and all that. And when it's long and how you stop it. Especially for people who are HIV positive – I saw that once they start using vitro viral drugs – even when they are not using them; you find that their periods are much longer.

E: Alright.

N: Yes. So they taught me which medicine to use for them.

E: What is it called?

N: It's an English name – it's very hard.

E: O. K. And where did you learn about that one?

N: It was this lady, while I was still in the village – you know I love talking to the old ladies. So she told if the person has the problem. Ya, because those people really have a problem. You just give them and it stops – it cuts short the days and then – a least they are a bit shorter.

E: O. K.

N: Even for diabetes, thyme – thyme?

E: What's that?

N: Thyme and rosemary. You mix them together you find that it – the diabetic. But if you have arthritis, coriander – very good. You put it in a cloth or something and put it on your wrist or wherever you feel arthritis. And it's very good for arthritis. So ---

E: And you're using all this?

N: *Ya! I write everything*. When my mother she sees me she goes, 'Ha! now you're coming with herbs again.' I'll come with them, put them and give her and all that. And so – really it's O. K. *And another one – O. K.* I - the leaves of the peach tree. You just crash them a little bit and pour – put them in a cup and pour boiling water. When you drink them – you sleep like a baby.

E: Is it?

N: Uhm, it's like a sedative. For those people who can't sleep. You put them to sleep.

E: O. K. Oh! I'm learning a lot today.

N: Ya! Ya!

E: So we should -------. (laugh)

N: You know.

E: O. K. now I want you to just come to your faith. You – when you were talking, it sounded like you were saying you are a Christian. Can you just say that to me – your faith?

N: You know I – can say I'm still young in faith but I'm coming. Cause at first when I was still a teenager and coming and becoming a youth, I used to go to church; I used to go to Sunday School; I used to go to youth meetings and all that. But I would just sit there then it would go out of my head is empty. I wouldn't remember, 'what were we talking about?' I just loved going everywhere. Youth camps and all that. But then I don't know what happened, something just came into my mind. One time I was in church and I thought, 'I know I've been coming to church for a long time but I don't really know why I'm doing this, so I should be more committed.' Ya, that's when I thought I should take a step forward and change the way I've been thinking and doing things. And then I thought I should really – when I say I'm a Christian I should really mean it. That's when I thought I should really be committed to Christ and I should be baptised, that's the first step you should take after you really said I want to be this. And then I thought, 'No, I should go and be baptised.' And then commit my life to Christ and all that. My family said that I've opened up and then I thought, 'O. K. so when a person say that really I'm a Christian, I'm a changed person; I'm a born again – this is what they meant?' and it was very nice thing, it was very nice. And so as I sit down I've been looking at things in a different way. Not taking them for granted, not taking life for granted – the way I live, especially when I look at those people – they live up there. When you are twelve years old, you quit school. After standard seven, you don't want to go to high school; you want to get married. And have – kids. So I thought, 'I am very grateful and privileged to have – to be living in town and be - .' because those people up there, it's not that they like the style of their living. They were young; they grew up like that. They saw everything like that. And that's the way the think life is. Even their kids, they're coming – they see – uh, uh, there's no way. So really, I saw that I should be grateful for a lot of things. Not living up there – sometimes it's below zero – it's cold. They don't have food – sometime they eat maize from Monday to Sunday. Then I thought, 'I should be grateful.' And I learnt a lot from those people and from my work really. Then I thought, 'ah, ah, it's time to change.'

E: Have you seen now your new found faith or your new found commitment playing a role at all in the work that you do?

N: Yes.

E: Can you explain?

N: Because at first, I would be so angry with people when they do some things which I think are irresponsible or --- not very good. I didn't know what they were feeling or seeing; and then I started saying, 'No, since I have changed and all this, I started seeing things in their eyes.' Things the way they see them. And then I thought, 'O. K. so this is how those people –'– like I said, it's the way they have been living. At first I thought, "ha, these people are doing it because they just want to irritate me.' Then I saw, 'no, no, no, this is not because they are ignorant or what, it's the way they have been living. So why shouldn't I change them? Why shouldn't I talk to them?' not think that I'm better than them or really - . And then I started seeing things in a different way; it's like God opened my eyes suddenly and said, 'You see, my child, this is how those people are and don't think it's because of this. This is because you *don't know* them and you should learn how

they are – be in their shoes and you walk; talk the way they talk – do things that they do and then you'll soon be part of them. And then they will open more to you and then you can convince them to change.'

E: Well, that's quite interesting. O. K. so if - that is – what you see your faith in that? Do you feel that you have had any support, maybe from your church? Where do you feel you have been able to draw your support from for your faith to be able to apply it in the community where you are working?

