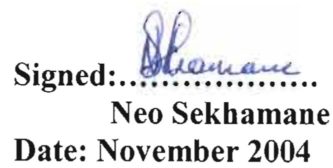
UNIVERSITY OF KWA-ZULU NATAL

IMPACT OF URBAN LIVELIHOODS ON WOMEN'S CAREGIVING BEHAVIORS, HOUSEHOLD FOOD SECURITY AND NUTRITION OF CHILDREN IN LESOTHO

Submitted in Partial Fulfillment of the Requirements for the Masters Degree in Population Studies, University of Kwa-Zulu Natal, Durban

Declaration

I, the undersigned, declare that this is my original work except for acknowledged supervision and reference citation. It has never been submitted to any University for any degree before to the best of my knowledge.

Signed:**..................**

Neo Sekhamane

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Abstract

This dissertation provides a review of the nature of urban environment and livelihoods in an attempt to improve understanding and awareness of challenges facing cities and towns in developing countries, in particular their impact on poor women and children. Some urban challenges are context-based and cultural, but there are special commonalities found in most developing countries like crime and unhealthy environment per se, that exacerbate poor people's vulnerability. Women and children are identified in series of research to be the most poverty stricken and vulnerable; hence prone to shocks. It is therefore important that factors such as urban poverty that increase their marginalization be explicitly identified if the global reduction of poverty is to be maintained. However, given the increasing global poverty levels and enduring children's malnutrition levels, it is clear that major factors that determine livelihoods such as income, food security and health are still inadequate to meet the challenges that urban areas offer today. Other than the material wealth, complex urban livelihoods have amongst other things, reduced provision of other socio-psychological factors such as caregiving, which are critical for children's development and nutrition.

Urban livelihoods force women to participate whole-heartedly in the wage labour. On one hand, this incidence may lead to household's food security, children's nutrition, women's empowerment (socially, economically and psychologically) and optimisation of their autonomy. But on the other hand this can result into reduced women's devotedness and effectiveness to child caring, thereby resulting into child malnutrition and child poverty. It is therefore the aim of this research study to demonstrate that while wage income can be a critical aspect of children's nutrition in urban areas, without adequate caregiving behaviours our goal of reducing children malnutrition is no where near to be reached.

This research has used qualitative data owing to the information needed, which is primarily based on opinions, beliefs and perceptions about children's health and nutrition status. The analysis showed that demographic and socio-economic status in the community and household levels are crucial in determining women's ability to sustainable food security, child care and nutrition. Other factors identified as crucial in child's nutritional status were health, education and age of a mothers and people who provide care to children when mothers are at work.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BOS	Bureau of Statistics
CWIQ	Core Welfare Indicators Questionnaire
DFID	Department for International Development
GNP	Gross National Income
GoL	Government of Lesotho
HIV	Human Immunodeficiency Virus
IDS	Institute of Development Studies
IMR	Infant Mortality Rate
LFCD	Lesotho Fund foe Community Development
LHWP	Lesotho Highlands Water Project
LNVAC	Lesotho National Vulnerability Assessment Committee
MOHSW	Ministry of Health and Social Welfare
SAPs	Structural Adjustment Policies
STDs	Sexually Transmitted Disease
UN	United Nations
UNDP	United Nation Development Programme
UNICEF	United Nations Children's Fund
VAC	Vulnerability Assessment Committee
WFP	World Food Programme
WHO	World Health Organisation

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CHAPTER 1. INTRODUCTION

1.1 Introduction

Urban[1] environments offer mixed opportunities, constraints and consequences for women and children. On the positive side, urban environments offer women stable wage incomes that may boost their children's nutritional status even when their mothers are at work. Urban women also become exposed to family planning services and might have small families that can be easily maintained. Urban children are so likely to get more education and become healthier due to the number of schools and health clinics accessible in urban as compared to rural areas. With more access to information and education in urban centres, women are likely to maintain and increase the level of their autonomy and social status in their families and men may increase their attention and role in child care (Engle et al.: 1997).

On the negative side, if women's employment requires long and inflexible hours, they often have less time to devote to childcare. Often this condition results in other older siblings in the households being forced to sacrifice their schooling and to serve as alternative caregivers (Engle et al.: ibid). Physical and mental health are critical for the well being of children, yet poor women in urban areas raise their children in urban slums with inadequate infrastructure and weak support systems leading to stress and family dysfunction. Given these factors, most poor urban women are likely to have infants at high risk of poor growth and high levels of malnutrition (Engle et al.: 2000).

This dissertation provides a review of the nature of urban environment and livelihoods in an attempt to improve understanding and awareness of challenges facing cities and towns in developing countries, in particular their impact on poor women and children. Some urban challenges are context-based and cultural, but there are commonalities found in most developing countries like crime and unhealthy environment that exacerbate poor people's vulnerability. Such common factors are identified to allow for policy and institutional interventions in the fields of urban poverty and livelihoods.

[1] This paper will not attempt to define 'urban' as opposed to 'rural'. A substantial amount of literature shows a common problem of varying definitions. This study will use 'urban' with reference to a city or a town (Oxford Concise English Dictionary: 2000).

Women and children are identified in this research to be poverty stricken and vulnerable and hence prone to economic and social shocks. Hence it is important that factors such as urban poverty that increase their marginalization be explicitly identified if the global reduction of poverty is to be achieved. However, given the increasing global poverty levels and enduring children's malnutrition levels, it is clear that major factors that determine livelihoods such as income, food security and health are still inadequate to meet the challenges that urban areas offer today. Other than the material wealth, complex urban livelihoods have amongst other things, reduced provision of other socio-psychological factors such as caregiving, which are critical for children's development and nutrition.

In this chapter, urban poverty as a concept is introduced and how it changes people livelihoods, attitudes and priorities towards their assets and capabilities. In doing so, the chapter seeks to draw a relationship between urban livelihoods and care as measured in terms of nutrition. As a departure point, the following section focuses on trends in urban poverty and constraints they impose on people.

1.2. Urban poverty, environment and livelihoods

Drawing from recent studies conducted in developing countries, the world has experienced a strong economic recovery during the 1990s as compared to the 1980s (Minujin et al.: 2002). This improvement does not lead to a considerable decrease in the proportion of the poor people, in particular in the low and middle-income countries. Rakodi (2000) draws on a body of empirical research by the World Bank that indicates that even though many developing states underwent economic growth, the proportion of people living below the poverty line has only slightly decreased while absolute numbers of poor people continue to increase. She adds that even in countries that have experienced rapid economic growth and transformed towards middle-income stage, levels of well-being and service provision are far from sustainability. This implies that poverty continues to pose a threat on the international and national development agendas. It also shows that economic growth on its own is not an absolute indicator of development.

As cities urbanise, income opportunities, technologies and modernised services persuade rural poor people to migrate to urban areas in search of opportunities to

improve their livelihoods. In the midst of struggle to systematically adapt to the new environment, people's livelihood strategies change, thereby exposing them to new forms of deprivation and opportunity to some extent different from the ones they faced in rural areas. Knauder (2000) describes these changes being in the environment as well as in people _ their habitats and lifestyles, their feelings, and competences. Another modification is in people's capital accumulation activities, which shift from agriculture to industrial production and the service sector in towns and cities. While the relative importance of agriculture diminishes in urban areas, labour increasingly turns out to be the greatest asset for the poor and the labour market becomes the primary determinant of wealth or poverty.

These changes coupled with increases in urban population have led to sharply intensified poverty in developing countries. IFPR (2000) explains the situation as having dramatically shifted the location of destitution from rural to urban areas. De Haan (1997) sees this transformation as resulting in the diminished predominance of rural poverty in the areas of research and policy and the rise of a new interest in urban poverty in the Third World. This new interest in urban poverty however does not imply a shift from rural development interventions to urban ones. But it suggests that it is also vital to gain knowledge about urban poverty dimensions if poverty reduction programmes are to be effective. After all, urban poverty cannot be divorced from its rural counterpart: rather they need to be addressed simultaneously (de Haan: ibid).

The increasing concentration on urban poverty derives from several factors amongst which the ones most mentioned in literature are listed:

- **Population increase**

By 1987, one third of people were urban dwellers (Beall: 1997). This population increased to half the world's population by 2000 and this figure is projected to reach 57% in 2025 (de Haan: 1997). In developing countries, the proportion of people living in urban areas will rise as these countries have yet to begin their urban transition (World Bank in Rakodi: 2000). Unfortunately this growth is not concurrent with development in these countries. Literature shows that these nations are still ill equipped to address changing and complex urban needs or even lay down frameworks that can take advantage of globalisation (IFPR: 2000, de Haan: 1997). Given this situation coupled with the dramatic global increase in the number of cities today it is

an undisputable fact that urban poverty will grow and perhaps exceed rural poverty (Rakodi: 2000).

- **Structural adjustment programmes and globalisation**

Structural adjustment programmes and globalisation trends[2] have adversely changed the livelihoods of poor urban inhabitants. These trends have come about with increases in retrenchments, contracting-out and unskilled manual jobs in the informal economy, abolition of controls and subsidies on food and other prices, reduced public spending and wage freezes (Beall: 1997, Knauders: 2000, Satterthwaite: 1997, Rakodi: 2000). The results have been increased unemployment, inequality, informalisation and impoverishment particularly in poor urban households.

Literature on urban poverty acknowledges that the urban incidence of poverty is lower than in rural areas and also that rural development serves as a better way in reducing overall national poverty than does urban development (de Haan: 2000, Beall: 1997, Wratten: 1995). But the alarmingly increasing rate of urban poverty requires strategies that can protect urban areas. Urban areas serve as engines of economic growth: they bring high benefits through higher productivity, services, employment and investments (de Haan: 2000, Knauder: 2000). Admittedly, as much as urban areas promise better standards of living, inequality is generally higher so that the majority of people do not savour what urban areas offer. Those who are poor suffer more than income poverty; they are likely to be subjects of air pollution, crime, violence and poor health conditions (Rakodi: 2000). As such, it is highly important to improve the livelihoods of poor people in urban areas but without compromising those in rural areas.

1.3. Definitions and measurement of urban poverty[3]

There is no agreed upon definition of urban poverty but the World Bank conventional economic terms that use consumption and income as proxies for wealth and poverty are widely used. These economic definitions are sometimes coupled with social indicators such as life expectancy, mortality rate, health, education, and access to

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[2] There are great disparities across countries resulting from structural adjustment programmes and globalisation. Some countries experienced major advances while some reinforced stagnation and poverty. See Rakodi, 2000.

[3] The incidence of urban poverty varies enormously across countries and the data available are not reliable. As a result, figures available do not reflect the real image of urban poverty. See Rakodi (2000: 18).

drinking water or a health clinic in order to classify poor groups against a common index of material welfare (Masika et al.: 1997). Alternatively, other social scientists define poverty in perspectives that encompass non-deprivation and social differentiation and describe welfare in terms of independence, freedom, security, self-security, close social relationships, decision making and political rights (Masika et al.: ibid). In addition to this economic description, poverty has been extended to include aspects of vulnerability. Vulnerability refers to exposure to contingencies, defenceless and difficulty in coping. Assets reduce vulnerability and such assets are human investment in education and health; productive assets such as housing; access to community infrastructure; and claims on international and national resources in times of need (Chambers, 1995: 193).

1.4. Characteristics of urban areas

While both rural and urban poverty are in the lexicon of poverty, there are significant features that differentiate the two. Wratten (1995) argues that these distinguishing features are nevertheless not exclusively associated with the urban sector, they can still be found in some rural areas and not all towns will exhibit all the features.

Major differences are apparent in the areas of production. Lack of ownership of land is closely correlated with rural poverty. Urban poverty is associated with the operation of the labour market, and trade and commodity markets. Additionally, social interaction and economic procedural patterns in wage labour distinguishes the poor urban dwellers from their rural counterparts (Chambers: 1995). According to Rakodi (2000), urban areas generally share similar economic, environmental, social and political characteristics, which influence livelihood strategies of the urban poor to be different from their rural counterparts. CARE (1999) states that urban environments have the following characteristics[4]:

1. **Access to resources through work (selling labour)**: unlike in rural areas, households earn their income through selling their labour. However, those with low income are forced to compete under harsh and unhealthy conditions in the informal economy. In most cases, informal activities are risky,

[4] Not all urban characteristics are negative. See Meikle (2000) for positive urban characteristics.

unreliable, and seasonal and offer low incomes that are inadequate to meet urban household needs.

2. **Frequent disasters**: physical disasters such as earthquakes, landslides and fires affect poor people particularly badly since they do not have assets to withstand shocks. State actions sometimes result in violent activities, riots and lootings that destroy poor people's employment activities and assets. With the poorly constructed squatter settlements build of flammable materials and often build in prohibited areas, disasters may destroy poor people's assets.
3. **Prioritising assets**: whilst assets may be the same for rural and urban areas, differences may be viewed in their priority.
   - *Financial assets*: access to resources in urban areas is through building financial assets, which for poor people implies working in the informal economy where financial assets are often fragile leading poor people into crime and debt.
   - *Human assets*: uncertain and complex livelihoods in the urban areas lead to unhealthy and less skilled manpower.
   - *Social assets*: there are limited social assets and a lack of social structures, social networks and relationships of trust.
4. **Rapid change and increased vulnerability:** urban areas are prone to dramatic changes such as growth of housing stock, shifting populations, economic changes etc. This state of affairs forces urban dwellers to change and diversify their livelihood strategies to accommodate urbanisation and globalisation forces.

1.5. Urban livelihoods and women

Forces of urbanisation, urban growth and globalisation have greatly increased the level of women's participation in the labour market (Masika et al.: 1997; de Haan: 2000; Engle: 2000. This has compelled more women to work for income than ever before and in some cases even more than men. While women's rates of participation in the labour force globally were 54% in 1950 and 66% in 1990, they are projected to reach 70% in 2010 (Engle: 2000). This has also increased the number of households that depend on women as the primary income earners. Despite women's increasing role in the labour market, women's work is nevertheless still concentrated in a limited number of sectors. They still work in low-skilled jobs with no security or protection,

home based, part-time and economically fragile jobs that are viewed as typically suited to women. Women still lack knowledge and skills to compete for highly skilled jobs that can earn them better socio-economic status and better living standards and such jobs are concentrated in the informal sector (de Haan: 2000). According to Moser (1994) the informal sector is characterised by poor working conditions, reliance on indigenous resources, low payments, small-scale operations, unregulated and competitive markets, and labour intensive and simple technology.

Women are entering the cash economy carrying with them a burden of domestic tasks such as caring for members of their households and fulfilling household duties. Their reproductive responsibility is inescapable. As a result, women find themselves caught between the need to simultaneously balance the reproductive, domestic and productive roles (Van Esterik: 1995). Often, and very unfortunately, the results of this triple burden are reflected in the reduced degree of care that women devote to their children and themselves, hence high levels of child malnutrition (Chateerjee: 1990).

According to Engle et al. (1997) 'care' refers to all "the behaviours performed by caregivers that affect nutritional intake, health and the cognitive and psycho-social development of the child, including the maternal health". Care as used here refers to behaviours such "feeding, bathing, comforting, responding to distress, protecting to harm and infection, seeking medical treatment, nursing, stimulating cognitive development and providing an emotionally positive environment" (Engle et al.: 1997). As such, caregiving has been marked as one component, besides health environment, health care services and food security that determines children's survival, growth and development (Engle et al.: 1997, de Haan: 2000).

The definition of care given above suggests two things about the quality and amount of care that children should have. One, caregiving is complex work where the caregiver needs to perform two or more activities simultaneously and that needs emotions, ethics, affection, interaction and resources (human, economic and social). Two, this is a role that does not have a time limit. A caregiver engages in several activities from morning until night if efficient and effective care is to be provided. Based on this information, it generally happens that women's labour activities, especially in the informal sector take priority over the caregiving role. Unpredictable

shift changes, night shifts and lack of control over work schedules make childcare difficult. As a result, most women are always faced with questions about "who will care for their infants, where this care will be located, and how much the care will cost, either in money, goods and influence in the family?" (Van Esterik, 1995: 19). For most poor women especially working in informal sector or other low positions of formal economy, infants are always left in the care of neighbours, siblings or unprofessional alternate caregivers (Maxwell et al.: 2000; Van Esterik: 1995; Engle et al.: 2000).

Not only does the employment of women affect childcare, but also research shows that the need for childcare has a significant influence on the kind of work opportunities women opt for. A study in Guatemala revealed that due to the limited number of formal care centres, women end up suffering from higher rates of unemployment and underemployment because they need to care for their children. It was found out that the lack of available childcare limits the ability of women to take advantage of the better paying jobs in the formal sector. As a result, many women have no option but to engage in informal work, despite the low pay, because it can offer them the flexibility to care for children while still working (IFPRI: 2000).

1.6. Rationale

Literature on urban poverty supports the notion of increasing shift of locus of poverty from rural areas to urban areas. It is therefore important to analyse urban environment, its context and poverty implications for the urban poor. If further urbanisation and urban growth are to occur, especially in developing countries, their effects should be known, in particular on vulnerable groups in the communities such as women and children. By providing an analysis of urban poverty and its impacts on child nutrition and food security, chances are augmented to enhance both women's and children's welfare and improve policy and facilitate institutional interventions for development. One may argue that developing countries already have antipoverty policy frameworks and programmes, but what should not be forgotten is that for a long time poverty was viewed as a rural problem and policies were rural biased, hence cannot be applied to emerging cities (Maxwell et al.: 2000; Wratten: 1995; Beall et al.: 2000). Reasons put

forward by Maxwell et al. (2000)[5] that justify the manifestation of urban poverty as a national priority that requires new policy development are:

- Unlike rural poverty, urban poverty has more adverse effects on determinants of nutritional status including livelihoods, food access, dietary intake the capacity of households to provide adequate care for all members, and environmental conditions (such as crowding) that influence health and the incidence of illness.
- Vulnerable groups in the urban areas suffer from fragmented safety nets (community and kinship networks), hence depend less on other people to assist when shocks and emergencies strike.

Empirical evidence from different countries shows that poor urban dwellers spend most of their money on purchasing food (Maxwell et al.: 2000, Engle et al.: 1999). This shows that food insecurity and malnutrition are to large extent subjects of urban poverty and far reaching analysis on their relationship is necessary for improving child development. Also, it has been shown that in-migration; urbanisation and globalisation are phenomena that partly manifest themselves into urban poverty and are phenomena that are here to stay (Rakodi: 2000, Knauder: 2000). This makes it important therefore to identify aspects of these processes that may hinder or improve childcare and nutritional status. This dissertation provides a case study of Lesotho as an example of a developing country whose incidence of child malnutrition and food insecurity are high, and which is also in the transition stage of urbanisation and urban growth. As such, as recent research suggests, this country offers a compelling analysis of the contemporary impact of urban environment on livelihoods, nutritional status of women and children and provides evidence of problems associated with care (Rabe et al.: 1997, CARE: 1999, Sechaba Consultants: 2000).

1.7. Hypothesis

An assumption is that the incidence of urban poverty is less than rural poverty because of opportunities for wage and cash earnings from casual jobs. With wage income, women do not have difficulty in caring for children as they can hire an alternate caregiver, put a child in a care institution and buy supplementary foods that substitute for breastfeeding. An alternative hypothesis is that with more women's

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[5] Maxwell et al. (2002) gives a story of Ghana. It is therefore important to note that the findings in this study cannot necessarily be generalised.

participating in the labour market, a woman's ability to care for a child is reduced regardless of whether a woman holds a better job or not. On one sense, a higher wage induces a mother to work more hours and choose a job that is less compatible with breastfeeding and care provision. On the other, lower paying jobs are associated with the informal sector, which comprises long working hours under harsh conditions. Consequently, women's time, energy and devotion to child health is reduced. In both cases women's nutrition and health status are affected (as a result of the workload), and this reduces their capacity to attend to other activities such as childcare. This can also reduce women's production of breast-milk.

1.8. Objectives of the study

Specific goals for this study are to:

- Examine the nature of urban poverty and how it relates to women's caregiving behaviours, children's food security and nutrition.
- Identify main urban conditions that constrain or improve women's childcare practices that affect food and nutritional security of children.
- Examine how strategies employed by poor women to secure their livelihoods affect their household food security and the care and protection of children.
- Provide information for policies and programmes that can improve urban livelihoods, empower women and reduce children's food and nutritional insecurity.

1.9. Key questions to be asked

This study will be centred on the following questions:

i. What is the nature and profile of urban poverty?
ii. Does the impact of urban livelihoods have differential effects on different households in the same area due to socio-economic characteristics of the primary caregivers and why?
iii. What factors influence women's caregiving and maximise or minimize its effectiveness in terms of nutrition?

iv. What are strategies that women adopt in order to strike a balance between productive and reproductive needs and how do these strategies affect the nutrition and health status of children?

v. In what way can the nutrition intervention initiatives be structured so that they recognise cumulative impacts of urban poverty and attempt to minimise the primary ones?

1.10. Outline of dissertation

Chapter One introduces the concept of urban poverty, its nature and scope and discusses its relation to childcare. Chapter Two introduces challenges and responsibilities that women face as a result of urban poverty, aspects of care and the relationship between care and nutrition. In Chapter Three, a literature review is conducted presenting a case study of poverty in urban Lesotho. Chapter Four focuses on a methodology, which comprises of population, sample frame and methods of data collection. Also, it depicts the justification of the choice of the methodology and its importance in this study. Chapter Five sets a backdrop to a poverty outline of a selected case study of Thabaneng in Mafeteng. It focuses its demographic and socio-economic profiles of the Thabaneng community. The findings of trends in urban poverty and childcare in relation to the case study are presented in Chapter Six. These findings capture both urban poverty and childcare. Chapter Seven discusses the policy and institutional recommendations and conclusions.

CHAPTER 2. THEORETICAL CONSIDERATIONS OF POVERTY, CARE AND NUTRITION

2.1 Introduction

This chapter focuses on the linkages between care and nutrition given the assets and capabilities in the household such as income, education and child care practices. For this exercise, two approaches are used to provide a background of how the linkages have been used by other scholars over the years. In the process 'care' as a concept and discourse is analysed.

2.2 Livelihood security approach at the household level

The previous chapter has explored the notion that there is a huge challenge for poor women in urban areas to preserve their asset base in order to protect their livelihoods. This implies that 'livelihood' is a theme that should be examined whenever the relationship between poverty problems and nutrition insecurity are discussed. In his book '*Urban Livelihoods and Food and Nutrition in Great Accra, Ghana*', Maxwell et al. (2000) maintain that the livelihood security framework serves a good approach for assessing the resources, capabilities and assets available in the household, and analysing how these are linked to strategies that are used to maintain sustainable livelihoods. This model therefore serves to clarify and assess the resources and strategies that women as main caregivers use to maintain sustainable livelihoods measured here in terms of children's nutrition.

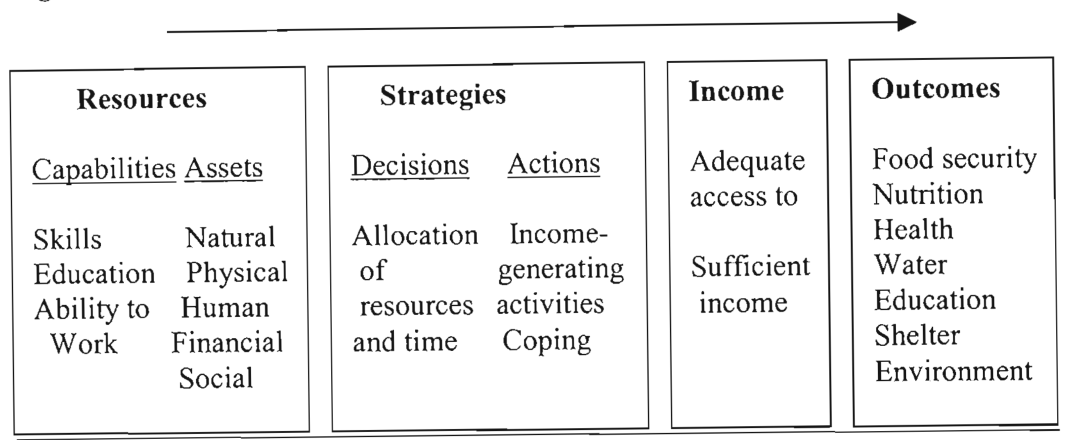
There are various ways that people use to define livelihoods depending on the capabilities and assets of a particular group in a particular area. For the purpose of this research study, Chambers and Gordon's definition is used:

> A livelihood comprises capabilities, assets (stores, resources, claims and access) and activities required for means of living: a livelihood is sustainable which can cope with and recover from stress and shocks, maintain or enhance its capabilities and assets, and provide...opportunities for the next generation; and which contributes net benefits of other livelihoods at the local and global levels and in the short and long term (Krantz, 2001:1).

From this definition and others not included here, a variety of livelihood frameworks and diagrams have been designed by different organisations and social analysts to mirror their perceptions of what they view as sustainable livelihoods (CARE: 2001).

Models most often used in the literature are designed by CARE, UNDP and DFID to serve their different objectives and goals. While these frameworks are not discussed in detail in this paper, Figure 1 presents a Sustainable Livelihood Security framework that encompasses aspects of different models by CARE, UNDP and DFID.

Figure 1- Livelihood Security Approach



Livelihood Security Approach simply demonstrates that the household's livelihood depends on the household resources expressed in terms of capabilities – skills, education and ability to work and also assets. According to Wratten (1996) categories of assets identified are:

1. Natural: access to assets such as land.
2. Physical: housing is central to the wellbeing of people by providing a shelter for meeting basic needs. Other physical infrastructure such as sanitation, drinking water and housing facilities are also crucial for living conditions and health.
3. Human: health and education are most crucial to improving the actions and decisions of people. Lack of health services and an unhealthy environment are greatest risks in urban livelihoods.
4. Financial: this includes savings and investments and also access to credits and costs of borrowing.
5. Social: there are relationships between and amongst households as well as civil society organisations. Social capital is essential for providing safety nets for collective action to improve livelihoods.

These resources cannot be effective on their own, but need strategies for their implementation. Strategies required here should be concerned with allocation of resources and time, coping mechanisms and income generating activities. To allocate resources, people should also develop coping measures to absorb all income shocks that come their way. Without a stable and sufficient income, neither strategy nor resource can be put in place in order to bring about the desired outcomes. As the Figure 1 shows, the outcomes comprise amongst others food and nutrition, which are themes central to this research study.

The Livelihood Security approach as used here helps to come up with questions underlying the objectives of this study: Is access to income a critical aspect of children's nutrition? Do urban livelihoods give poor people especially women opportunities to have their own assets- social, financial, human or physical? Do women have time and opportunity to allocate the resources they have efficiently? Whose education and decision making count in the development of the child, the one of the head of the household, the primary caregiver or the alternate caregiver? Do women's coping mechanisms aimed at generating household income or maintaining the children welfare?

2.3 UNICEF conceptual model of care

The UNECEF model of care is an essential framework for assessing the capacity and the ability of the caregiver and family to provide care. However, this model does not concentrate only on the caregiver's behaviour but also assesses the child's behaviour and characteristics. That is, it demonstrates that not only does caregiver behaviour influence child survival and development, but also aspects and qualities of the child influence caregivers' decisions and investments in their children[6] (Engle et al.: 1999). It also indicates that food and health are all necessary, but not sufficient conditions for women and children. Three elements namely care; food and a healthy environment should be satisfactory for good nutrition. The connotation here is that when poverty causes limited health care and food insecurity, enhanced caregiving can optimise the utilisation of the available resources to promote children's nutrition levels (Engle et al.: 1997).

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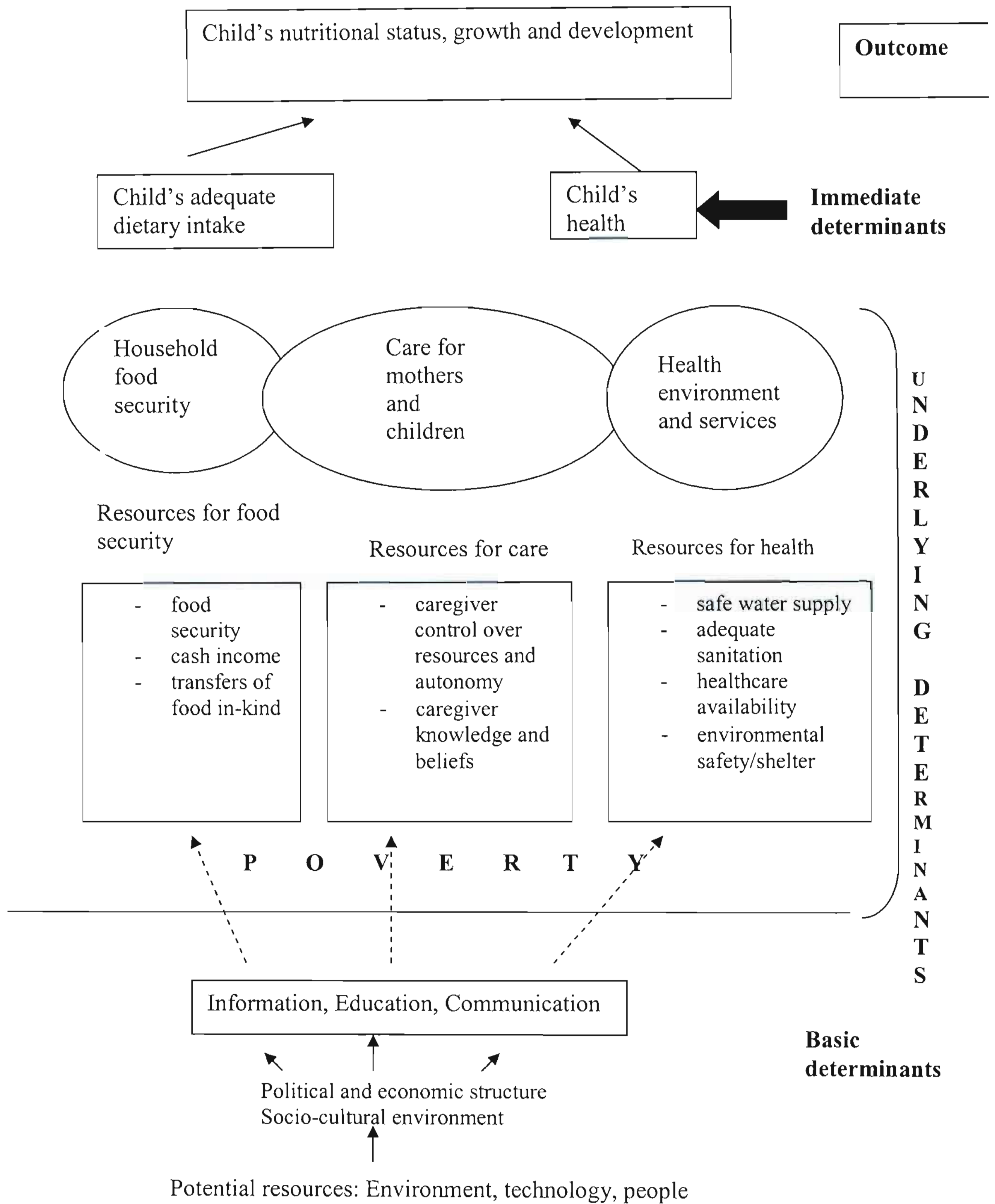
[6] Aspects of children such as endowed healthiness, perceived vulnerability, perceived weight and physical appearance affect the practices of their caregiver. See World Bank: 1999.

Figure 2 - UNICEF Conceptual Model of Care



Sources: Adapted from UNICEF 1990, 1997, 1998, and Engle, Menon, and Haddad 1999.

According to Figure 2, a key factor embracing all the determinants of a child's nutrition is poverty. Poverty here is measured at the national, local or community level and also at the household level. In the national level, determinants of a child's nutritional status include the potential resources available to a country or community, and which depend on natural environment, access to technology and skilled manpower. Political, social, economic and cultural factors affect strategies that mobilise these potential resources into resources for food security, care, and healthy environment (Smith and Haddad: 2000). It is also at national levels where policies regarding the status of women and men, health care and consumer protection are designed. Engle et al. (1997) assert that it is the full responsibility of the society to fulfil the child's right to the enjoyment of the highest attainable standard of health. That is why it is necessary to analyse the local poverty trends of a country under study to assess whether the available resources are capable of transforming resources for care and to improve a child's nutritional status. It should be noted however that these signs of poverty happen in the community or national level and cannot on their own guarantee a children's nutrition status.

In the household level, underlying poverty determinants as identified include:

- Resources for security - food, income and income transfers in-kind
- Resources for care - caregivers' knowledge, education, autonomy and control over resources
- Resources for health - water, sanitation, healthcare, shelter and environmental safety.

All these resources enhance sustainable household food security, care of both mothers and children, a healthy environment and services which in turn result in a child's high dietary intake and good health status. These two elements are themselves immediate determinants of a child's nutritional status.

It is however worth noting at this point that a family's ability to provide care also depends on the political structures, socio-cultural context and the economic structure of the society (Engle et al.: 1997). This means that care in both the family and community are complementary contributors to the development and sustainability of childcare and nutrition.

The use of the UNICEF's conceptual model of care employs both the use of resources at the national/community and household levels. The structure of this study of analysing poverty profiles at both the country level and the household level fulfils this objective. This model takes note of some of the outcomes that appear in the livelihood security framework. This role alone makes care a contending theme in the field of livelihoods and also one of the major determinants of a child's nutrition. With this model, it is easy to explore which set of indicators can be used to measure and maintain care. Moreover, it is from this model that most researchers who focus on household care have constructed care resources and practices necessary for a child's nutritional status (Engle et al.: 1997). The framework also provides appropriate information for decision-makers to devise policies and programmes to support the prerequisite of care in urban poor households (Maxwell et al.: 2000).

2.4 The role of care in children's nutrition

The debate about child's food and nutrition accrues from studies made on the causes of malnutrition[7]. Literature on food and nutrition shows that levels of malnourished children in the world are currently growing at an unacceptably high rate. In 1995, 167 million children under the age of five were reported malnourished and about one-third of them were from Sub-Saharan African countries (Smith and Haddad: 2000). The most recent study of UNICEF found that malnutrition and death are caused by a combination and interaction of dietary intake and disease. These in turn, are caused by a combination of interrelated factors such as "insufficient household food security, inadequate maternal and child care and insufficient health services and unhealthy environment" (Maxwell and Smith, 1999: 24).

There are controversial debates on the importance of care in a child's nutrition and welfare. On one hand, one may argue that care is the major determining factor in child's nutrition. As in Maxwell et al. (2000: 10), the importance of care is stated as follows:

> Where there is poverty, food insecurity, and limited access to health care, enhanced caregiving within the household can optimise existing resources to produce good health and nutrition in young children....care [therefore] is a particularly important determinant of good nutrition under urban conditions.

[7] Malnutrition is associated with both undernutrition and overnutrition. For the purpose of this paper, it refers to undernutrition as measured by underweight rates. See Smith and Haddad (2000).

On the other hand, others may argue that the relative importance of health and care may be less important than is being claimed, especially during non-famine conditions. According to this argument, stable good environmental conditions are conducive for stable food security status and nutrition outcomes. It is therefore important not to overemphasize the virtue of caregiving in a child's development but to simply recognise that care is one necessary element in a child's life but not sufficient on its own for adequate nutritional status to be achieved.

In most cases, the caregiver is the mother, but research has extended the spectrum to include fathers, older siblings, relatives, hired caregivers, and child care centres. However, mothers still remain the primary and most effective caregivers to children (Engle: 1997; de Haan: 2000; Maxwell et al.: 2000). In this paper, we refer to the person providing care as a 'caregiver'. Given their increased role in the labour market, time constraints, workloads and income become very critical in their responsibility to access caregiving resources and offer adequate care to their children. Care, as shall be seen in this study, is critical for all children at least under age seven, but nutritionists have recently marked age three as an appropriate age group for measuring care of children in terms of nutritional status. This is because evidence shows that while children under seven can be affected with malnutrition, their risk of mortality from malnutrition decreases dramatically after age three (GSS and Beaton quoted by Maxwell, 2000: 14).

Caregiving[8] is not only important for improving child's cognitive, mental and physical development but also plays a critical role in women's development. Caring for women equip and empower those women with practices and resources that can be transferred to children to improve and maintain their food security and nutrition. Women's health and nutrition status is a key determinant of the survival and healthy development of their children (Leslie: 1995). Moen (1995) adds that caregiving promotes an individual's prestige, resources and emotional gratification, social recognition and heightens the sense of identity. It is therefore contends that one should argue for women's empowerment and development if health and welfare in developing countries are to be achieved.

[8] The effects of caregiving can be viewed from perspectives of costs and benefits. For the purpose of this research, only benefits of caregiving shall be reviewed. See Moen et al. (1995) for costs of caregiving.

Care practices and resources determine the course of children's lives, and limited care can retard their growth and development. It is important therefore that care practices and resources be protected and maintained as households respond to urbanisation and globalisation. Women's increased economic role and population increase require appropriate adaptations in care practices.

2.5 Care practices and cares resources

Engle (1997) contends that there are several care practices that caregivers should use to improve food security and ensure nutrition for children. These are:

2.5.1 Care for women, including care for pregnant and lactating women

The health and nutritional status of pregnant and lactating women are critical for the outcome of pregnancy and subsequently for children's growth. Pregnancy, childbirth and lactation are particularly demanding for women and a family should provide support at this time through providing them with an extra amount of family foods, reducing their workload, facilitating prenatal care and safe birth. Evidence shows that uncared for and poorly nourished mothers have higher rates of miscarriages, stillbirth and maternal mortality. A fair share of food and resources plays a significant role in the birth weight and subsequent nutritional status of the child. These factors are not on their own vital for the care of women, but the status that women have in their societies is also critical in terms of the care they receive.

2.5.2 Nutritional status and mental health of women

Literature on care practices notes that poor children's health and nutrition depends on maternal health, energy and the consequences of care. Thus, if caregivers do not obtain enough care and experiences cases of ill health, provision of care to children becomes a difficult task for a caregiver. Evidence shows that psychological factors associated with an urban environment such as stress and depression is associated with less caregiving and lower achievement in children's nutrition. Also the biological effects of nutrition on pregnant and lactating women can affect the child's characteristics, both physical and behavioural. The physical and emotional abuse that women and young girls experience at all stages of their lives affects their mental as well as their physical health. Caregivers' happiness impacts dramatically on the

child's nutrition. Caregivers who consider themselves happy have the best-nourished children. This is because maternal happiness contributes to self-confidence and mental health, which lead to better responsiveness to children's needs and better quality of the childcare.