N: I think I – I receive support from my mother – she has been supporting me all along. Even before I became a real Christian – a real believer. She was always saying, 'No, I know you can do well.' And she loved what I did. She didn't – sometimes I would come home so angry. She would always say, 'No, it's because you don't see.' I didn't know what she was saying. And then she supported me, she --- me, she would advice me. And then secondly, our boss – he's O. K. he's very great. You go to him with a problem. He will sit down with you and show you another way. Whereas you thought there is only one way. And then I think at church also, it's very supportive, although not in a way that you'll see. They say, 'how is your work?' you know if somebody asks you, 'How is your work?' it shows that this person has been following what I'm doing and this person cares. And the youth, they go like, 'Oh! Your work is very interesting.' - which means that you see that, 'Oh! People actually see what I'm doing is good – and they even call it interesting.' Which means that's good. So we should tighten up everything and go on doing what is your best. So I can say everybody has been very supportive on what we're doing and that gives you a lot of strength to go on to want to do more. And even sometimes when you didn't – in fact – 'now what we're doing is not very good.' The nurses here, the nurses there call us, 'why aren't you coming, we still want you? What you did was great.' So you see, 'O. K. even those people up there they see what we are doing really is good.' So that makes you – more encouraged and want to do more than really your share.

E: So, in other words what you are saying is you see sort of a network of support – from church, from your mother; from the people you are working with in that community; from your boss.

N: Ya.

E: O. K. and maybe to come, to be a bit more personal; when you are going through difficulties yourself or whether it's stress or sickness or something like that, where do you turn to?

N: Ah! In those issues that I really already said, I just keep up to myself – I don't really know how to – come out and say something – really, it takes me a long time – a while. I can say I keep it to myself until I can find a way to solve it. But then I find that – recently I found that the most encouraging thing or the helping thing when you've got a problem and like me - you don't talk – it's praying. Even if you can say you are walking and you pray, 'You know God I don't know what I'm going to do there.' It helps a lot. Because sometimes you know, I remember last of last week we had to go Nohana, and I didn't know what I was going to say there because I was *out*. I didn't want to go. I was depressed – I don't know – it just comes and goes. Then I said, 'Ah! Why should I worry, because God is always there - He's everywhere. It's not like we're leaving Him in Maseru now and I'm going where He's not there.' So I thought, 'Ah! Just let me keep quiet and sit and see and I'll see as time goes on.' And then it's just like it passes – in my

mind it's like something was lifted up after I said that. Then I said, 'O. K. so this is how I should be doing things. If I can't talk to people, then I should talk to somebody who can keep my secret forever.' And then when I got home that's when I told my mother, 'I didn't even want to go there.' She said, 'you were O. K. with it.' I said, 'no, I pretended.' Really, so I can't say there's anyone I can speak to, I just keep to myself.

E: Maybe I mustn't go there – but I just want to know, is it because you find people not trustworthy or is it just you who can't see yourself trusting people?

N: *Not trust as such*, but it's just that – I don't know. You know in my family – it's very strange – we find it strange. We don't talk. I'll mention it out to you. If my sister she had a problem somewhere – she wouldn't tell – you just see it on her face – or what she does. When – even when I'm sick – I wouldn't tell my mother. When I'm really sick, I wouldn't tell my mother. She'll see by the action. So I can say ----- or something – we don't talk – talk about our personal – so I don't know. And it's bad coz sometimes you find that you really need help and it's not there because you didn't say. So I can say – I didn't know what – really – it's not because I don't trust people or what– it's just that we don't –

E: Is it like a habit that you have developed--?

N: You know – a very bad habit. (*Evelyn chuckles*) I think we take it from mother because when she wasn't working, when we were in school – the three of us - my cousin from South Africa, me and my sister – she had to pay a lot of money. She didn't say anything to – 'I even do this' – and she didn't even tell her best friend – 'can you please help me?' so I think it's something that really – I don't know –

E: Can you describe your family – health-wise?

N: *Ah*! my family health-wise? *They're O. K*. they're --- now that we have somebody else.

E: What?

N: ------, Ya, but – *they're O. K*. I can say that it's average like any other family.

E: What would you desire your family health status to be like?

N: I think it should be good. Not that it's not good now or today but I think it could be a little bit better – than it is now – a little bit of change couldn't harm.

E: (laughs) When you are sick, you said you don't normally talk to anybody – what do you do? What's the process you take when you are sick?

N: You know, it's very funny. First of all, even before I go to the clinic because I hate doctors, you know what I do; I find ---- myself. I think, 'Do I have a headache or do I have a soft pain?' then I say, 'I read in a magazine that you can use this, that and that.' Then I go and mix it. If it doesn't work, I'll go to another level and then *finally*, I'll take my book; *I'll hide it* – so that my mother won't fuss over me. I'll hide my small clinic book and go to the clinic – to her work actually; mother works at WHO. There have a clinic down there. I wouldn't go up –I'll just go – clinic – and just go, 'ma'am, I'm having this problem.' (whispering). And then I'll go home. But if it worse then she'll see and say, 'Hey, mwanana, what's wrong?' I'll tell her, 'No, I haven't been felling well for a long time.' And then you know, she'll help me out.

E: Oh! O. K. I think I'm just coming to the end now. Do you think there are any teachings or things that you have gained from your church or from the faith – where you draw out your faith from – that have helped you in the decisions that you make on your ---?

N: The one thing that – problem with me – forgetting. You know that thing that, 'forgive and forget' I can forgive but I'll never forget. And then - last year when we were at this camp

– youth camp – then our Pastor and our youth coordinator - Youth Leader – Emmanuel – they said, 'You should forget the debt that somebody owes you, so that God can forgive you.' The debtor even might forget ---- or might feel he owe anything. So I thought , I know I can still remember something you did ten years ago. Even if I said, 'I forgive you.' Or I wouldn't even ask you, but I remember. So I really prayed about it because that's the problem I have. Another problem is, if somebody had wronged me, I wouldn't go to that person and say, 'You see, I didn't like this and that,' I would just keep quiet until I think it's passing. So that's – those two were my real big issues and weaknesses which – now I'm learning to deal with them because at first I couldn't. And then I talked to my Pastor and told him, 'Hey, Pastor this is worrying me.' And then he told me how to handle those things. Another thing was – the issue of - we girls – we say we don't want to get married but in real life – *we want to*. And then I had a problem back because I was thinking, 'Ish, sometimes you find that you work *hard* and then you find somebody who doesn't care and all that.' And Pastor said, 'Why worry, don't worry about that. You go on with your life and if somebody comes and you think he's the right one and pray about it. Then you'll see that god --' Really, I had a problem with guys because I had an incident where – actually I had a boyfriend and - as I was going out with him, *he was courting somebody* - and then he got married and they have a baby – a cute baby boy – then I thought, 'Can I trust them again?' and I really had a problem with guys then. I really prayed about it and the Pastor said, 'Well, you should just say that anybody – everybody is the same as you.' My weaknesses really --.

E: So you are getting some ---?

N: Ya, I'm getting --.

E: O. K. I think I've gone through everything really I wanted to ask. O. K. maybe the other - thing I just want you to think about. You talk about using herbs; do you see a relationship between western medicine and traditional medicine?

N: Yes, yes.

E: Would you like to talk about that?

N: We always felt that you couldn't use them. Especially traditional leaves – it was too risky – to mix them with that it will ruin it. But now I've just found out that if you want to use a panado for pain, panado is only for pain. But if you want to use herbs or traditional medicine for pain, it's very strange – you find that it's not only for pain. If it's for pain, it's for something else; cleaning the system; making you more healthy or something. So I found out that if you use both of them, since these people like them; why don't we just encourage them, 'No, while you are still using your TB treatment, you can also use that, it's O. K.' As long as they know what measurement you should use on the traditional because usually we don't use measures. If you say five litres, you drink it all; we do not know the side effects because we *think* there are no side effects. So really I think there is nothing wrong with mixing them as long as you know and you got it from somebody who knows; not just anybody.

E: O. K. Thank you so much. I don't know – is there anything else you would like to add?

N: No, I just want to say that my job is great.

E: Oh! That's good. You are enjoying it?

N: I'm enjoying it – working with people has always been my dream.

E: Oh! By the way, do you fell that this job –how do you feel you came to be in this job? Just because --?

N: Well really, I want to confess. I think it's just because I went to church with them.
E: *O. K!*
N: *Really!* I think because I had experience with the Ministry of Agric, that why they really thought this could be good because I already had been working in the community and with my peers. Even my certificate and all that and my knowledge in general, I think they were looking for somebody – coz I had been working now for six years before I came here. coz again I was a volunteer at Queen II in ward five and ward six where they are critically – the unit where they are critically ill patients. Especially in ward six – women's ward you find that many of them were HIV positive. So every –
E: So what did you have to do?
N: It's like we had to feed them in the morning, give them their medicine; clean their bed or anything – clean them and actually – just generally be there for them. Even for talking, at that time there was a lot of – a huge shortage of nurses. We were like ward attendants – but not paid ones. We were just volunteers – so really it was fun.
E: So – how long is this project you are involved in?
N: This one right here - it's for three years. So next year will be the last year; we finish in September.
E: So what do you see yourself doing?
N: Oh! I've just applied – actually I faxed the University of Natal a long time ago; told them what I was doing and I wondered if they could - give me application forms and all that. I wanted to go to the university after this to do psychology and sociology - and community development. So I've just applied. So if I'm successful, I would like to go the university to do those courses.
E: What is your ambition? What do you want to be?
N: Ah! I want to be somebody *great!* Who people can look up to and say – *she's the life of our life - light of our life!* I want to help people really; be there for somebody when they need me.
E: So do you feel that sociology and psychology are going to help you –
N: uhm.
E: Do you feel that you want to pursue – do you feel like it's your calling or your ambition – something you love doing?
N: I feel it's my calling because when I was in standard one, I always said that, 'I want to be a nurse – I want to be a nurse. If I'm not a nurse I want to be a teacher.' So you can see a nurse and a teacher there are always working with people. So now I'm working with people although I'm not a nurse but I think it has been my calling ever since I was very young. So I think - it's something I had to do. If I leave it, I wouldn't survive.
E: Well, thank you so much.
N: Thank you.