2.5.3 Caregiver's knowledge, education and beliefs

Studies commissioned in different countries reveal that there is a strong relationship between child and maternal education (Engle et al.: 1995). While findings from some countries show that the effect of education through improved care practices in terms of improved childcare skills and better utilisation of care practices are critical in child's growth and development, other experiences demonstrates that education further increase maternal income through increment in wages. Educated women are also associated with better homes; health care and hygiene and are more likely to seek help about children's welfare. Education to a large extend has been proven to influence behavioural change. It improves self-confidence of women in the society and increases knowledge about the potential resources and how the on hand resources can be used effectively for the benefit of their families. Communication plays an important task in the well being of women. It increases participatory actions and changes certain attitudes and practices that were impediments to the development of women and to children's nutrition.

As previously highlighted, education however may have a negative impact on the child's health if a woman is fully married to her career or academic life and her labour reduces her ability to endow with childcare. Moreover, there is evidence that better-educated women have a tendency to terminate breast-feeding early in the children's lifes[9]. This kind of a negative behaviour associated with maternal education is limited and the literature has recorded more positive behaviours of education on child health than negative ones.

2.5.4 Control of resources and autonomy

A number of studies have shown that there is a noticeable relationship between women's autonomy and decision-making in the household and children's nutritional

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[9] A detailed analysis on the relationship between nutrition and breatfeeding is on section 2.5.6.

status (Engle: 1995; Engle et al.: 1995; Leslie: 1995). These studies show that children growing up in female-headed households turn to have better nutritional status (depending on the household income) than their counterparts growing up in male-headed households. This is because in the female-headed households resources are highly likely to be directed towards children because of women inborn capacity of being naturally nurturing and caring. Within the female- headed households, also women have control over household income and this may increase her decision-making power over some of the households' assets. Most women in the male-headed households however have neither access to decision-making or autonomy, which constrains provision of care resources such as health care, food and support. Women's status and her capacity to distribute resources according to Engle et al. (1997) is due to family and society structures, which allow for inheritance laws that often disadvantage women thereby inconveniencing children in the process .

2.5.5 Social support

Children do not depend only on their mothers for care, affection and protection but also depends on the community and other members of the household such as siblings, relatives or an alternate caregiver. When mothers work, provision of childcare from other people can be very important. The amount and quality of care provided depends on the age of the alternate caregiver. Evidence shows that care provided by pre-teens is associated with low child nutritional status (Leslie: 1995; Engle: 1995; Engle and Ricciuti 1995). There are however mixed results on the impact of grandmothers' provision of care (Leslie: 1995). While grandmothers have likely to have substantial experience on how to care for children, they can nevertheless be constraint by resources such as lack income to supplement breast-milk. Also old age and fatigue can have poor care results. Institutional care is seldom available in most developing countries but where available, it is often unaffordable for most low-paid women.

Social support from the society and the family is crucial for the health of women. Engle et al. (1997) assert that in some societies girls and women are denied access to some foods, health care, education, attention and affection, whereas in other societies girls receive equal treatment. This discrimination is risky not only to the lives of these potential mothers and their subsequent children but it also is dangerous regarding the decisions that women later make towards their families. Women who have and still do

experience discrimination in their lives are not likely to give their own children equal support. They follow the discrimination pattern and tend to give boys a fair treatment over girls.

Social support should also be through advice and encouragement from all society members. Engle et al. (1997) maintain that enforced emphasis should be on decisions regarding their reproduction and family planning. Health facts show that women of all ages should be encouraged to space births. In contrary women in most societies especially in Asian and African countries are under pressure to have as much children as possible and within a limited time period (Engle and Ricciuti: 1995). These frequent births bear risks for both the mother and the child in that they do not allow a mother to have enough time before the subsequent birth to reload nutrients and have time to care for each child (Van Esterik: 1995). Further family support should be inevitable on areas of breastfeeding for the child's adequate nutritional intake.

2.5.6 Breast feeding and complementary feeding

Breastfeeding is very crucial in the growth and development of a child especially in the first six months of the child's life. Engle et al. (1997) state that children who are breast fed have lower rates of infection with diarrhoea, acute respiratory infections earaches, dental caries and more other infections that may develop in the later stage of the child's life. Breast-feeding is not only a care practice but also has a positive psychological impression on the bond between the child and the mother.

However because of the of the ongoing changes in patterns of women's work in urban areas, there has been a major decline in the rates of breastfeeding, which in turn have a negative effect on children's survival and nutritional status (Leslie: 1998). As has been discussed, urbanisation brings with it increased women's employment and education. As a result most women, especially employed, terminate breastfeeding in the early stage of a child's growth, which for most children results in earlier faltering in growth. Specific factors for shortened breast-feeding are heavy workloads and time constraints. Other countries' experiences however show that early termination of breast-feeding is not always a function of employment. Instead, it may be regarded as personal sacrifice in terms of time and mobility and as reducing their capability to maintain their 'body image' (Leslie: 1995).

Complementary feeding in addition to breast milk is essential at the age of about six months. Complementary feeding should comprise of foods high in nutrient density to provide proteins and energy for the growth of the child. Energy dense foods are expensive and may not be afforded by most households, thereby resulting in high consumption of lower energy density foods. Hence women are encouraged to stick to breast-feeding. Complementary feeding on its own does not guarantee the child's nutritional intake also necessary is frequent feeding. Due to the small stomach size of infants, frequent feeding is necessary for the provision of energy (Engle et al.: 1997). Frequent feeding and complementary feeding largely determined by the time and income caregivers have. While poor urban caregivers may not be able to afford these foods, they may also not have enough time to provide frequent feeding sessions (Leslie: 1995).

2.5.7 Feeding practices and caregiver's ability to feed responsively

Caregiver practices that are important to the dietary intake of the child include adaptation to the child's characteristics and appetite. Such characteristics involve ability to handle a spoon when eating and to chew or munch. More emphasis should be put on the responsiveness of the caregiver such as encouraging a child to eat, offering additional foods, stimulating eating through imitations, timing of the feeding, responding to poor appetite, protection of the child when feeding, supervision, and frequency of feeding (Chatterjee: 1990).

Active feeding plays an important role in the child's dietary intake. Active feeding involves encouraging a child to eat, talking to a child during an eating session, imitating eating behaviours and monitoring the child's food quantity (Engle et al.: 1997). Several studies have found that passive feeding is closely related to child anorexia (Bentley quoted by Engle et al.: 1999). Passive feeding entails leaving the initiative to eat to the children. According to Engle et al. (1997), this behaviour may be encouraged by lack of time and energy, or the beliefs and perceptions that children should not be pressured to eat, and that "the stomach knows its limits"

The situation and environment where the child is being fed may affect the dietary intake of the child. If the child is fed in an uncomfortable situation or in an

environment that he/she may easily get distracted or food can be easily contaminated, the child may not finish the food. Close supervision is needed therefore that the child is comfortable and has a good appetite. Less appetite may be due to a monotonous diet, some sickness or anxiety. In case of low appetite, caregivers should ensure that they have enough time, knowledge, resources, self-confidence and support to ensure that the child eats (Chatterjee: 1990, Blau et al.: 1994).

2.5.8 Workloads and time constraints

Maternal workload has been found to be one of the constraints to care provision in many ways. For instance, it restricts time and energy for breast-feeding, frequent and active feeding sessions, and giving love and affection. Women undertake different activities simultaneously, most of which are labour intensive and time consuming. Such activities include carrying water, gathering wood, washing children and doing wage labour. For some women, these households' activities are coupled with wage labour. One may argue that the time costs of household production have been decreased through appropriate technology such as food mills and household water resources. Indeed, this may have worked for some women but has not decreased the workload of the majority of poor women in the urban areas who work in the informal economy or in positions considered suitable for females in the formal economy.

2.5.9 Psychosocial care

Psychosocial care refers to the provision of affection and warmth, encouragement and responsiveness to the child. There are three dimensions of measuring this care and they involve assessment of the home environment, child-caregiver interaction and child's appearance. Engle and Recceuti (1995: 457) assert that a child's early home environment can be assessed in terms of various demographic or "structural" characteristics (family income, parent education or occupation, family size and composition), or in terms the physical or social environment in the home (housing quality, crowding, noise, birth order, presence of newspapers, radio). In addition to these characteristics, various parental characteristics such as age, child-rearing knowledge and attitudes, and mental and physical health can also serve as "environmental" measures. Since many of these characteristics tend to be related to child developmental outcomes and may significantly influence the quality of care parents provide, they can be utilized as "proxies" for early experience and childcare

(Engle et al.: 1997). Caregiver-child interaction is another dimension of measuring psychosocial care. This interaction can be shown through physical, visual and verbal contact with children. Hostile, harsh and abusive behaviour towards has been acknowledged to hinder cognitive and physical development of a child. It also impedes a child's ability for self-exploration and self- expression consequently leading to unhappiness and loss of appetite. Finally, a child's appearance reflects his/her health status and both the amount and quality of care a child receives (Engle and Recceuti: 1995).

2.5.10 Hygiene practices

Hygiene practices are simply about cleanliness of the environment and the people directly interacting with a child. The practices determine the health status of the child in terms of the number of infectious agents children ingest either through contaminated food or water or by placing contaminated objects in their mouths (Maxwell et al.: 2000, Engle et al.: 1997).

Whether these practices are implemented depends on the accessibility of resources that the caregivers have. It also depends on whether provision and distribution of resources that enhance care receives support at the community, regional, national and international level (Engle et al.: 1999). Without these resources, childcare behaviours are likely to be negative resulting in less maternal responsiveness towards children, limited hygiene and health care behaviours (Engle: 1997, Maxwell: 2000). In fact, care resources in virtue precede care practices because it is through them that care practices can pursue desired nutritional outcomes.

2.6 Conclusion

This chapter has evaluated the role of caregiving on the children's nutrition, growth and development with a special emphasis on opportunities and constraints of caregiving in urban areas. The use of Livelihood Security framework highlights the role and importance of assets, capabilities and strategies at the household level in producing sustainable livelihoods with nutrition as one of the outcomes. UNICEF's conceptual framework shears knowledge on how well children's nutrition can be sustained. This framework suggests that while household assets such as food security, income and health may be necessary; they are not on their own sufficient for a child's

nutrition, growth and development. The last section of this chapter highlights caregivers' practices and resources for the provision of adequate care.

CHAPTER 3. POVERTY IN LESOTHO

3.1 Introduction

Understanding socio-economic phenomena such as urban poverty needs a contextual analysis of the political and economic processes, major events and policy developments of an individual country in the global arena. At the household level, major contextual factors to consider are those that decrease or increase vulnerability. These are the political, economic, social and institutional context in which the household is situated (Maxwell et al.: 2000). Reviewing cross-country case studies is an important task because some variables that might be important determinants to child nutrition such as democracy and women's status may vary between countries (Smith and Haddad: 2000). It is the intention of this chapter therefore to provide a contextual analysis of characteristics and distribution of poverty in Lesotho in order to highlight some variables embedded in poverty that may enhance or restrain caregiving, food and nutrition security. Key historical events are also discussed in order to provide a holistic overview and a probable direction of poverty and wealth in this country.

3.2 Overview of poverty and inequality

Lesotho is a small mountainous country geographically surrounded by South Africa. With a total area of 30, 355 square kilometres, its population is approximately 2, 096,000 and has a population growth rate of 2.3% (1999 est.). However, the increasing prevalence of HIV/AIDS has adjusted estimated population growth rate to 0.92% p.a. (CARE: 2001). The country has about 50% of its population below 18 years of age of which 14% are children aged 0-4 (Ntsonyane and Sebatane: 2000). Lesotho is one of the poorest countries in the world. With a GNP of US$ 415 per annum, it falls in the 49 least developing countries, and ranks 120 out of 163 countries on the United National Development Index (UNICEF: 2003).

Drawing from the evidence of 1986/7 Household Budget Survey conducted by Sechaba Consultants, it is obvious poverty is not a new phenomenon in Lesotho. At this time, at least 58.8% of the overall population was living in poverty. When the same study was repeated in 1994, there was a slight reduction in poverty to 58.3%, which is a cutback that is not statistically significant (May et al.: 2002). Between this time (1986-1994), research findings show that the severity and depth of poverty have

significantly increased with many parts of the country being poorer than they were in the previous six years (Gay and Hall: 2000).

There are often disputes on who should be categorised as being 'poor'. While this is determined by the country's total income and consumption, the 1986/7 and 1999/2000 Household Budget Surveys defined the 'poor' as those with a monthly expenditure of R 80, 00. Out of the poor people, there is another group that was defined as 'destitute' and had a monthly expenditure of less than R40.00 (GoL: 2000).

Like most developing countries beginning the transition to urbanisation and globalisation, Lesotho is experiencing a dramatic rural-urban migration and urban growth. There are controversial debates[10] on the precise number of people living in urban areas today, however a 1999/2000 national survey shows that 27% of the population reside in urban areas and this figure is projected to rise to 58.9% by 2025 (CARE, 2001: 42). This implies that poor people from rural areas are and will continuously add to the numbers of the poor in urban areas, thereby increasing the overall share of urban poverty.

Studies in Lesotho indicate that urban poverty is less severe than rural poverty, but acknowledge that it is likely to increase given the combination of inability of the state to contain urban challenges and the continuously accelerating rural-urban migration (Rabe et al.: 1997; Sechaba Consultants: 2000; CARE: 2001; Senaoana: 1996. At the moment, urban areas still continue to have a greater share of the national income than the rest of the country, at least three and half times as much as the areas in the mountains. Also urban areas experience a relatively significant increase in employment incomes, especially in the informal sector and the foreign owned clothing factories. But this economic performance in urban areas is likely to take a huge reverse in the future if this rapid urban population explosion persists. There is no doubt that urban poverty will go alongside the population explosion. The 1999/2000 survey shows that 23% of urban dwellers are without any income whatsoever and are classified among the 'very poor' group (Sechaba Consultants: 2000). This leaves urban areas as classified among places where some of the most impoverished

[10] There is no agreement on the exact definition of 'urban' in Lesotho; as a result, different authors and institutions draw up different boundaries and definitions between rural and urban areas.

livelihoods in the country are to be found (CARE: 2001). These areas face a tremendous shortage of resources for health, care and food security as required for sustainable development and children's nutrition status, as explained in the theory.

The projections about the future urban poverty and population indicate the need to review and address urban poverty in the country. Given the fact that urban poverty has been ignored and underestimated for a long time in this country, little is known on the dimensions and nature of urban poverty (CARE: 2001, Rabe et al.: 1997). However, the increasing evidence of urban poverty observed in Lesotho's towns imply that urban livelihoods for the poor are more complex than what need be given the lack of measures that can facilitate urban sustainable livelihoods among the poor.

3.3 Inequality

Analysis of poverty distribution and intensity is based on the distribution of income in this country. Literature from UNDP National Human Development for Lesotho shows that about 45% of the national income flows to 10% of the population which constitute the richest proportion of the population, compared to 1% distributed among the poorest 10% (GoL: 2000). These disparities have always existed in Lesotho, but the increases in unemployment and poverty coupled with the consistent economic boom experienced in the early 1990s resulted in high inequality between the rich and the poor. The increase is such that between 1986 and 2000 the Gini index climbed from 0.60 to 0.66 (May et al. 2002). Compared to Gini coefficients of other countries (both developed and undeveloped) this increase marks the country as falling among countries with the highest levels of inequality in the world (GoL: 2000; Sechaba Consultants: 2000).

3.4 The economic boom and its reversal

In spite of the high poverty levels, Lesotho experienced an economic boom that noticeably raised the country's economy profile in the period between mid 1980s through mid 1990s (CARE: 2001; May et al.: 2002). It is unfortunate that little of this significant economic recovery failed to bring reduction in poverty levels. To most researchers, the explanation for this failure is that the economic growth trickled down to a few, leaving the bulk of the population in absolute destitution and further

widening the poverty gap between the rich and poor (Sechaba Consultants: 2000, CARE: 2001).

There are several causal factors for the economic boom of the early 1990s. Firstly, remittances from the mines were contributing a significant source of revenue for many people and they accounted for a third of GNP (Senaoana: 1996). Secondly, the advent of Lesotho Highlands Water Project (LHWP) increased employment opportunities, infrastructure and investments leading to higher foreign exchange and growth. The third factor is the impact of Structural Adjustment Programmes (SAPs) that were implemented in Lesotho around this time. Even though some scholars argue that they have hit hard on poor people, they have nevertheless been successful towards reducing government expenditure and borrowing (Sechaba Consultants: 2000). Fourthly, the export growth in textiles and light manufactures also created an environment conducive for economic growth (Senaoana: 1996; Sechaba Consultants: 2000).

In the late 1990s, poverty and growth trends took a different course. As a result of the 1998 political uprisings, growth trends dropped to the level they previously were in the 1980s. All macroeconomic indicators of wealth gained in the 1990s turned sharply downward, investments became more risky and people were left exposed to a series of aspects of vulnerability (CARE: 2001). At the end 1998 political uprisings, the economy grew sluggishly. Number of variables has been marked as being accountable for this sluggish growth. Firstly, the national income share of mine remittances had decreased tremendously. Thus, the number of Basotho men working in South African mines had been retrenched, resulting in many individuals and household heads loosing their stable remittances. Retrenchments increased unemployment to over 65%; which is the condition that forced approximately 35% of the population to return to subsistence farming (Mufanechiya: 2002). Secondly, a couple of disastrous droughts had hit Southern Africa, resulting into a decline in cereal production in the whole region. Tremendous environmental degradation, soil erosion and low rainfalls also added to crop failure and starvation. Compounding the low food production were the increases in food prices. UNICEF (2003) estimates more than 14% increases in prices for bread and cereal-based foods at least between January and February 2002

only. Finally, production of wool and mohair had dropped and this had led to a drop in foreign exchange.

3.5 Geographic distribution of poverty

Although poverty is a widespread concern in Lesotho, poverty distribution varies systematically across regions and locations. There are three geographic classifications designed in previous studies by the government to map poverty distribution in the country and they are 'Maseru urban', 'other urban' and 'rural areas' (Sechaba Consultants: 2000). Figures from the 1987 and 1997 Household Budget Survey reveal that the incidence of poverty is high in the rural areas and this figure has increased. In contrast, poverty in Maseru urban and other urban areas has declined in relative terms (May et al.: 2002). According to the 1996 survey, it was estimated that 54% of rural households were poor, compared to an average of 27% in urban areas and 23% in Maseru urban (Senaoana: 1996). However, there has been a decrease in the proportion of poor people in rural areas, while contrastingly the poverty share in urban areas has increased. This is due (to a larger extent) to the significant rural-urban migration observed over the years in this country (May et al.: 2002).

3.6 Demographic distribution of poverty

Similar variations in poverty are also inevitable between individual households depending on the family size and composition, type of household head, age, income gender and age of the head (May et al.: 2002; Sechaba Consultants: 2000). Larger households are likely to be poorer than the smaller ones. One reasonable explanation is that larger households are forced to feed a large number of heads and satisfy household's needs instead of accumulating wealth and investing (May et al.: ibid). Also, a larger household size implies significantly higher dependency ratio. Thus, most poor households have many children under the age of 16 and persons of retirement age (Senaoana: 1996; May et al.: 2002). This follows a tradition that many children in a family form a household labour pool and are a security at old age. Distribution of poverty is also characterised by segregation, in which case poverty is more inevitable among women than men. In Lesotho, women earn only 30.9% of the total national income, while men earn the remaining larger share of 69.1% (Sechaba Consultants: 2000). Further poverty distribution profile show that female-headed households are more disadvantaged than households headed men (Senaoana: 1996;

CARE: 2001). 54% of very poor households are headed by women (LNVAC: 2002), making the majority of women in the country very poor. Relative concentration of poverty in women can be argued from the perspective of their occupation and position in the society. They earn low wages, have high dependency ratios, fewer assets, less access to high paying jobs and productive resources and long hours of housework (CARE: 2001).

Senaoana (1996) further demonstrates that poverty is most prevalent in households that use farming, herding, informal business or casual labour as sources of income but nevertheless higher in households relying in mine remittances and formal wages. Finally, a strong relationship is recognised between age and poverty. Households headed by an older person in Lesotho are likely to be vulnerable to poverty especially if they do not have access to retirement income (May et al.: 2002).

3.7 Other Socio-economic characteristics of poverty

3.7.1 Education and literacy rate

Lesotho has committed itself to increasing the quality and quantity of standard of education. Key attempts to address high standard education range from provision of subsidies, improving teaching staff and physical facilities to recently free primary education starting from January 2000 (Sechaba Consultants: 2000, GoL: 2000). CARE (2001) demonstrates that the amount of educational exposure people have received has increased in the 1990s. But nonetheless nothing is mentioned about the quality of education received. UN (2000) claims that in terms of literacy rate, improvements have occurred. For instance in 1997, Lesotho ranked number 5 out of more than 40 Sub - Saharan African countries in adult literacy. But again, nothing is speculated about the quality of education received. From both UN and CARE studies, men score lowest in terms of literacy and educational exposure.

However there are a number of areas of concern about the educational system of the country. Some of the qualitative and quantitative indicators of education have been disturbingly pitching downwards since the 1980s (May et al.: 2002). According to the UN (2000) the latest available data reports that about 55% of children attended primary school in 1998, compared to 77% in 1989.

Also reported are the high dropout and repetition rates. UN (2000) reports that 2 out of 3 pupils are promoted from standard 1 each year. School dropout cases readily occur among children whose parents have low income and cannot afford to pay for school fees. However, it is expected that these problems of affordability and inequitable access to schooling will decline with the current free primary education program in place (May et al.: 2002). Sechaba Consultants (2000) argue that great care should be taken with regard to reviewing the number of dropouts though. While Sechaba Consultants (2000) admit that affordability is one reason accelerating dropouts, this is not the case with children in the highest economic quintile. The reasons given by these children include failure, lack of interest, informal learning at home, and being too young to enter school. Teachers also are poorly paid and many subsequently flee to South Africa for better paying jobs. The combination of all these problems has added up to the low morale and devotedness amongst the teachers and students resulting into a depreciating quality of education.

Educational attainment is lower among boys than girls. Unlike in other countries where education favours boys against girls, Basotho sent more girls to school than boys. The UN (2000) reveals that approximately 30% more girls than boys attend school. This is due to the traditional tendency of sending boys away to herd the livestock and later to be sent to the mines in South Africa (Senaoana: 2006; UN: 2000), while girls at home get the opportunity to attend school. Differences between boys and girls' school attendance are also inevitable in female-headed households than in male-headed households (May et al: 2002).

According to the UN (2000: 31) other factors that keep education standards low include "weak school management, inadequate facilities and teaching materials, overcrowded and understaffed classrooms, and the tendency of the government to focus on quantity rather than quality in its design and implementation of educational sector policies". Lastly but not least, teachers are also not qualified on areas of English, Mathematics and Science.

3.7.2 Health, mortality and life expectancy

Unlike education, the health sector has received steadily less government support in terms of expenditure and resources (Sechaba Consultants: 2000). However, this sector

is credited for its valuable improvements in physical infrastructure of health centres, introduction of public health programmes concerning diseases such as HIV/AIDS and TB; and in increasing the number of health institutions and services throughout the country (UN: 2000). All these improvements are credited to have increased people's access to health services and their health standards (May et al.: 2002).

However, there are still major problems encountered in the field of health. One of the many but very important challenge the health sector is brain drainage. A lot of qualified staff migrates to the neighbouring South Africa and abroad for better working conditions and incomes. Other equally important challenges include lack of facilities, high doctor-patient ratio, low incomes and long distances travelled to reach the hospitals (Sechaba Consultants: 2000).

Health standards have not increased in absolute terms in the country. CARE (2001) demonstrates that there are variations in the health standards of the people, not necessarily caused by the ineffectiveness of the health sector in the country but by an individual economic status. Given the fact that people in rural areas have relatively poor livelihoods, their risk of catching disease is undoubtedly higher than their counterparts in urban areas. But it is important to note that since some of the poorest groups are found in towns, it is probable that they too score low shares of health standards. Note should be taken also that congestion and pollution in urban Maseru and other urban areas make inhabitants of these areas very prone to diseases than people residing in rural areas (Senaoana: 1996).

Another variation in disease occurrences is found between men and women. Households headed by females have lower occurrences than households headed by men or de jure by women (CARE: 2001, GoL: 2000).

When reviewing life expectancy, UN and Bureau of Statistics show that the life expectancy for the average Mosotho was estimated to be 55 years in 2000, compared to 37 years in the 1950s (UN: 2000). This raised Lesotho's position to appear remarkably in the top five performers in the African continent (BOS and UNICEF: 1999). Following the recent statistics about life expectancy in this country, there are already signs that reflect that this significant performance is soon to decline given the

high prevalences of HIV/AIDS pandemic in this country and throughout the region. Life expectancy is projected to drop to 45 years by 2010 (UN: ibid). This UN Study further reveals that life expectancy varies between sexes, with women enjoying three years higher life expectancy than men.

UN (2000) reports that there has been a significant improvement in the Infant Mortality Rates (IMR) since the 1980s, recording a drop from 166 per 1000 deaths in 1986 to 55 deaths per 1000 in 1996. This reduction is primarily due to the long-term increases in the immunisation coverage. Among the adult population, the same UN study reports that mortality rates have decreased over the past three decades probably due to the increase in cure rates of diseases such as TB, but again estimates suggest that mortality rate is likely to increase due to growing number of HIV/AIDS deaths.

3.7.3 Drinking water and sanitation

Reduction of poverty through human development requires equitable services fundamental to human needs. Access to drinking clean water is one service that improves the health and well-being of people. In Lesotho, there has been an increase in access to clean drinking water- at least from 63% in 1986 to 75% by 1994 (May et al.: 2002). This change however has not impacted on the rural areas where most poor people reside. May et al. (ibid) demonstrate that in 1994, 91% of people in urban Maseru and other urban areas already had a full access to safe water compared to 50% in rural areas.

Adequate sanitation is another livelihood asset required for human welfare and development. CARE (2001) shows that there have been developments on provision of sanitation facilities. Comparing poverty studies conducted in 1993 and 1999/2000, CARE found that the use of Ventilated Improved Pit latrines in 1999/2000 has increased three times from 1993, however acknowledges that over half of the total population of the Basotho households still have no toilet or latrine of any sort. Sechaba Consultants (2000) demonstrate ecological variations in the distribution of types of sanitation. Urban dwellers especially in the high and middle livelihood quintile have a flush toilet or a latrine and while a few have simple latrines in the rural areas, quite a number of people have no toilets at all.

3.7.4 Employment

The economic boom the country experienced in the early 1990s has been described as a jobless one. With the government as the main employer in the country, the Labour Survey of 1998 found that the total domestic labour force was estimated only at 593 000, with a labour participation rate of 53% (UN: 2000). The same survey revealed that unemployment[11] has increased and it is estimated to be over 40.5 %. The rate is relatively higher for women (48.6%) than men (31.9%). In terms of age, it is reported that 42% of the unemployed are below 24 years of age.

A number of factors are responsible to the continuously increasing levels of unemployment. The retrenchments in the South African mines coupled with the high population growth have increased the surplus labour in the country of which the larger proportion is not skilled. If skilled, the country has no mechanisms to absorb the growing number of the labour force. According to GoL (2000), 25, 000 youths enter the labour force every year, but only 9, 000 find employment. The increase in retrenchments has increased the labour surplus. Also the country's inability to absorb labour even if skilled is one possible explanation behind the increasing 'brain drain' currently experienced. Wereko (quoted by UN: 2000) asserts that at least 126 professionals of whom a quarter of them are doctors left the country during the period between 1990 and 1994.

Given the increase in unemployment and the need for a cash income by most households, wage labour has become the most trusted livelihood strategy for the people. The type of work in the labour market differs according to the position of livelihood and education. Poor unskilled people are faced with unstable piece jobs or the government short term labour intensive public work programmes. Other employment positions are inevitable in the foreign owned clothing factories. While not every body get the chance to explore their opportunities in either factories or public programmes, a vast majority of the unemployed people especially in urban areas have engaged whole heartedly in self-employment – "selling beer, setting up small *spaza* shops and street vending and so on" (CARE, 2001: 93).

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[11] There are differences in the unemployment rate between surveys and authors depending on the methodology one used when defining the 'unemployed' and 'employed'.

3.7.4 Food security

The decline in Lesotho's economy, agricultural output and the HIV/AIDS pandemic has borne adverse impacts on the food security of the country. Once a food granary of the Southern African region, Lesotho is currently experiencing a devastating humanitarian food crisis, which compels the government to vigorously seek food aid from First World countries. LNVAC (2000) asserts that by 2000, 30% of the population seriously required emergency food assistance. The rate of increase of people in need of emergency food assistance is alarming because by March 2003, this population has been reported to have increased by 12.5 % (ReliefWeb: 2003).

CARE (2001) shows that food security and sufficiency differ considerably between households. Households that seem to be fully assured of food security often are the rich and the middle income ones. Similarly, as observed that females are predominantly poor, their households are less self-sufficient and assured of food than male headed households.

While decreased agricultural production is often blamed for food insecurity in this country, UN (2000) adds factors such as decreased arable land due to erosion, urban sprawl and the increased degradation of rangeland to represent other important risks in the long-term sustainability of food security.

3.8 Other crosscutting themes

3.8.1 Gender

The government is the main employer in the country and 51% of the people employed by the government are women (UNICEF in Letuka et al.: 1997). Despite their economic activeness and vibrancy in the local labour force, their social status still remains low. This follows the cultural practices and both the customary and common law, which regard women as inferior to men. Such practices not only expose women to discrimination, but they render them economically, socially and politically dependent (UN: 2000). That is, women have no access to decision-making either in the household or in public. In the household, women exercise little control on issues pertaining to the use of resources such as land and livestock, yet all family resources are left in women's hands when men are away. In the case where women hold leases, it is often if the husband is deceased or the woman is a head of a de jure household

(Senaoana: 1996). Only 30.3% of the total land is owned by women in this country (Letuka: 1997). Moreover, the fact that men possess higher job opportunities and incomes leaves women with no choice but to be completely dependent on men for money to maintain their families' sustainability.

Letuka et al. (1997) however demonstrate that great care should be taken when assessing women's access to their husbands' incomes. Not every man provides his wife with his remittances. He argues that about 90% of the miners do not regularly send money home. As such, often women are placed in the middle of stress and risks trying to earn alternative income to meet family basic needs. As a result, women engage in activities illegal or informal in order to find alternative incomes (CARE: 2001).

3.8.2 HIV/AIDS

Literature shows that cases of HIV/AIDS are increasing at an alarming rate (CARE: 2001; Sechaba Consultants: 2000; GoL: 2000; UN: 2000). In the recent World Bank study, it was found that the prevalence of HIV/AIDS among the total population is increasing at the rate of 26.5 % and 35.3% per annum for the adult population. It is further estimated that from the advent of this disease in Lesotho in 1986, up to the end of 1997 a cumulated 15, 000 deaths have been reported and have produced 9, 500 AIDS orphans (UN: 2000). Ntsonyana and Sebatane (2001) add that there are about 14,000 new STD cases diagnosed every year in Lesotho. Today, the country is ranked the world's fourth highest with HIV/AIDS prevalence (LNVAC: 2002).

There are great disparities reported in the distribution of HIV/AIDS between ecological zones, sexes and age groups (UN: 2000). Urban areas are the worst affected with Maseru urban at the forefront. Surprisingly, Qacha's Nek, which is one of the most rural districts in the country, has one of highest prevalences of the pandemic. Adult prevalence rate in this district has risen as high as 42%. All through the country, females at all age groups have been reported to have more HIV/AIDS cases than males. While 55% of people who are infected are females, only 45% of the infected population are males (BOS and UNICEF: 2000). In the past, the increase in infections was prevalent in young mothers and children below the age of 4 years but now the situation has changed and more and more youths between the ages of 20 and

30 years are becoming infected (MOHSW quoted in Ntsonyane and Sebatane: 2001). Within the youths, females are reported to be predominantly affected. In the 40 to 59 age group there are more males infected than females. This is because men at this age group are reported to be highly promiscuous (UN: 2000).

3.8.3 Child's nutrition and food security

The increasing poverty in the country causes serious threats to the health status of children. Ntsonyana and Sebatana (2001) demonstrate the intensity of child nutritional deficiencies in this country and report that generally malnutrition rates have increased from 19.1% in the 1980s to 33% in the 1990s. This percentage has doubled rapidly so much that UNICEF (2003) reported an average of about 85, 000 children under the age of five that needs emergency supplementary feeding and 30, 000 that need therapeutic feeding for at least twelve months. Research points to the persistent low agricultural production and high unemployment rate as the heart of the children's nutritional crisis (UN: 2000; UNICEF: 2003, GoL: 2000).

Apart from malnutrition, there are other signs of bad nutrition among children. Wasting and underweight are persistent problems and more dominant on younger children during their first three years of life than in the older groups. Recent studies show that almost 18% of the children under the age of five are underweight and 4% are classified as severely underweight (BOS and UNICEF: 2000). More other diseases inevitable are Acute Respiratory Infections[12] (Ntsonyane and Sebatane: 2001). It is estimated that almost 29.2% of children are treated with these infections every year in the country (BOS: 2000).

Given the poverty severity in rural areas, more cases of children's ill health are apparent in rural than in urban areas. The BOS and UNICEF (2000) survey shows that children in the rural areas have a higher proportion of underweight condition (22.5%) and wasting (8.6%) than children urban areas. Further findings show that children of educated caregivers are found to be less likely to be undernourished. The increasing urban poverty coupled with complex and harsh urban livelihoods expose children to excessive abusive conditions and neglect. Without suggesting that these conditions do

[12] Children with ARI are defined as those who have an illness with a cough accompanied by rapid or difficult breathing whose symptoms include pains in the chest and a blocked nose (BOS: 2000).

not happen in rural areas, UN assessment (2000) reveals that child abuse, family violence and sexual abuse predominate urban more than rural centres. Since these events are normally not reported, it is difficult to refer to any statistical data. UN (ibid) further asserts that the occurrences of abusive practices will not lessen any time soon since the protection mechanisms currently in place in the country is insufficient to address the issues of child protection. Moreover, the legislation still allows for corporal punishment of children for minor breeches of law.

Statistics for infant and under-five mortality show that there has been a fluctuating pattern on the infant mortality rate (BOS and UNICEF: 2000). From the 1980s up to 1991, there has been a noticeable downward trend followed by a sharp increase from the year 1996 up to 2000. In the later period, infant and the under-five mortality rates were 79 and 111 per 1000 live births respectively (BOS and UNICEF: ibid).

3.9 Factors affecting children's nutritional status

The UNICEF (1999) study points to different factors that impact adversely on the nutritional status of children. The study demonstrated that, generally children from the south and mountainous regions of the country have the worst nutrition in the country. This is basically because these areas are dry and prone to severe droughts. Again in the mountains people are poorer, hence are vulnerable to food insecurity. The study also found out that there is correlation between crop production and malnutrition. Thus, households with low nutrition status produce half the cereals compared to households with higher nutrition status. However, this relationship is not significant given the fact that in a number of cases, there were years of high production that resulted in household self-sufficiency yet failed to reduce cases of malnutrition.

The study further demonstrates that household income has an immediate impact on the nutrition status of children. Children from households with low wage incomes have higher cases of malnutrition, underweight and wasting (UN: 2000). This study however found that high income is not a guarantee for a child nutrient intake as the income may be spent on other things such as beer purchase other than on child welfare. Further findings showed that maternal education, water supply and sanitation have an influence on a child's nutrition. It was found that children of educated mothers have low levels of malnutrition. This is probably due to the fact that they

know how to feed their children better and possibly have higher incomes. In the same manner families without sanitation and water supply were found to have malnourished children. Lastly but not least, Also, households that have no livestock and practice no subsistence farming were found to have a higher number of cases of child malnutrition (BOS and UNICEF: 2000).

During the collection of data for the 1993 UNICEF study, caretakers of the malnourished children were interviewed in hospitals throughout the country and were asked to state their perceptions of what they thought the cause of children's malnutrition could be. The top most mentioned sources were unemployment and low agricultural production (BOS and UNICEF: ibid).

3.10 Conclusion

This chapter has demonstrated the demographic and socio-economic status of Lesotho. This contextual analysis is important for understanding the experiences of developing countries in the transition to urbanisation. The country is experiencing dramatic migration, economic growth, and improved health standards on some diseases but also increased inequality, urban poverty, food insecurity and a high prevalence of HIV/AIDS.

CHAPTER 4. RESEARCH DESIGN AND METHODOLOGY

4.1 Introduction

One of the objectives of this research study is to understand the care practices and behaviours of women given a certain social phenomenon such as urban poverty. Generally, this study seeks to investigate social behaviours of people and factors influencing this behaviour. Research shows that more in-depth intensive information in the context of qualitative data is useful for this kind of investigation (Babbie and Mouton: 1998; Huysen: 1994; McNeill: 1985). Qualitative data for this dissertation comprises the socio-economic status of the identified households, the extent to which primary caregivers can provide care to children and their perception of the nutritional and food security status of children under investigation. This chapter lays out research design, setting, techniques and methods that were used for data collection.

4.2 Research design

There are a number of reasons why research of this nature prefers qualitative over quantitative data. Qualitative studies seek to promote an understanding and description of a human behaviour from the perspective of the social actors themselves. Informants are active agents in constructing and making sense of realities they encounter. Qualitative methods seek to gain the insight of the social action from the natural setting of research agents (Babbie and Mouton: 1998). They can also be used to "explore people's knowledge and experiences and examine not only what people think but how they think and why they think that way" (McNeill, 1985: 270). Despite being time consuming qualitative research allows for a wide variety of data collection techniques, enhances the study's validity and enables the researcher to use methods he/she is most comfortable with.

Qualitative methods can be presented in different methods including ethnographic studies, case studies and life histories (Babbie and Mouton: 1998). Case studies in particular, have been used for decades in social research due to their ability to access qualitative data (ibid: 1998). According to Bromely (1986), a case study is an intense account of something interesting or problematic about a person, group, institution or an event in a certain situation. The units of analysis are studied mainly to understand their uniqueness and peculiarity given a certain situation (Huysamen: 1994). Case

studies have many purposes including demonstrating a typical or representative state of affairs, illustrating the range of phenomena (Bromley: 1986) and investigating the dynamics of some single bounded system of a typically social nature (Huysamen: 1994). They have an element of integrating theory and practice, through applying certain concepts of theory to the practical world. Furthermore, they present a practical, realistic and detailed representation of what is happening in the real world (Bromley: 1986: 42). Accordingly a case study was used as a research design to meet the goals mentioned above.

Disadvantages of case studies

The acknowledgement of advantages of case studies in social research does not limit the number of criticisms levelled against their use. They are viewed as 'non-scientific', in the sense that they cannot describe the causation of the social behaviour. Their provision of their contextual analysis does not offer a pre-test of the behaviour, but only permits the post-test measurements (Babbie and Mouton: 1998). Thus, they do little more than defining the problem. Case studies also suffer from 'investigation effects' in a manner that subjects of investigation are altered in specific ways comfortable to the researcher (Babbie and Mouton: ibid)). This study also shows that case studies have a little reliability and generalisation. It is difficult to assume that the perspectives and behaviours of the participants reflect in every aspect the ones of people who did not participate.

4.3 The field site

Urban Mafeteng was identified as a case study and Thabaneng as the study community. No research on the Thabaneng community could be identified. The limited literature of Mafeteng nevertheless provides the information that this district is the second biggest in Lesotho. Mafeteng covers an area of approximately 35.98 square kilometres and has the total population of 203 535 (GoL: 2000). This is one of the poorest districts of Lesotho and has in the past years been greatly affected by drought and famine, political conflicts and retrenchments of mineworkers.

The town of Mafeteng experienced a significant population growth and renewal in the 1980s and 1990s when social services increased in this area and people decided to change their livelihoods from agricultural to industrial production. In the late 1990s

and early 2000, decentralisation of services, employment in the foreign owned factories and growth of the informal economy increased population in this town. Indeed, Mafeteng possesses the required qualifications of the study in that it grows under forces of globalisation and urbanisation. The advent of foreign-owned labour intensive factories in this area encourages many people, mostly women to migrate from their rural areas to settle in villages around town such as Thabaneng. In general, Thabaneng possesses most characteristics of the urban environment described in Chapter One and hence can be used to test the hypothesis of this study. The socio-economic status of Mafeteng combined with its continuous rapid growth provides grounds to assume that urban poverty is becoming a challenge among communities in this town. As with all urban areas experiencing urban poverty, it can be assumed that most households have problems associated with food insecurity and children's malnutrition.

4.4 The sampling design

The fieldwork was conducted over the months of February and March of 2004. The data was collected from the participants possessing similar characteristics: women whose children have cases of malnutrition[13], working in the foreign-owned factories and staying in Thabaneng. Their children should be at least under the age of three[14] and diagnosed with malnutrition at least a month earlier. These women are termed 'primary caregivers' for the purpose of this dissertation. A purposive sample of five women bearing these characteristics was recruited. To obtain these women food distribution centres of World Food Programmes (WFP) were visited. The staff of WFP had lists of people and households that are to be granted food on the basis that they are very old, are orphans or their children have been diagnosed with malnutrition. This recruitment strategy was advantageous because it provided as many households as recognised by WFP with malnourished children in Thabaneng and other villages surrounding urban Mafeteng. However this method did not provide the addresses of

[13] Malnutrition was measured by height and weight. According to Blau et al. (1996), these are some of the good indicators of long term and short-term nutritional status. Women in Thabaneng got information on weight and height of their children from the local clinics and hospital, which in turn referred them to WHO/WFP offices for high nutrient food grants.

[14] The under three group has recently been marked by nutritionists as an appropriate age group for measuring nutritional status of children, not the under-five group as used to be the case. Evidence shows that while growth is still affected in children under five, the risk of mortality from malnutrition decreases dramatically after age three (GSS and Beaton quoted by Maxwell, 2000:14).

households identified. The lists also said nothing about the employment status of the women.

To find the identified households, the community leader of Thabaneng was visited. He, together with his assistants provided the addresses of households identified. Not every household identified was initially interviewed because not all women identified were working at the foreign-owned factories. It was at this point that the snowball method was used to identify research agents.

It became evident that the identified women were very busy participating full time in the labour market and hence had no direct involvement and experience with children. The women's lack of close involvement with children limited the objectives of investigating the possible causes of malnutrition in children. Therefore interviewing a set of 'alternate caregivers' expanded the sample. Alternate caregivers are people looking after children while their mothers are at work. An alternate caregiver can be a relative, grandmother, sibling or a nanny. The inclusion of the alternate caregivers in the study was done to find as many and diverse views and perceptions about children's health as possible. This strategy also broadened the scope of findings. The alternative caregivers chosen were of the same households whose women were initially interviewed.

Although each household chosen was visited with the aim of conducting an interview with a respondent, interviews were turned down in most cases because respondents did not want to disclose their employment status. Despite introductions, proof of identity and discussion of study objectives, women were suspicions and thought the researcher was a spy from the government or WFP. The rumour was that if they disclose their involvement in the factories, their children would be deregistered from the WFP food grants. These problems for several times forced new households to be identified and visited.

Some of the children were not staying with their primary caregivers. While mothers were working in factories in other towns, children stayed with their alternative caregivers at Thabaneng. This was very difficult because the aim of the study was to get the perception of primary caregivers who are working but at the same time getting

an insight of the child's life within the few hours that she gets in the evening and on holidays and weekends. This meant that while some of the visits to the households were expected to precede the actual interviews, this never actually occurred since the mothers and the children were staying in different locations.

During the days spent in Mafeteng, the WHO/WFP distribution centres at Thabaneng were visited on the day when this village together with other neighbouring communities were summoned to collect their food grants. The mission of this visit was to talk to Thabaneng women about their children's status. During registration process, staff of WFP informed women about the interviewee presence and their purpose of the study and encouraged women to participate. A high number responded positively resulting in a focus group made up of nine women who also were working at the foreign-owned factories.

4.5 Research Techniques

As highlighted before, it is normal to couple case studies with various methods such as participant observation, life-stories, documentary, records and questionnaires (Bromley: 1986). In this study, a combination of intensive face-to-face in-depth interviews, focus groups and observation techniques were used to collect data.

4.5.1. In-depth open-ended interviewing

Interviewees were visited in their homes and the interviewing protocol was conducted using semi-structured interviews attached in appendix. Most women get home late and instead of relaxing they prepare their family's dinner. Therefore food was brought for all the members of the sampled households so that in the evenings after work, women could direct their attention to the interview.

Interview guides were prepared for guiding the interview during the course of the interview process. An advantage about these guides was that even though respondents were asked more or less the same questions, the interviewer was able to alternate different terminologies depending on the social background, level education and experiences of the interviewee. This method was helpful for the purpose of achieving the main aims of this thesis because unlike structured interviews, these are inflexible and give the opportunity for probing allowing for further elucidation of vague and

unclear responses. As a result, the responses were of the required quality and standard.

During the interviews, primary caregivers were asked to provide information about their household's socio-economic status, their health and nutritional status and those of their children. In addition they were required to recall different periods, events and activities that they shared together with their children. For more additional detailed information regarding nutrition and health status of children, alternate caregivers were brought aboard for interviewing. For information that entails some care behaviours such as feeding, hygienic behaviours and psychosocial care, alternative caregivers were observed.

4.5.2. Observation

According to Engle et al. (1999), it is important that simple observation be a supplementary technique because unlike recalling it increases the chances of getting accurate measures of time allocations and allows the investigator to assess degree of involvement and quality of child care at the same time. Observation techniques involved the gathering of data that could not easily be obtained up through interviews. Observation sessions were done during the day at homes in the presence of alternate caregivers and children under investigation. Each observation period lasted for at least three hours. During the sessions, detailed notes were made of empirical observations and interpretations of the phenomena under investigation. Factors under investigation that were observed in the care setting included the psychological elements of care provision like patterns of interaction and expression between a child and alternative caregivers, supervision and frequency of feeding and hygiene of the house. Much as it is difficult to measure the spiritual bond between the child and the caregiver, signs of emotions and affection were noted. Coding of ongoing events of the frequency of particular practices and sequences of caregiver's interaction formed part of the systematic observation and a reference for the relationship between the two. The alternative caregiver knew the purpose of the observation and it is therefore probable that some of the alternate caregivers' behaviours were reactive to the interviewees' presence. Informal discussions and conversation with the alternate caregivers provided further information for assessing the child's behaviour and activities.

It is worth noting that some of the alternative caregivers were hesitant to reveal the socio-economic status of the households, children's health status and their own perceptions about children they are caring for. It may be because most of them were young and uncomfortable to open up to a stranger. Again it may be because they could not open up in the presence of other members of the household[15]. To them, giving information was like revealing family secrets and they felt that they had no privilege to talk to strangers about members of their households. The fact that the families had been visited before and interviews had been contacted with the primary caregivers helped some to talk freely and give their own perceptions about the whole situation, but made others more uncomfortable. It transpired that they were suspicious that the information obtained from them might be revealed to the primary caregivers. Others felt that the information from primary caregivers had been sufficient.

4.5.3. Community focus groups

As in all other interviews, a semi-structured interview guide was used and questions addressed to women were the same set of questions that were addressed to women visited in their homes. The discussions allowed the assessment teams to gain a group level overview of the food security and nutrition situation of children.

4.6 Research procedure and analysis

At the end of the fieldwork a total of 19 women had been interviewed – five were primary caregivers interviewed at the household level, five were alternate caregivers and nine were primary caregivers who participated in the focus group discussions. In general terms, responses from all the participants were satisfactory and did not vary significantly between individual households and individuals. As with most qualitative research, it cannot be certain that the participants' experiences and perspectives in this study were representative of women who did not participate both within Thabaneng community and in any other place. But since participant's personal characteristics reflected their community, the results of this study were unlikely to be biased by the sampling procedure. During the focus group discussion, a research assistant helped with facilitation and moderation of the discussions. In all the interviews sessions a

[15] The next chapter reveals that most of the sampled households are crowded and yet have small houses. This means that some of the informal discussions that I had with the alternative caregivers were held in the presence of other members of the households.

tape recorder was used. At the end of the fieldwork, the interviews were transcribed with the use of a computer programme, N6.

4.7 Limitations of the study

This study is limited in many ways. The sample is based on of households with children under the age of three yet there are children with malnutrition older than three years of age. Also the study did not include households where women were engaged in other places of wage income that drain their time and energy besides foreign owned factories. A specific focus on women working at the factories limited the study's ability to capture extremes of diversity of urban livelihoods, urban poverty and children with malnutrition. The emphasis on women providing care has provided a little information on the role of men in caregiving, yet there has been a lot written about the role of men in children's growth.

During the sampling protocol it was hard to differentiate between children with malnutrition because of their low nutrition intake and those malnourished due to HIV/AIDS related infections. It was established from the WHO/WFP staff that most of the children diagnosed with malnutrition are HIV positive. Neither the local hospital nor WFP could provide the statistics of those who were not infected to use as a basis for a sample. The problem of limited data was a problem throughout this research. There was little data regarding Thabaneng as a site of investigation and Mafeteng was no exception.

Some of the children were not staying with their mothers. Their mothers have moved out and were staying with friends. This was very difficult because the aim of the study was to get the perceptions of primary caregivers who are working but at the same time getting an insight into the child's life within the few hours that the mother gets in the evening and on holidays and weekends. To contact the primary caregivers who were not staying with their children, other factory employers who happen to know their whereabouts were consulted.

Some data was meant to be collected through recalling technique. Women were required to recall such things as morbidity symptoms, time spent with a child and activities involved. It was however difficult to use recalling technique to capture

detailed information about care practices and behaviours since such activities are regarded as frequent, simultaneous and not-very-important activities. This in turn made it difficult for individual activities to be easily encoded and remembered.

The kind of qualitative data needed for this type of research study required more than the two weeks that was accessible to collect data, especially when collecting data on care behaviours and practices. Time restrictions failed this research study in that exploration of events and activities that can be related to people's attitudes and behaviours was not adequate. Instead of simple observation techniques, participant observation could have been a corner stone for this research study given a longer period of time. With participant observation collection of data could have entailed various research tools and activities and interaction that could have produced more detailed and unbiased qualitative information. Again, this could have reduced the levels and degree of reactionary behaviours the informants gave towards the interviewee throughout the two weeks of data collection.

4.8. Conclusion

The chapter has outlined methods and designs on the way the data was collected and analysed. The qualitative method of research was used and interviews and observation methods were central to collection of data. The chapter has also examined the protocol of fieldwork and described methodological considerations of selection of the sample and field site and looked limitations of the study.

CHAPTER 5. CONYEXTUAL ANALYSIS

5.1 Introduction

Urban areas comprise diversity in people: culture, organization and attitudes; and Thabaneng is no exception. This chapter intends to provide an overview of the past, profile, experiences and characteristics of the community of Thabaneng that may be responsible for the affirmed hypothesis. The profile may not apply to all households in these communities but helps examine and understand the findings of the fieldwork derived from the sampled households. It is through this information that implications about the socio-economic status, livelihoods and environment in which the children are growing into can be suggested. Further implications will embrace direct factors in the households that may affect the nutritional intake of children besides household food insecurity in the urban context. This information includes labour-based livelihoods, income generating activities, total household income and income diversification, potential income shocks, safety nets and coping strategies. All of the information is summarized in the Tables.

5.2 Demographic characteristics of the sample

5.2.1 Composition and size of the households

The study results show that a larger proportion of informants are single, separated or widowed. Whatever marital status, all of them have numerous children and dependents. More than half on of the sampled households comprise the household average size ranging from four to twelve members. The households' members include the parents (either biological or the in-laws), other siblings and relatives. There was however a decreasing trend in the dependency ratio among households whose members are newly married couples and single parents. The smallest household interviewed was composed of five members.

Table 1

Demographic characteristics of primary caregivers (n= 14) and alternate caregivers (n=5)

Characteristics	Primary caregivers	Alternate caregivers
Gender		
Female	14	5
Male	0	0
Marital status		
Single, widowed, divorced	9	4
Married	5	1
Relationship to the child		
Mother	11	0
Grandmother	2	0
Relative	1	0
Nanny	0	2
Sibling	0	3
No of people in the hh		
1 - 5	2	0
5 - 8	4	4
8+	8	1
Age		
8 - 15	0	4
15 - 25	11	0
25 - 35	3	0
35 – 55	0	0
55 - 65	0	1
Migration		
Native	3	-
Migrants	11	-

The gender breakdown shows that there are more females than males occupying the sample households. As with all other poverty-stricken households, females dominate the household headship. The female dominance in household headship is in harmony with that of Lesotho as a whole owing to number of factors: despite the retrenchment some men are still working in the South African mines; there is high probability of

widowhood, divorce and never married women; and men are left in the rural areas when women migrated to towns to work in the labour market.

5.2.2. Relationship to the child

As highlighted, mothers play a major role in children's health care. However, different circumstances can lead to situations where an infant is raised by relatives, friends, siblings or foster parents. In the sample of the primary caregivers, mothers are predominant primary caregivers followed by grandmothers and relatives. It was found that relatives and grandmothers have taken the responsibility of the mothers after the children's mothers died[16]. In one case, the child was the sole responsibility of the maternal grandmother because the biological mother was not staying at home. She left the child and was staying with friends.

There are different categories of alternate caregivers. Many children were taken care of by siblings[17] and followed by nannies. Most of the siblings are taken out of school for the purpose of caregiving. In the case where there are many siblings in the house, it is common practice to exchange the role of caregiving. If one goes to school, there other looks after the child and then the responsibilities are exchanged the following day.

5.2.3. Age

The age distribution shows that primary caregivers fall between the ages of fifteen and thirty-five years. However it cannot be concluded from the findings that generally women facing a problem of children malnutrition solely fall within this age group. If the sample of this study could have been extended to comprise unemployed women in Thabaneng, the results could have covered women at all age groups. First of all with the widespread of famine and food insecurity in Lesotho, most women regardless to their age groups are faced with a series of problems related to household food insecurity and children malnutrition. Secondly, in the WHO/WFP food distribution centres, women falling in all age categories were found up queuing for their children's

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[16] Due to high prevalence of HIV/AIDS and anaemia amongst women, most of them die during child delivery or soon after child's birth.

[17] Only five alternate caregivers were interviewed and this information is solely based on this sample. However, during the focus group discussions, most women alleged the opposite: those nannies other than siblings provide childcare to the young ones.

food grants. It should be highlighted therefore that the sample of this study happened to fall within the identified age group only because the sample comprises of women employed in foreign owned factories where the tendency is to employ relatively young women[18].

There is a huge disparity in the age groups of the alternative caregivers. The alternative caregivers fall within the age group of 8-15 and 55- 64 years. This is because alternative caregivers found in the sample households happened to be grandmothers, young or old nannies and siblings. Households having nannies explained that they prefer young and old to middle aged nannies because they are less demanding in terms of wages and benefits.

5.2.4. Migration

It has been shown in Chapter One that economic growth, rural-urban migration and urban growth of towns and cities are among factors that change people's livelihoods especially of vulnerable people like women. The study reflects that there have been changes in the livelihoods of the sample women brought about by the state of urbanization in their villages. A larger proportion of households had migrated to the areas they are currently residing. Before, their parents or they themselves were staying in the rural areas of Mafeteng or other districts. For those who are not local, they migrated to Thabaneng to be near services and work places. A few have moved when they got married.

5.3 Socio-economic characteristics

5.3.1 Education

Although Thabaneng community does not have educational services located within, children nevertheless have adequate access to educational services from the nearest villages and the town of Mafeteng. There are at least six primary schools and six high schools found in the neighbouring villages and town - permitting approximately a maximum of twenty minutes walk to the nearest school. One would assume that the number of schools accessible in Mafeteng would contribute to the high quality of

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[18] See a section on 'employment conditions and environment' in Chapter Six for more details on why preferences are on young women.

education both in the local and district level. The findings issued by the CWIQ[19] survey (2002) reported that Mafeteng ranks in fifth position in terms of adult literacy among all the districts of Lesotho. The survey further reported that Mafeteng district as whole has a high level of dropouts because of great dissatisfaction people have of their education system and standard. Illiteracy and lower levels of education are more common among males than females. This can be related to what has been explained before that the tendency for males in Lesotho is to join the mines or initiation school at an early age. The incompatibility between the quality and quantity of education appears to result from deficiency of facilities and teachers (CWIQ: 2002).

Table 2

Socio-economic characteristics of primary and alternative caregivers

Characteristics	No.
Education	
Primary caregivers	
Have completed primary education	2
Have some secondary education	10
Have completed secondary education	2
Alternate caregivers	
Have completed primary education	5
Have some secondary education	0
Have completed secondary education	0
Housing Ownership	
Rented	2
Own	2
Parents/ relatives'	10
Facilities	
Electricity	0
TV	0
Radio	7
Water and sanitation	
Piped water	0
Public underground water	11
Bought water	3
No toilets	5
Pit latrines	9

[19] CWIQ survey 2002 was conducted in Matelile in Mafeteng as part of the poverty reduction programme by the government in partnership with UNDP and LFCD.

Nearly all of the primary caregivers have some secondary education and apparently none of them are attending any form of formal or informal training. Close to half of the respondents have expressed their dissatisfaction about their level of education. They explained that their level of education has in many ways limited their chances to obtain high-income jobs.

None of the household heads finished secondary education but a large percentage of them has completed primary education. Financial constrictions commonly are amongst other factors that brought about a low education enrolment among the heads of the households followed by the need to work in the fields, or marry at an early age.

5.3.2 Housing: Ownership and facilities

Household assets and facilities are good indicators for social and economic welfare of the sample households. Not all indicators that measure socio-economic status of households were used, only the key ones that may be good assessing tools for determining the environment in which the child is growing and the hygienic behaviour of the caregiver were used. The identified indicators were housing, availability of electricity, availability of a dumping area and an area for disposing dirty water and ownership of a television set and radio.

There are a few significant differences identified between the sample households. Of the entire sample, two households owned their houses and both were composed of two rooms. As in the rest of the sample, houses had only one to three rooms. As most primary caregivers were young and single, they did not own houses but lived with their biological or relatives. A few women stayed in rented houses which all comprised of one room. A level of dissatisfaction is apparent amongst these women since their rented houses were neither in good shape nor within a healthy environment. There was high level of dissatisfaction amongst women dwelling in rented houses rising from their eroded quality and unhealthy environment. Women staying with other household members also complain about such things as congestion, family disputes, a lot of noise, high food consumption and having lot of people to support.

The availability of either the television or radio is useful for equipping women with general information for informed decision-making and right choices, hygienic skills and strategies to improve children cognitive and physical development (Leslie: 1988). None of the sample households had electricity hence did not own any electrical appliances such as fridge and TV. Some respondents asserted that their children got to watch TV at the neighbors or at the local shops. A large proportion of households have no radios. A few women who happen to own radio sets exclaimed that they have never heard of any programmes about children nutrition and growth. They are not aware of these programmes because they have no time to listen to the radio as they spend most of their day at work. Alternative caregivers on the contrary explained that they have not heard of such programmes.

5.3.3 Water and sanitation

Water is the most important component of both personal hygiene and public health. The contemporary drought has reduced access to water of most households in Lesotho. Results show that all sample households have access to water from public taps. However the distance traveled to fetch water and the quality of water available is a problem. A larger fraction of households maintained that they walk at least between 10 and 30 minutes to the public water taps and use wheelbarrows and their heads to carry water. In addition, some of the underground wells are drying up due to drought and hence produce muddy water. As a result, a significant number of households are forced to buy drinking and cooking water from their neighbors who have piped water within their compounds. For cooking and drinking water only, usually an amount of approximately R30.00 is paid on a monthly basis.

All households have pit latrines, usually uncovered and they are located an average of 20 meters from the house. There is a less disparity between households as far as the availability of dumping area is concerned. While most households have a hole where they deposit and burn their wastes, others just throw them on the open space. Again not every household burns the wastes after every disposal. Some respondents assert that they do have much of the waste material so there is really no need to burn the wastes after every disposal. They added that some of the wastes are important for the children to collect and turn them into toys. Less than a quarter of the sample has a

defined area for disposal for dirty water. They either dispose dirty water in gutter or empty lots. The majority of households have separate areas for depositing wastes and disposing of used water.

5.4 Urban livelihoods: activities, income, shocks and coping

5.4.1 Employment

All of the interviewed primary caregivers are employed in the foreign owned factories. Before the current employment, the majority was unemployed and the rest were engaged in various informal activities such as beer brewing; knitting; and food, vegetables and fruit vending in the streets. They have quitted their informal activities because they wanted to improve their working conditions through formal sector employment, which they see as more reliable, protective of their working conditions and providing relatively fixed salaries[20]. Of the whole sample, a relatively larger group of women are satisfied about their employment status despite their working environment and conditions. To them, unlike the government and private sector that has ignored them for a long time; the factories enable them to put bread on the table for their families. There are different activities that these women are engaged in within the factories. Nearly half of them are sewing garments and the rest are cutting fabrics, counting scores or supervising the factory activities.

5.4.2 Other income generating activities and resources

Literature on urban livelihoods shows that there is a high incidence of diversifying livelihoods for purpose of income generation in urban areas (Maxwell et al.: 2000, Haddad et al.: 1996). The study findings show that the interviewed sample's full time engagement in wage labour limits their flexibility to engage in other income generating activities. More evidence however shows that there are other members of the household engaged in multiple income generating activities both in the informal and formal sector. For the whole sample though, the average number of income generating activities is very low as is the number of people engaged in these activities. Perhaps this is because a relatively larger proportion of members of the sampled households were children, the aged and sick. An issue of concern however is that

[20] There are diverse descriptive ways that explain formal sector. However there are elements of formal sector that are all embraced in all the definitions and were invented by ILO. To see more details on formal/informal sectors, see ILO (1972).

having one or more members in the household engaged in other income generating activities does not guarantee support to women.

For the Thabaneng born households, their livelihoods have completely changed from agriculture to income labour. While sampled women wish that they could practice small vegetables farming, their limited time offers no opportunity to do so. However, other members of the households produce vegetables at the backyard gardens. But with the occurrence of bad climatic conditions, irrigation has been very difficult resulting into relatively low yields. Production of vegetables is more common in large families. For households in rented homes, vegetable gardening is almost impossible. Livestock rearing is difficult due to scarcity of grazing land and the concurrent episodes of livestock theft around Mafeteng area. Only one household out of the total sample has a cow.

5.4.3 Income levels and sources

The amount of income women earn depends on the type of work they are doing, the factory and the amount of overtime hours a day. Monthly incomes of women who cut the fabrics range between R 400.00 and R500.00. For those who are sewing, their wage income ranges between R500.00 to R600.00 per month. Supervisors' salaries lie between R600.00 and R800.00 per month. Given the fact that there are more women sewing, most of them fall in the income category of R500.00 - R600.00. With more overtime hours these wage incomes may be increased. It is important that the average monthly income of the household includes earned income from other income generating activities by other members of the household, gifts, savings, lottery winnings and net borrowing or lending (Maxwell et al.: 2000). Given the general low levels of income producing activities, it was discovered that all the sampled households have a low share of income from these sources. The lower the levels of education of the household's head, the lower household's monthly income. The study notes that the average income of the male-headed households is significantly higher than of the female-headed households. Again, families with more male members stand a better chance of a larger income. More evidence shows that the total household income for households with few members and dependants is higher than large sized households.

Other strategies of income generation include inter-household transfers in terms of gifts and borrowing. The respondents admitted that more than half of their household income is from gifts, borrowing and lending. Migrant households find cross-sharing complicated in towns. People do not just share food and exchange gifts; they do everything with the expectation of being repaid. Friends, neighbours and relatives are a good source of this kind of source of income. Lately, after their children have been diagnosed with malnutrition, WHO/WFP has granted them food every month. Besides friends, relatives and neighbours, there are community organisations both in the villages and at work places for money lending. A large number of the members of the sample population maintained that they are members of at least one community organization. There is a decreasing trend in membership with small sized families and single mothers having no or at least one membership. Most single women are not members themselves but if they need help their parents who are members can transfer benefits to them. A noticeable trend is that small sized families have a strong preference for organisations that concentrate on buying food for members, clothes and furniture instead of their counterpart organisations concerned about funeral services and money lending.

On the question of the level of satisfaction in urban areas the respondents demonstrated that there are no other places better than urban areas where they can express their happiness and acquire well- established livelihoods than in urban areas. Unlike rural areas, urban areas enable them to meet different people and engage in different activities that can mitigate their poverty levels and social deprivation. One of the interviewee said "unlike in the rural areas, here you get work in informal sector, meet people and engage yourself in different recreational activities".

5.4.4 Shocks, safety nets and coping strategies

Literature shows that poor households develop strategies that generate income for coping with economic stress. However, the full time participation of women in the labour market limits their flexibility for dealing with stress. It was found that there are community organisations and groups of which women are members, which help individual and household members during social and economic crisis such as funerals. A small number of households are not members of money lending organisations. Those who are not members complain about high interest rates. Almost all of the

respondents' households are members of funeral groups. Households with young couples or single mothers are more concerned with organisations dealing with social issues than the ones dealing with funerals.

Nearly all households maintained that with or without inter-household transfers and community organisations, their total income is still insufficient to serve the household's basic needs, let alone cater for everyone's needs in the household. As a result, households resort to cutting consumption and spending. This exercise is not done at all times but more specifically when an individual household attempts to settle down medical bills, pay school fees or want to achieve a particular project like building a house. The common strategy used by many households is to cut down food expenditures. Other respondents mentioned that they have sold their livestock in the past because they wanted to meet their economic needs. Another strategy for cutting down expenditures is to take children out of school and often send them to work as herd boys, taxi drivers, domestic workers and factory workers in order to survive and supplement the family income.

5.5 Conclusion

This chapter has provided an outline of the characteristics and profile of the sample women and households in Thabaneng. It is established that large and female-headed households are associated with food insecurity and vulnerability. There is generally a deficiency of services in Thabaneng rendering the population to further vulnerability. While women are reliable sources of income, their wages are insufficient to satisfy their households' needs. Given the chance, they would engage in other income generating activities but their tied schedule limit them. Other members of their households would manage to engage in activities that diversify income but are by and large limited by education, limited skills health status and age. Despite the limitations to diversify income, a larger share of household monthly income still comes from different sources such as inter-household transfers in the form of gifts, borrowing and lending.

CHAPTER SIX: FACTORS THAT AFFECT CHILDRENS' NUTRITION

6.1 Introduction

This chapter presents a descriptive analysis of factors in women's employment that can impact on the livelihoods, health and nutritional status of women and children in Thabaneng. In examining the links between the employment conditions and environment, it takes into account factors in women's wage labour that affect women health status physically, socially and psychologically and that may in turn affect the nutritional intake and the amount of care devoted to children. Other concerns are in the community and household levels and can affect the caregivers' cognitive development and ability to provide good care to their children. These include availability of health and educational services, caregiving resources, behaviours and practices.

6.2 Employment conditions and environment

Income is one resource identified to contribute to the women's ability to offer resources. Primary caregivers in this study are working women hence all access to income that can improve children's food and dietary intake or maybe pay for alternative child care. However literature has demonstrated that income is not necessarily a major asset in caregiving (Engle: 1995, Leslie: 1995). Other conditions inside the labour market have been found to have an influence on the quality of care mothers give to their children.

There are critical debates about employment conditions and environment in the foreign owned factories in Mafeteng and how they affect women's care practices and behaviours. On the positive side, respondents were grateful for their employment in the factories as weighed against the government's food for work programmes. Unlike these programmes which are often periodic, employment in the factories is viewed as reliable, long-term with a relatively fixed wage income. Moreover, at the factories, one is away from the scorching wind, sun, rains, noise and stigma one experiences when working at the food for work projects. Unlike other formal jobs, factory employment provides a relatively easy entry to employment given accurate working skills, tidiness and good looks. The relationship between physical appearance and

employment is shown by the employees' perceptions that employers in the factories tend to employ individuals with these qualities. Employers associate old age, obesity and untidiness with laziness, inefficiency, irresponsibility and untidiness.

Despite their general tolerance towards their employment, respondents offered a significant list of complaints about their employment conditions and environment. Their first complaint was related to their low wage incomes. As seen in the last chapter, most women earn a monthly salary of between R400.00 and R600.00. These amounts hardly meet the consumption needs of most households owing to the fact that the majority of households' members are dependants.

Several other complaints are related to the bad treatment women get from their employers. One of the respondents said:

> *"If the Chinese employer doubts your progress, he smacks or pinches you. What can you do? Nothing, because you fear to be dismissed! I have seen many women trying to fight back and at the end being dragged away by the security guards. Who wants to lose her job? You have to tolerate every bad treatment!" This woman showed me the marks and scars on her ear where her employer had pinched her a week before. As a supervisor, her punishment came as a result of failure to accomplish all the work given to the group of women she supervises.*

Respondents also claimed that management at the factories could dismiss an employee at any time. Unfortunately due to the low level of organisation among the employees it is hard for the workers to voice their dissatisfaction and opinions. They asserted that even the labour unions they have registered for do nothing about their complaints.

Another subject worth considering is the women's long working hours. Women at the factories are expected to work at least ten hours. However this time slot is not consistent to all individuals, factories and workloads. Other women take more overtime hours so that they can earn excessive income at the end of the month. Overtime work significantly diminishes time and energy one should be spending with the family or perhaps building social networks. The tendency of taking on extra hours of work also extends to weekends. More than half of women maintained that they

spend up to twelve hours at work during weekdays and ten hours on weekends, especially during periods of financial shocks. It is at these periods that their children seldom see them because they hardly ever get home when children are still awake.

The conditions at work are such that no one should miss a working day other than having gone to a hospital. Having missed a day, one is required to produce a doctor's letter. Failure to producing this letter leads to a woman's monthly salary being reduced by a day's pay regardless to how severe and critical the reasons were. More than two days of missing work can lead to loss of job. Seitebatso explains the situation as follows:

> *"When you have missed work due to other reasons that are not directly doctor related you might lose your work completely. Other important reasons like taking care of the sick members of the household or visiting your child's teachers are not considered important by our employers. As a result for every reason that leads women to be dismissed from work, they lie to the doctors that they are sick for reasons of getting doctor's letter approving consultation". The doctor's letter only protects women from being expelled from work, but does not stop the deductions on their money. "...this one major reason I avoided attending all my prenatal post-natal clinic sessions". At the time when her child was ill, she explained that she missed work so many times that she ended up earning a monthly salary of R200.00, which was torn between buying foods and paying medical bills.*

The majority of respondents expressed their fear of working in the factories for a long time in case they catch diseases induced by their working environment. Such diseases as TB, asthma, arthritis, pneumonia and back pains are common to most women working at the factories. Respondents explain their diseases to have come as a result of prolonged sitting behind the sewing machine, lack of heating systems during winter and inhaling textiles dust during the sewing and cutting process. A majority of women complained of at least one of these ailments[21].

[21] A detailed analysis on the health status of women will be in the section on 'maternal health: nutrition and health statuses'.

6.3 Caregivers' education, knowledge and beliefs

Maternal education, knowledge and beliefs play an important role in women's decisions and actions daily. They enable women to process information, seek advice and acquire skills and to model their behavior (Engle et al.: 1999). All the primary caregivers in the sample have low education levels and the lowest level of education the caregivers have achieved was Std 4 and the highest is Std 10. The level of education for the alternate caregivers is also low. The highest educational attainment is Standard 7. The reasons for failure to complete education differ amongst women; however lack of finances was the most common. A small number of women stopped because they had either got sick, married or got pregnant. Others mentioned that they had to compromise their education and work so that they can earn income to educate their siblings. A few of the young caregivers cited the reasons of the uselessness of education and failure in examinations. Sibling caregivers explained that they dropped out of school to look after their younger siblings. Others stopped schooling because of their parents' unwillingness to send them to school.

> *Masize stopped going to school because her father was against a culture of sending girls to school. Her father argued that girls are not good investments since they marry once educated and subsequently work for their in-laws not biological parents who sent her to school. He insisted that instead of sending girls to school, they should be forced to stay at home and learn household duties and also prepare food for herd boys.*

Most women expressed their wish to go to school if only their husbands were working or they had enough financial support from their parents. Others showed that they could have gone to school had it not been for their dependants who are young, old or sick. With marriage, some women explained that they could no longer go back to school because they have new responsibilities and their husbands would not agree with the idea.

6.4 Health and educational services

A national access to basic health and educational services is important in achieving a significant input to poverty reduction and household management. This study shows

that one or more people in the households have health problems. Not everyone is laying down sick, but most people experience intermittent or seasonal episodes of sicknesses in their daily lives. Having seasonal attacks of diseases make people to relax; resulting into some diseases ignored and never reported to the health practitioners. Women explained that they only consult doctors in cases of severe ailments or emergencies. For most women, hospitals are most useful though traditional doctors are useful as well especially in the cases of illnesses emanating from witchcraft. Preference for hospitals especially government ones is influenced by their low prices as compared to traditional doctors who always demand high prices in the form of a goat, a cow or a celebration to the ancestors.

Public acceptance and motivation to use health services also plays a critical role in improving the health status of the society. The entire sample population has access to health services even though problems such as limited time; high medical costs and distance to the health centers constrain frequent doctor's consultations. It was indicated that a majority of the sample take between 30 to 60 minutes walk to reach the health centers. Of all people who consulted health centers, relatively a few are not satisfied with the health services. This is a point worth considering because commonly the general situation of the health centers pre-determines the rate of the use of the facilities by the public. Additional factors that commonly discourage people from visiting health centers are long queues, unsuccessful treatment and rude health providers. Time and high costs were major constraints in particular, given the women's tight working schedules and low wage incomes.

The acquisition of education improves the quality of life. An emphasis on maternal and head of the family's education does not undervalue the importance of education of other members of the household. Acquisition of education by all is vital for the welfare of the whole family, enhance informed decision-making and pre-determines the future education level of the infants in the households. The study shows that other siblings in the sample do not go to school. A fraction of those who are schooling are predominantly in lower primary education where the government has introduced free education[22]. Other siblings who are older and education is not free are not schooling

[22] Up to the present moment (2004) free education in Lesotho is available up to Standard 5.

due to high costs. Other factors that are responsible for high school dropout are teenage pregnancy, committing crime and a need to go the initiation school.

6.5 Household spending and expenditure

This section provides information about the socio-economic status and livelihoods of the sample households, their nutritional status, the quality and quantity of food beverages that can substitute for or supplement breast milk. Generally, most households spend their budgets on purchasing food. This is an immediate priority because circumstances in urban areas are such that most households abandon their traditional agricultural livelihoods and depend on market food commodities. From the households' monthly incomes at least between R200.00 and R300.00 is used to purchase food. Note should be taken that when buying food, households do not necessarily concentrate on the quality of food they are buying, but on food quantity. This is because large quantities of food can accommodate all the members of the household for the rest of the month. Other priorities include buying paraffin for fuel and other groceries, settling medical bills, paying rents, school fees and clothing for all the members of their households, relatives included. The pattern is that all these food and non-food expenditures such as health and education increase with the family size.

Mealie meal gets the highest mean household expenditure because it is a staple food among the Basotho nation. But once the household's are incorporated into WHO/WFP food distribution programmes, mealie meal starts getting the lowest household total expenditure. Other foods and beverages women get from these programs include one bottle of oil and two bags of beans per month until the child is healthy. Nowadays, the household monthly budget is spent on affordable vegetables like cabbage, sorghum meal, soups, canned fish and eggs. There are a few variations in food spending pattern across households with a majority of households having members engaged in other income earning activities further spending their total household expenditure on meat and bread. The diversified diet in most households does not last to the end of the month though; often the sample enjoys non-staples only at the beginning of the month while the rest of the month is finished with consumption of staples only. Reasons for this variation may arise from the fact that

households buy a limited amount of food that does not accommodate households' consumption needs and sizes.

6.5.1 Food bought for the whole household and for children

A larger proportion of households from the study do not buy children's food separately from the overall household food commodities. This is because their children can already consume hard food. In addition, separating budget expenditures of food is very expensive. For young children, food maybe softened in order to be palatable depending to the age of the child. The only food commodities that are bought specifically for children are sorghum meal and soft soups. Most households substitute sorghum meal with maize meal to make children's porridge. This means that children also consume large amounts of staples and cereals, as do the other members of the household.

The entire sample spent little of their monthly budgets on non-staples such as fruits, and vegetables such as carrots and legumes. The reasons for this consumption pattern are low wages, high prices and large households. The sampled households only afford to buy these food commodities only if they have excess money in their budgets and at such periods, this food normally does not last because none of the households have refrigeration. In an attempt to minimise expenditures the respondents asserted that they spend a large percentage of their food budget on street food. As compared to the food market street food is cheaper, for example fat cakes and vegetables. Street food consumption is not only used to minimize expenditures but also saves time and provides an alternative source of food. A quarter of respondents do not carry lunch boxes to their work places because some have no food to carry from home or have no time to prepare them. Respondents their income is inadequate to cater for their lunch boxes for the rest of the month. Women time constraints sometimes force them to buy already prepared food for themselves and their households. This tendency is noticeable in households headed by young and single women.

Even within the category of street food, there are certain foods that the respondents do not buy. For instance fruits like bananas and pears. These fruits are unaffordable to most women but as a supplement to entertain their children they occasionally

purchase street popcorns, snacks and sweets. One of the participants in a focus group discussion expressed her concern in the following manner:

> *"Our children don't know some of the fruits sold around here because they have never tasted them. Having seen them on the streets means they have already eaten them. Things get much better now during the season for peaches and grapes because every household has got a peach tree, allowing children to have access to fruits without financial restrictions".*

High prices and low income are not only reasons restricting women from buying healthy and non-staple food for their children. A tendency of the alternate caregivers to eat children's food in particular fruits, prevents most women from buying their children these kind of food. The primary caregivers as a result opt to buy their children food in small quantities so that they can finish them while their mothers are still at home. But this strategy is almost impractical because primary caregivers sometimes get late home when children have already taken supper.

Other non-staples such as alcoholic beverages like liquor and beer fell among the expenditures of the caregivers. According to the alternate caregivers some of the mothers of children are using a lot of money to buy liquor. This does not only decrease the amount of money needed to buy children's food, but it also decreases the amount of time and energy that a woman has for the child. In some cases, women end up totally depending on alternate caregivers to look after their children as they are always away during their spare time.

6.6 Maternal Health: nutrition and health status

Maternal health has a dramatic impact on both pregnancy and lactation and subsequently on children's nutrition. According to Chatterjee (1990), bad health of women leads to premature births, low birth weight and inadequate breast milk for the baby. This section provides an account of women's health status from their own evaluation point of view. Some women maintained that they generally feel healthy and whatever their medical conditions, have no direct causal relationship to their children's nutritional status and health condition. Nevertheless, they still complained

about attacks of high blood pressure, diabetes, pneumonia, teeth aches, tonsils, headaches, back pains and period pains.

There are different opinions about the primary causes of these diseases. While some women believe that some of these illnesses were natural, others are believed to accrue from witchcraft. Some other diseases are believed to be stress related. A majority of women are under stress most of the time, worrying about the next meal for their families, medical bills, school fees, abusive husbands and in-laws. Some of the most stressful things, especially for young and single mothers are abusive boyfriends and pressure to get married. Stress in not new in women's lives, most of them mentioned that they have been stressed for the most of their lives. For instance:

> *Puleng left school when she was about sixteen years old because of financial constraints. It was a shame to her to see other girls of her age leaving each morning to school. After long years she finally accepted that she would never go to school again. As she was getting older she began worrying about her family's poverty. With some secondary education she possessed, she had to struggle to find work. After getting work in the factories, she thought that things would change. But this time her worry was to generate small income and how she can optimise it to accommodate everyone's needs in her family. In the mean time, she fell pregnant and her taxi conductor boyfriend rejected her. She was depressed and confused and battled to keep the pregnancy secret from her parents and friends. When finally the baby was due, she had to face the humiliation and anger from her family. Now her boyfriend is back but has not married her. She feels much pressurised to get married since most of her friends are married. Puleng has been hospitalised with high blood pressure.*

Puleng's example shows that her worries may cost her mental health and self- esteem. Stress throughout her life may cause hatred to everything even to her child and this may lead to lack of responsiveness to her child's needs and quality of childcare.

Some sicknesses are believed to have resulted from the bad working conditions and environment at the factories. As highlighted before, women work without heating systems in winter and most of them consequently are infected with flu, athritis and

pneumonia. Some women have back pains, asthma, ulcers and TB due to stress, working hard, bad eating habits and the textile dust they inhale during sewing and cutting process. It was in many ways women felt that these infections affect their children health. Some of them require them to keep away from their children to avoid transmission of diseases. Others are painful that they cannot concentrate on anything, let alone interact with a child. Most importantly, children should not grow up in a household where any household member especially mothers are ill because children are very vulnerable and easily get contaminated with infections. Breast-fed children are perhaps more at risk because the infections can easily be transferred from mothers to infants through breast milk. Getting severely ill can make one to stay away from work too, leading to reductions in wage income[23], which in turn reduces chances to ease household food insecurity and enhance the child's nutritional status.

6.7 Health status of children

Short-term morbidity symptoms were measured by common symptoms recalled from the previous two weeks before the interviews and observation. The measuring symptoms used included intense coughing, fever, pneumonia, diarrhoea, difficult breathing, vomiting, rapid breathing, allergies and nasal congestion. According to Maxwell et al. (2000), these symptoms are closely associated with hygiene and feeding practices. It was found from the study that a larger proportion of women feel that their children are in good health. There are several perceptions that women hold about their children's health and nutritional status. For instance, some women maintain that the condition that their children are underweight does not mean that they are ill; instead it shows that a child was born immature or implies household food insecurity. According to them, the child is not ill but rather needs a well balanced diet to gain weight. A few participants explained that sometimes a child is not necessarily malnourished or underweight but have small bones naturally which may be a bone structure inherited from one of the parents. In such cases, the child is still healthy but looks underweight to the world.

Other women maintained that their children's health status has always been bad since birth and their condition has contributed to their contemporary children's nutritional

[23] See the section on 'working environment and conditions' for details on the relationship between wage income and number of working days.

status. Common infections identified were pneumonia and asthma. The maintained that they are aware of their children's health status, but their low incomes do not allow them to access health services that can solve this problem. Moreover, their restricted income does not allow them to buy high-energy food that can improve children's nutrition status.

In reference to the infections related to malnutrition such as diarrhoea, most women perceive that these are frequent and normal infections to children. That is, by right, children should grow up simultaneously having such infections here and there in their growth process since children are naturally susceptible to infections. In Lesotho, it is thought a bad omen to have a child who does not fall ill occasionally there at an infant stage because, he/she will frequently be infected with all types of infections later on and perhaps die at an early age of life.

Only a fraction of women expressed fear about their children's health status. They maintained that this bad health is primarily due to food shortages in their households. They further asserted that their children's health and nutritional status has improved since joining the WHO/WFP programme. Some women claimed that their children's bad health is a result of their low socio-economic status. For example:

> *Rethabile maintains that at the time she delivered her baby, she was not working. So she did not have money to go to the hospital for baby delivery. As a result, she and her boyfriend (unprofessional house builder) delivered their baby themselves. "It was a cold night and we had no heater or enough blankets because we had just moved in together, and my boyfriend was the only one working". Her newly born baby caught cold and later was admitted in the hospital with pneumonia.*

Other women blamed their working conditions for their children's health conditions. They contended that women who become pregnant in winter suffer more than others and their unborn babies are more at health risk than others. In winter pregnant women go to work in the freezing cold mornings. At work, they still work within the cold environment without any installed heating systems. During lunch, they eat cold food and later go back home in cold evenings.

There were differences in opinions of women in regard to their children's health status. However the extent to which women are able to assess their children's health status depends on their age and education level. Most young caregivers with low education believe that their children's health status was stable. On the contrary, old and relatively educated caregivers were among caregivers who agreed that their children's health was bad and needs medical attention.

There was also a sharp contradiction between the perceptions held by the primary and alternate caregivers as far as children nutritional and health status were concerned. While some of the primary caregivers feel that the health status of their children is stable, most of the alternate caregivers interviewed reported that the children's health conditions are bad. Even though most of them were young, perhaps it was easy for them to recognise children's nutritional status because they spend most of the time home with children. For instance:

> *Tsoepe is twelve and Lisemelo's younger sister. She looks after Lisemelo's baby when Lisemelo is at work. During the interview with Lisemelo, the child's health status was reported. The only problem reported was the underweight condition, which is a condition Lisemelo alleges results from the premature birth. On the contrary Tsoepe in the interview held after Lisemelos, disputed Lisemelo's claims and maintained that the child's health status is bad with frequent vomiting, diarrhoea, and loss of appetite. She maintained that sometimes the child cries for the whole day or night to an extent that they have to call neighbours who sometimes offer traditional medical help or take the child to the hospital.*

This difference in opinions may be explained in two ways. One, some caregivers might have felt not confident enough to express their true opinions about the real cause of their children's health status. Two, they might have been genuinely ignorant about their children's health conditions due to the limited time they spend with their children. While on the other hand, alternative caregivers are exposed to all dynamics, fluctuations and transformations in the child's health and life. Hence, alternate caregivers are able to make clear judgements about children's lives in general. Primary caregivers are possibly ill informed about their children because they do not

get to know every detail about their children's health status. Due to their limited time at home, often alternative caregivers have no chance to report everything that happens in the children's lives. As a result some of the illnesses in a child are recognised by mothers in their late stages sometimes when they are improving without medical help. Sometimes the ignorance of primary caregivers is a product of the women's busy lives involved social interaction instead of family life.

6.7.1 Causes of malnutrition

There are many factors women perceive to contribute to children's health and nutritional status. According to the caregivers, food is the key factor. Due to the general food insecurity in most households children hardly have adequate food to eat. Not only is the quantity of food necessary for children's nutritional status, a significant group of caregivers reported that their children are malnourished due to the quality of food other than the quantity. While some women believe that breast-feeding is a central element in the quality of children's food, others believe that a well balanced diet is a critical component in a child's health and nutritional status. Other factors mentioned in the focus group discussion are social factors such as child's happiness and freedom to explore.

With reference to food quantity, women explained that due to poverty and low-income, they have no money to buy food for the whole household, let alone for the children. Food insecurity in most households is not only a problem of low incomes, but owes a lot to the present drought that prohibits small vegetable gardening within households' compounds. Food scarcity is so severe that sometimes children have meals three times a day like the elders instead of frequent meals. While food quantity is not much of a problem among households, quality of food is the main challenge. Most households have basic staples such as mealie meal but have no other supplementing foods and vegetables. The most popular meal within the Basotho households is mealie and wild vegetables or *moroho* (cabbage, spinach or radish). Unfortunately a mixture of high prices of *moroho* and low incomes does not allow women to buy *moroho* everyday throughout the month. A recent common meal for these families has become a mixture of mealie meal and water or hot oil. Most women explained that the preferred alternative to mealie meal is porridge, which in most cases is made up of sorghum meal, but due to lack of money to buy sorghum, people

still use maize meal. A point worth noting is that these are not meals taken by elders only; children have their share also. And these foods are taken from morning to evening without other diversified diets.

Consuming large amounts of carbohydrates, as is the case with the respondents' households is associated with a slow mental and physical development of the body, especially if the child is under five and is not breastfeeding. Furthermore, eating the same food deprives a child of other minerals needed for the body, causes a child to lose appetite and may expose a child to infections such as diarrhoea (Chatterjee: 1990).

Respondents maintained that the quality and quantity of food they eat during pregnancy and lactation has a significant influence on the children's nutrition. A large percentage of women explained that during their pregnancy they did not have special diets rich in nutrients or mineral supplements because they could not afford any of them. They have always lived on foods rich in carbohydrates with no other nutrients needed for the body especially during pregnancy. Not only quality of food was a problem but also some had inadequate food during their pregnancy owing to the general lack of food in their households. Some women maintained that they went about without food in fear that people would recognise their pregnancy status. They believed that if they starve themselves their tummies would not grow. This behaviour is most common among young girls who are ashamed of their pregnancy.

Inefficiency of the alternate caregivers to care and feed the child at appropriate times is one of the many contributors to children's malnutrition. Most women employ alternative caregivers who are very young, uneducated, or old to care for their children. Often the young ones specifically, have little or no experience in child nutrition and caregiving. The choice and preference of the caregivers is determined by their age and wage income. Very young girls below fifteen years of age and older women of above fifty-five years of age are paid as little as R150.00 per month. Most women avoid having alternate caregivers between the ages of 15 and 55 years because they are economically demanding and require wage between R200.00 to R300.00 per month. If there are no alternative caregivers employed, grandmothers and other siblings in the households are forced to take the responsibility of caregiving. While

there are a least two households from the entire sample that has forced a sibling out of school for purposes of caregiving, half of the sample depends on the children's grandparents or other relatives to look after children. In one other household, other siblings were not completely taken out of school but were alternating as caregiver and attending.

There are diverse opinions on the amount of food the child is receiving. On one hand, due to a general food deficit, alternative caregivers often have a greater share of food while the children are left starving, especially if the child has lost appetite or is still too young to express his/her consumption needs. This tendency is more prominent in the families where the alternate caregivers are very young. On the other hand, the problem of child malnutrition is often not a subject of primary caregivers' inefficiency but primary caregivers' irresponsibility. Half of the caregivers interviewed explained that while there is generally household food insecurity, primary caregivers do not buy food even for their children. An explanation for this behaviour is that most of the primary caregivers are still young and find it hard to care for and raise children. As teenagers, fashion and entertainment are still more important than anything and prioritisation has not yet made sense in their lives. But this pattern is also common among older women, who unfortunately put social life and liquor before their responsibilities of buying food for their children. Below is an example showing the situations of some of the alternative caregivers.

> *According to Masize, Japa cares less about the health status of the child and what she eats. Japa is only 19 years of age. Japa hardly spends a time with her child because she is always out with friends. She rarely gets home early and when she is home, she minimally interacts with her baby. Japa cares less about the health status of the child and what she eats. She does not buy food for either Masize or the child. This forces Masize to use her own money to buy fuel and food for herself and the child. If Masize does not buy food, the child depends on the food they get from people or eat a mixture of mealie meal and water. She cannot leave this baby and look for work elsewhere because she has been looking for this child since birth and fears that if she leaves, the child will die of hunger.*

Early termination of breast-feeding is amongst other causes of malnutrition mentioned in the focus group discussion. Early termination of breast-feeding deprives a child of complex nutrients a child gets only from breast milk. It also cuts the bond and interaction that a mother shares with a child when breast-feeding. A large number of respondents mentioned that they are not breast-feeding due to various reasons ranging from their busy schedules, sore breasts, children's rejection and loss of interest in breast-feeding. While a small group of women believed that breast feeding is necessary in the first three years of the baby's life, another set of women asserted that breast feeding is required only in the first six months of the child's life for health reasons such as getting the womb back to its original location, getting milk out of breasts and preparing a child for harder food. After the period of six months, it is believed safe to terminate breast-feeding as long as a child has an adequate amount of supplementing food to consume. A relatively small number of women feel that breast-feeding is not directly associated with malnutrition. Their argument is based on the fact that there are many women out there who are breast-feeding yet have children with malnutrition.

Despite differences in opinion about the relationship between malnutrition and breastfeeding, evidence nevertheless shows that early termination of breastfeeding is associated with bad health and malnutrition in children. While early termination of breast-feeding is obligatory for some women, it is voluntary for others (Leslie: 1995; Blau et al.: 1994). Respondents mentioned that they avoid prolonged breast-feeding because it is associated with disfiguring their bodies. Other claimed that they were ill and feared that continual breast-feeding will transfer mothers' infections to children through breast milk. Other cases were obligatory in the cases where mothers have left their children with their parents and stay somewhere else. Some children never breastfed because their mothers' HIV status. Due to a number of conflicting episodes among couples on who supports the child, there are many cases where a child was moved from one place to another, usually away from the mother and to the father's place. It is in such cases that children are forced to stop breast-feeding and depend on the food that their parents and caregivers provide. Some of these conflicts manifest between women, their spouses and their in-laws and often children are forced to stay away from their mothers and live with their fathers' families, especially if the conflict is between the father and the mother.

It was on a few occasions that women terminated breast-feeding because they were sexually active. They maintained that sexual intercourse is an activity not to be carried out simultaneously with breastfeeding because it is associated with child malnutrition, running nose, diarrhoea and passiveness in the child' behaviour.

Early introduction of table foods (complementary) is regarded as having a negative impact on a child's nutrition. According to Abbi et al. (1991), if these foods are provided together with breast milk, they tend to dissolve nutrients of the breast milk. But if they are provided to children on their own, great care should be taken because most of them provide no nutrients at all to newly born babies. This study shows that sugar solution is the first supplementary food given to children. For all children who are breastfeeding, they were bottle fed sugar solution once their mothers returned back to work, which for most women was a week after the birth of their children. A majority of women alleged that they introduced their infants to formula when they were a month old. But because of high market prices, they maintained that often their children have to receive much diluted milk.

6.8 Knowledge about a child's nutrition and growth

Like maternal formal education, beliefs and attitudes, caregiver's knowledge has strong links to the child's nutrition status. Knowledge about the baby was measured by assessing the mother's perception of the planning of the child, prenatal clinic attendance and the extent of processing information. From this study, all women interviewed mentioned that they did not plan their children's births beforehand. None of them are using any method of contraception, not in the past nor at the period of interviewing, mainly because of their negative beliefs and attitudes towards contraception. But as their children are still young and unhealthy, they confirmed that they will not have children soon because some are abstaining from sexual intercourse while others are using traditional methods of birth control. There were differences in the opinions of married and single women with reference to the reasons why they did not plan the births of their present children. On one hand, married women found it difficult to use birth control measures because they felt that it was their duty to have children. On the other hand, young and single women explained that they did not have chance to plan their children because they were young, hence ashamed to queue in

family planning clinics. It was in the discussions about family planning that it was learnt that a majority of women discard the idea of using a condom as one method of birth control; instead they put too much trust on traditional methods of pregnancy prevention. This is one saddening fiction that best explain the high prevalence of HIV/AIDS in the country.

All of primary caregivers who are biological mothers have attended prenatal care at some point during their pregnancies. While a large percentage of the sample confirmed that they attended all the sessions of prenatal clinics, others maintained that their limited time restricted them from attending prenatal care sessions. Women maintained that it was through the prenatal clinic sessions that they learnt about care practices and behaviours hence felt confident that they know everything about children's growth.

It was also found that alternate caregivers especially the young ones, have minimum knowledge about health and nutrition of children. Sibling caregivers reported that they have not been trained on how to prepare food for children; instead they imitate most care behaviours from their parents. Observation results show that sibling caregivers also are neglectful of their duties and other caregiving practices like washing hands before touching food. Games and other children playing outside also easily attract and distract them from their responsibilities. Nevertheless, observation results show that sibling caregivers are able to play with children and allow them to explore on their own.

6.9 Feeding practices and caregiver's ability to feed responsively

We mentioned in Chapter Two that caregiver's practices such as child feeding has a direct impact on the dietary intake of the child. This again is associated with the characteristics of the child's appetite and characteristics. Feeding practices were observed through active feeding of the child. During the couple of feeding sessions observed, it was found that most caregivers are passively feeding children. The passiveness may have been influenced by the fact that caregivers knew that they were being observed. Passiveness of feeding refers to lack of intimate interaction between the caregiver and the child, coaxing behaviour that stimulates eating during the child feeding process. Perhaps active feeding was unnecessary during the first term of

observation sessions because all the children eating indicated a strong willingness to eat. Even children who were reported to have lost appetite for days were eager to finish their share of food. Caregivers explained children's eagerness to eat merely as a response to the food that the researcher provided. On the second round of visit there were no food brought along for the households visited. The observations of the feeding habits at these sessions were contrastingly reflecting the first ones. Most children this time, showed a hostile response to food provided by their caregivers. There was no encouragement of eating whatsoever; instead most caregivers had no patience and occasionally made threats to make children eat. With the child crying and rebelling it was hard to determine a caregiver's knowledge that in turn reflects good feeding habits such as supervision. Perhaps it was not possible for the caregiver to supervise the child on how to eat and chew while children rebels against food. It was exactly this behaviour that compels most women to force food down the child. It was on two occasions a child was observed being forced to eat porridge. On one of these occasions feeding was successful while on the other the child ended up vomiting.

Age played a critical role in the quality of feeding practices. That is, it was observed that with the older caregivers, feeding was relatively active even though this was difficult to measure given the time limitations and the extent of reactivity among the caregivers. As for the young caregivers, children's rebellions and food rejection were often interpreted as the child's satisfaction or aggressiveness. On one observation when a child was being rebellious and the caregiver was young, the caregiver decided to stop feeding the child and finished off the rest of the food, interpreting the child's behaviour as 'being full'. Sometimes the caregiver ignores the child because she hates engaging in a battle with a child, in which case the child sometimes vomit or cries for a long time. Siblings observed showed minimal competence in feeding children.

Even though observation was not done over a considerable length of period, it was discovered that caregivers have irregular feeding times, regardless to age. The irregularities accrued from factors such as the shortage of food or the child's rebellion that discouraged the caregiver's urge to feed the child. In addition, the timing of feeding was in response to the appetite and nutrition intake of the child. On two occasions that a caregiver was observed taking more than twenty minutes trying to

feed the child and offering additional foods. On other occasions an alternative caregiver spent less than twenty minutes feeding a child because of her workload in the household. Due to their other household engagements, most alternate caregivers tend to transfer the feeding responsibility to other members of the household or other siblings. The situation of Mapenane gives a picture of the unstructured feedings.

> *Mapenane is 64 years old and a alternate caregiver to the five children of her son. She is taking care of these children because she claims their mother has no responsibility for them. The two eldest of these children do not go to school due to financial constraints, hence are helping with the household activities while the other two have enrolled in free primary education. The youngest that is malnourished and stunted is two and half years and is left in the care of Mapenane. However Mapenane is very busy trying to generate a household income through brewing and selling traditional beer to the villagers. This means that she does most of her duties such as drawing water, cooking, preparing and selling beer with a child at her back. She also looks after other children and her own daughter who is HIV positive and very sick. All of these roles limit her time and energy to spend with this child. She does not recall the time in the previous two weeks when she really sat down and fed the child. She feeds the child while doing other activities like serving her beer clients. Sometimes she waits for other siblings to come back from school so that they can take over the responsibility of caring for and feeding the child. On two occasions that I observed the feeding process of that child, Mapenane was very busy and could hardly monitor the eating process of the child. On one occasion she transferred the feeding responsibility to the other sibling who was very angry because he was called from a soccer match.*

From other household observation sessions, it was not always the case that other siblings would hate to come and feed the child as in the case of Mapenane's household. On one occasion that one sibling was very pleased to feed the child because she was certain that by feeding the child she would get a taste of what the child was eating. It is understandable that in a situation where siblings have a meal once or twice a day, feeding a child offers a good opportunity to eat the rest of the food if the child rebels against eating.

6.10 Hygiene behaviour

Maxwell et al. (2000) maintain that hygiene practices directly affects the number of infectious agents children ingest, either through contaminated food or water or placing contaminated objects into their mouths. Hygiene behaviours were measured by a check strategy of hygiene-related aspects. These included the appearance of the caregiver and the child, cleanliness of the compound; whether the house was clean, whether drinking water was covered, whether there were unwashed utensils, garbage and stagnant water in the compound and poultry faeces. In two out of five alternative caregivers observed were clean and the children they were looking after were clean also. Their houses and compounds were clean too. The three other households did not have a clean environment. In one of the households beer was being brewed and sold, teenagers headed the other one and no one wanted to clean up. There were papers around and one household had stagnant water at the back of the house.

6.11 Time spent

Walking home from work is not a time consuming activity for all the respondents since the factories are right within Thabaneng community. The importance of getting home early varies between individuals depending on the responsibilities awaiting one at home. An average number of women arrive early at home because they have to cook for their husbands and other dependants especially the sick ones. Others get home late after overtime at work. The entire sample confirmed that they generally have less time with their children to play and supervise them in their learning experiences, or to put them to bed. Alternative caregivers seemingly have adequate time and energy to devote to children.

It is important to note that labor market is not only the factor constricting the caregivers' limited time. To some women, social interaction with friends is important, specifically for young women. There were different opinions between the primary and alternative caregivers in regard to the amount of time a primary caregiver spent has with the family after working hours. A larger proportion of women confirmed that they immediately go home after work to take care of their families and perform some of the domestic tasks. These allegations do not coincide with some of the caregivers' allegations. Alternate caregivers claim that most of the time some women go to social

gatherings and shebeens after work instead of rushing home. However, the focus group discussions gave the impression that some of women's claims of overtime are not accurate. _After work, they go to their friends' places[24] and participate in prostitution activities for a least the first half of the night. Later they leave to their homes, sleep and early in the morning, they wake up for a shift at the factories. Some of them never go home and stay at their friends' places for weeks without seeing their children. For instance:

> *Mathuso works as a cleaner in the mental hospital. Her daughter Lerato, working at the factories has an infant of six months. Before she conceived the child, Lerato did not stay home but came when she was pregnant. After the delivery, she stayed with a child for only two weeks and disappeared. "I know she is still around town and is working. After work, she goes for prostitution so that she collects more money. At the end of every month she comes home and brings money for the child and for us. Her money helps but I don't like what she is doing!" It should be noted that while Mathuso goes to work, her youngest son who is ten years old is looking after Lerato's baby.*

6.12 Psychological care

For this study, psychological care was measured through spot-checking caregivers' attention, affection and involvement with a child. Aspects of these care behaviors are touching, holding and talking, encouragement of talking, exploration and playing, singing and talking to a child. Data from these elements was collected from alternative caregiver's psychological activities. It was observed that in average there was a little interaction between alternate caregivers and children. In one household it was observed that affection and involvement of a caregiver was apparent. Other alternative caregivers were busy or were not interested or were stressed out and depressed that they continually carried children at their backs. It should also be pointed out that the time for fieldwork was very limited; therefore such psychological behaviors such as affection could not be effectively captured over a period of two hours of observation.

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[24] It was found in the focus group discussions that most young girls have left their families in rural areas and stay in the rented houses in Mafeteng. Most of these rooms are shelter for prostitution activities during the night.

6.13 Conclusion

This chapter unfolds many aspects of caregiving that have been highlighted in Chapter Two. It reveals that there is a generally adequate health and education service but there are number of factors that reduce access, ranging from limited time, lack of finances to lack of trust. Lack of education reduces women's access to protected employment that pays reasonable incomes and offers good working conditions. Without education women are also left with obsolete perceptions and beliefs about themselves, their children and alternative caregivers. The ignorance has many impacts on the decisions women take towards the kind of environment needed for a child, the type of food required and behavior necessary for the wellbeing of the child.

CHAPTER SEVEN. DISCUSSIONS, IMPLICATIONS AND CONCLUSION

7.1 Introduction

This dissertation had sought to understand the nature of urban poverty and how it constraints or allows women's ability to exercise care practices and resources to improve children's nutrition. The challenge now is to link the findings in the two previous chapters to the conceptual models of livelihood and care identified in Chapter Two. In the process, the chapter seeks to discuss the questions outlined in the hypothesis and objectives of the dissertation based on the study findings. This discussion lays a ground for useful policy interventions both at the community and household levels for improved child nutrition and for reduction of urban poverty.

7.2 Urban livelihoods

According to Livelihood Security model illustrated in Figure 1, sustainable urban livelihoods can be obtained through access to assets such as labour, human capital and socio-economic assets such as housing. It goes on to show that people's capabilities are central in making these assets effective to reduce urban vulnerability. Drawing from our case study, the findings show that women have no/few of the assets identified:

1. Physical: they have housing of low socio-economic standards- small and crowded with lack of hygiene. The infrastructure and housing facilities are also of low socio-economic standards.
2. Human: they have less/no knowledge and skills to influence their capacity to work, improve their self-esteem and enhance informed decision-making for better child health care and nutrition.
3. Financial: due to their low incomes, women have neither good savings nor investments. Moreover, they have no access to regulated formal credit and money lending institutions.
4. Social: women's social networks have slightly broken as compared to rural areas. The food transfers between households in the form of gifts have decreased because of the general national food insecurity and changed urban livelihoods.

This study shows that women are faced with many trade-offs that force them to choose between the need to meet basic needs for their families and the cost of reducing vulnerability of their households. To succumb to these trade-offs, they have developed coping strategies that allow them to survive within the urban environments. While some of these strategies are good, some bear health risks and others are not morally good. The common coping strategy used by most women in the study is minimising food expenditures. Strategies include:

1. Eating smaller proportions of food
2. Buying less expensive foods
3. Buying street foods
4. Engaging in low social spending of education, health, housing and water
5. Engaging in prostitution activities in order to generate more income.

However due to small incomes and big families, women's strategy to keep savings in most cases is not effective. Firstly, their income does not allow them to make high savings. Secondly, little savings they have are spent on food purchase and other groceries; and settling medical bills for their household members. The transaction from traditional agricultural to industrial livelihoods had changed the food expenditure patterns to fully rely on purchased food commodities. Of importance to note is that the kind of food poor women opt for is very high in carbohydrates with little nutritional value to improve children's nutritional status.

7.3 Working women and care

According to UNICEF model for care, provision of care should be both from the community and households. It further suggests that care should complement food security, income and health services in achieving a sustainable health and nutritional status for a child. However, our analysis shows that not only is income, food security and resources for health scarce, but also there is inadequate childcare. Full participation in wage labour has reduced time and energy to focus on care practices and resources required to optimise resources for the development of the child. Workload also has a significant impact on a caregiver's capacities to attend to caregiving practices. Also time constrains reduce women's involvement in attending to the needs of the child like breastfeeding and feeding.

Income is positively associated with nutritional status. In the hypothesis, it was assumed that economically independent women have many avenues to improve nutritional and health status of children. But our case study has proven this hypothesis insignificant. It should be stressed however that this finding does not apply to all working women. It applies to women in this case study because they were employed but had little access to income they earned because they have to fulfil the needs of almost everyone in their households: children, husbands and relatives. The analysis has also shown that inadequate income may be directly associated with higher quality diets and better nutrition but has proved not significantly important to care practices and behaviours.

Maternal education and age are associated with good care practices and behaviours. Mother's education and age are important in determining the use of resources that women have. The findings have shown that both primary and alternate caregivers are uneducated. As a result they have no/less informed knowledge about children's dietary intake and health tips. They are also not aware of the consequences of inadequate provision of care like poor feeding habits. Age and education of caregivers also have a correlation to the decisions that women make. For instance some of the coping strategies they opt for are risky, dangerous and encourage them to further neglect their children, as in the case of prostitution and beer selling.

Maternal health has a significant impact on children's nutritional status. During both pregnancy and lactation, bad maternal health condition can be easily be transferred to the child. Women in this study have experienced some kind of physical or mental health problems all through their lives that contribute to the bad health condition:

1. Women take small proportions of food during pregnancy and lactation
2. As girls, women have experienced some kind of discrimination in their lives, a patriarchal system and hard work.
3. Poor women often occupy positions that expose them and increase their vulnerability to many diseases.
4. Circumstances in urban areas expose poor women to a lot of stress that causes deterioration of their health status.

7.4 Implications and policy interventions that could reduce child malnutrition in urban areas

- The Lesotho government should ensure good employment policies, specifically in the factories where most Basotho women are concentrated. These polices should aim at improving working conditions and environments that cost women their health, time and energy. More importantly, they should attempt to increase wage incomes to lift women's socio-economic status and improve children's health and nutritional status.

- Perhaps government should recognize that urban poverty exists in Lesotho and is increasing at an alarming rate. This calls for government to concentrate not only on rural poverty but also to concentrate on understanding profiles of urban poverty so that policies and strategic interventions solely targeting urban poverty should be put in place.

- The study also implies that Lesotho should also address the needs of vulnerable groups like women and children, specifically through higher education attainment. Efforts to increase educational status can either be through subsidizing education or employing free education not just for primary education only but to all levels of education. This study shows that high levels of education for women reduce poverty in that it empowers them economically, socially and psychologically. It is also indicated that higher levels of education improve health and nutrition status of both women and children. Perhaps with education women would learn more about the risks of having children at a young age. Maybe_this kind of education will decrease the increasing prevalence of teenage pregnancy.

- To reduce high levels of teenage pregnancy, perhaps education in Lesotho should also not concentrate only on career development. The curriculum should also revolve around the use of family planning and schools themselves ensure easy access to measures that stop teenage pregnancy. Curriculum should also cover household hygienic practices and importance of breast-feeding. Incorporating health and nutrition education in the formal education will not only improve

women's health, nutrition and control over resources, it will also change attitudes of boys based on patriarchal system in their societies.

- There should be availability of subsidized formal daycare in poor urban areas to ensure safe and reliable childcare for infants whose parents are working.

- There has to be further research on the area of child malnutrition in Lesotho. A further inquiry should focus on coping strategies of women who work in the factories whose children are well nourished. Also there is a need to investigate causes of malnutrition among children whose mothers are working outside the factories.

7.5 Conclusion

This chapter aims to demonstrate that the findings provided in the previous two chapters support literature on urban poverty, care and children's malnutrition in many ways. The study has shown how urban poverty together with lack of / less assets and capabilities limit women's abilities to maintain food security, childcare and nutrition status. In order to survive in the urban environment, women are faced with trade-offs between production and reproduction roles. The analysis showed that productive roles are preferred over reproductive tasks; hence women provide less care practices and behaviors to their children resulting in high incidences of child deprivation and malnutrition among children of working mothers.

On the question of whether income is crucial to a child's nutrition status, the analysis showed that income is essential in improving households' socio-economic and health status and a child's dietary intake but cannot significantly improve women's care practices and behaviors. This study agrees with literature on care that education and health are important inputs in a child's nutritional status but adds the significance of age into the picture. It shows that women who are uneducated but old can still optimize the available resources for sustainable childcare and nutrition although this places a burden on these women who may have anticipated being free of such responsibilities. This study concludes by outlining recommendations for policies and

programmes that aim at improving urban livelihoods empower women and reduce children's food and nutritional insecurities.

The findings presented in the study are based on a small study but can serve as a pilot for a much larger survey about women, poverty, work, childcare and women. To compliment this study, there is a need for a comparative study which focuses on coping strategies of women who work in the factory but whose children are well nourished.

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APPENDIX 1

1. Information about the family

1. Information about the caregiver – age group and marital status.
2. Information about the head of the family, age, sex and marital status.
3. Number of persons living in the household, and their age and employment status.
4. What is the total number of persons living in the household?
5. How many children do you have?

Level of formal education

6. What is your level of education?
7. Would you like to study further?
8. If you are currently going to school, what class are you attending?
9. When are you attending your classes, during the day or in the evening?
10. Do you have any training in your workplace and what kind of training is that one?

If the interviewee is discontent with her/his level of education and does not attend any school

11. What are the main reasons of not attending school?

Occupation

12. What is your occupation?
13. What kind of a job do you do at your workplace?
14. Describe your working environment?
15. Describe your job conditions?
16. How many hours do you spend at work?
17. How many of your sons/daughters over the age of five who live with you neither goes to school nor have a job?
18. Do some members of your family work?
19. Do they support your family regularly? If yes, in what way? If not, why?
20. What activities do you do at home other than your income earning activities?

Migration

21. Where were you born?

22. In which year did you arrive here?
23. Where did you live before?
24. What were your reasons for migrating?
25. Do you have relatives here? If yes, what kind of relationship do you have?
26. Do you help each other and in what way?
27. Do you feel isolated/ or lonelisome?
28. Describe your relationship with your neighbours?
29. Do you frequently exchange the things you produce with your family, friends and neighbours for other things?

Health environment and services

30. How many of your children go to school?
31. How far is the school from here?
32. Describe the school environment and learning conditions of your child?
33. If children are not going to school, what are the reasons?
34. If family member is ill, where do you most frequently take her/him?
35. Are you satisfied with the health services that you get from this place?
36. How far are the health services from here?

Housing: Ownership and facilities

37. Where do you draw your water for drinking and cooking? How far is the place?
38. Do you have a toilet, and what kind?
39. Is this your house or not? Who built the house?
40. Do you have a dumping area, where and what kind?
41. Do you have an area where you dispose your bathing and dirty water, where and what kind?
42. Do you have TV? If yes, do you watch programs that teach caregivers and mothers how to raise a child?
43. Do you have a radio? If yes, do you listen to programs that teach caregivers and mothers how to raise a child?

Urban livelihoods: Activities, Income shocks and coping strategies

44. What type of livelihood activities are you engaged in? Where and whom are working for?
45. What is your income category per month e.g (i) R1 – 500, (ii) 501- 1000, (iii) 1001- 1500, (iv) 1501- 2000, (v) 2001+?
46. Do you have any other income generating activities? What are they?
47. How much income do you have from these activities in a month (refer back to the income categories).
48. Do you have other sources of income like the husband, relatives, lending or borrowing?
49. What kind of shocks do you encounter in your family, at work and also in your community?
50. What do you normally do to overcome these problems? (An interviewee should be probed in such a way that she responds to each problem mentioned in q = 41).

Household spending, consumption and food security

51. What do you do with your wage income every month besides buying food? An interviewee should list them according to their priorities.
52. At least how much do you spend in fulfilling these activities?
53. How many times do you buy food in a month and how much do you spend?
54. What kinds of foods do you buy?
55. What about for children?
56. Do you have other sources of food?
57. Are there times when you spend your budget on non-staple category? And what do you always buy?

Nutrition and health status of women

58. How can you rate your health status? Comparing yourself to other women, what can you say about your health status?
59. Do you have mental illness? Do you have any kind of chronic disease and for how long have you been suffering?
60. Do you ever feel like your health status affects your child's health and how?

Information about the child under care

61. Age and sex of a child.
62. What age were you when you gave birth to this child?
63. How do you see your child health status?
64.Would you say your child is ill?
64. What factors contribute to you child's health status?
65. Are there any recent episodes of illness that you noticed in your child's life in the last two weeks? If yes, what did you do?
66. If there are cases when a certain illnesses of a child got cured without you taking him/her to the health expects, when was that, what happened so much that a child got cured?
67. What do you think caused these episodes?
68. How do you compare your child's health with other children from this village?
69. Are you familiar with the use of contraception? Were you using one method before the birth of this child? So, can you say the birth of this child was planned?
70. Did you attend any prenatal clinic? If yes, were you familiar with the knowledge that was being disseminated to you? If not, why not? Do you think you have enough knowledge for maintaining the nutritional status and development of your child?
71. Who looks after your child when you have gone to work or are you taking your child with you to work?
72. If an alternate caregiver looks after a child, how old is she or he?
73. Describe the relationship between an alternate caregiver and your infant?
74. If you are taking a child to work, are there any problems that you meet along the way?

Care behaviours

75. Are you breastfeeding? If not, why not? If yes, when are you expecting to terminate your breastfeeding and why?
78. At what age was the child when you started bottle-feeding and mixed feeding?
76. What kind of foods do you think are vital for your child's nutritional status and survival?

77. What do you do if you child refuses to eat?
78. Are there times when your child looses appetite and what do you normally do with the situation?
79. How can you detect that your child has lost appetite?
80. Are there some foods that you belief are not morally bad for your child?
81. Do you think you have enough time and energy for your baby? If not, what can you change given the chance and opportunity that you feel is necessary to meet your child's needs?
82. Can you recall activities in sequence that you overtook in the past two days that you think are responsive to you child's needs?
83. How long do you spend time with your child together?

APPENDIX 2