

THE MATERNAL NUTRITION AND HEALTH CARE PROGRAM

FINAL REPORT

**PARTICIPATION OF WOMEN IN PRIMARY HEALTH CARE IN
SWAZILAND:**

A Study of Factors Influencing Health-Related Decisions

A.I.D. # DAN-1010-A-00-7061-00

Jean Rutabanzibwa-Ngaiza

JULY 1989

BEST AVAILABLE COPY

TECHNICAL SECTION

PARTICIPATION OF WOMEN IN PRIMARY HEALTH CARE IN SWAZILAND
A Study Of Factors Influencing Health-Related Decisions

By

Jean Rutabanzibwa-Ngaiza

Evaluation and Planning Centre for Health Care
London School of Hygiene and Tropical Medicine

JULY 1989

10

ACKNOWLEDGEMENTS

I would like to extend my sincere gratitude to the Ministry of Health, Swaziland, for allowing me carry out this work and also for their unfailing support and co-operation throughout the whole exercise. My thanks also go to the Regional Administrator, Mr. Tshabalala (Shiselweni) for giving the project the final go-ahead, the health staff at regional and clinic levels for allowing us to interrupt their busy schedules.

Since it is impossible to put down the names of every one who provided assistance, both personal and professional, I can only extend my sincere gratitude to all for what they did for me.

My research assistants, Buzile Dladla (Matsanjeni), Nonhlanhla Mazibuko (Hluti) and Celiwe Nkonyane (Interviewed TBAs) who persevered under sometimes extreme conditions, throughout the months we were "out there" collecting data. Like myself, they gained some insight into the lives of rural women and have indeed been enriched by this experience.

If it had not been for the cooperation of the communities we worked in, there would not be much to report on. Therefore, our gratitude go to the Chiefs and their subjects for welcoming us into their communities and their homes.

The women in these communities, who are the subjects we sought to study, willingly opened a window onto their lives, even if we were only able to see through half or even less of it. Our presence in their communities as people 'from The Ministry of Health' was welcomed but also raised many expectations. It is sincerely hoped that the results of this research will be used in devising strategies that will lead to the betterment of women's lives, especially in rural Swaziland.

This research was made possible through grant support from the following organizations NORAD (Norway), International Development Research Centre (IDRC) in Nairobi, SAREC (Sweden), and the International Centre for Research on Women (ICRW), Washington D.C.

CONTENTS

	<u>Page</u>
Acknowledgements	i
Summary	ii
Swaziland	1
INTRODUCTION	6
OBJECTIVES OF THE STUDY	9
MAIN RESEARCH QUESTIONS	10
STUDY DESIGN	10
METHODOLOGY	16
Designing the Questionnaires and Interview Schedules	18
Selection of Research Sites and Hypothesis/Assumptions	19
The Rural Development Area Programme: A Brief Outline	19
Recruitment of Field Assistants	20
Training of Field Assistants	21
Homestead Sampling Procedure	23
Selection of Study Population	24
Preliminary Visits to Areas Selected for Study	24
Revised Homestead Selection Procedure	25
Selection Procedure for Matsanjeni Homesteads	25
Selection Procedure for Hluti Homesteads	25
Clinic Based Study/Selection of Clinics	27
Selection of Users	28
Data Collection	28
Instruments used	29
Identification and Interview of Traditional Birth Attendants (TBAs)	29
Problems Encountered During Field-Work	30
Limitations of the Data	31
Data Analysis	32
HOMESTEAD BASED STUDY	33
Characteristics of Study Homesteads	33
Characteristics of Study Population	37
Women	37
Children	41
Women's Knowledge of Health Services	44
How women First Heard about MCH services	46
Services for Children	47
Services for Women	47
Knowledge of what Specific Services are For	48

Women's knowledge of Traditional Birth Attendants (TBAs), Rural Health Motivators (RHMs) and Traditional Healers (Tinyanga)	50
Women's Awareness of the Concepts of PHC, Health for All by the Year 2000 (HFA/2000) and Community Participation	53
Knowledge of and Involvement with Women's Groups/Organisations	55
WOMEN AND HEALTH DECISION MAKING	57
Who decided to have the children vaccinated?	57
Women's Illnesses, what action was taken and why	58
Illnesses During Pregnancy	59
Women's Health Care Options - Who Decides?	60
Use of Preventive Health Services by Pregnant Women	61
Education Level of Ante-Natal Clinic Users	61
Children's Illnesses, Action Taken and Why	61
Why No Action was Taken	64
Children - Use of Preventive Services	65
WOMENS' DECISION-MAKING CONCERNING FERTILITY ISSUES	66
Contraceptive Knowledge and Practice	66
Decision to Use Contraceptives	68
Conjugal/Couple Communication	69
Why Men Agree to Women's Use of Contraceptives	69
Reasons For Not Using Contraceptive Method	69
Ideal Number of Children	72
Preferred Sex Ratio of Ideal Number of Children	72
TBAs AND THEIR BELIEFS, ATTITUDES AND PRACTICES PERTAINING TO MATERNAL AND CHILD HEALTH	74
Introduction	74
Pregnancy	74
Pre-Natal Care	78
Methods of Protection for the Mother and the Unborn Child	81
TBAs Knowledge About When the Baby is Due	81
Child-Birth	82
What TBAs Do When Faced with Difficult Delivers	85
Post-Partum Care	89
Still-Births and Neonatal Deaths	93
Protection for the Newborn (against Diseases)	94
Some Infant and Childbirth Illness	94
Birth Spacing and How to Prevent Pregnancy	97
How Some of the Traditional Beliefs and Practices May be Influencing the Utilisation of MCH Services and Maternal and Child Health	99
CLINIC BASED STUDY	104
Introduction	104
The Clinic Sample	104
Staff	105
Use of MCH Services - Who Decides?	105

d.

Reason(s) for Utilising MCH Services	106
Preventive Services - Children	106
Ante - Natal Care	107
Participation in Clinic Activities	108
Relationship Between Staff and Patients	110
Clients/Patient Satisfaction With Services Offered	110
Clinic Problems Mentioned by Nurses Interviewed	112
How Services Can be Improved - Clients/Patients Views	113
How Services can be Improved - Staff Views	114
Reasons for Preferring Non-Government Clinic	114
Summary	115
DISCUSSION AND CONCLUSIONS	116
Homestead Based Study	116
Clinic Based Study	126
RECOMMENDATIONS AND AREAS FOR FUTURE RESEARCH	129
ANNEXES	

- 2 -

TABLES

Table 1	Breakdown of Main Questions into Substudy Level...	11
Table 2	Hluti: % Distribution of Women by Age Group	38
Table 3	Matsanjeni: % Distribution of Women by Age Group	38
Table 4	Distribution of Children by Age (Months and Sex)	41
Table 5	Distribution of Children by Area and Vaccination(s) Received	43
Table 6	Distribution of Women Mentioning Specific MCH Services(s)	45
Table 7	Distribution of Illness Episodes by Type of illness	58
Table 8	Distribution of Children's Illness Episodes by Type of Illness	62
Table 9	Distribution of Women by Knowledge of Contraceptive Method and Current Use by Type	66
Table 10	Distribution of Women by Area and Type of Method Used	67
Table 11	Distribution of Women by Number of Living Children and Type of Contraceptive Method Used	68
Table 12	Distribution of Women by Decision-maker for Contraceptive Use	68
Table 13	Distribution of women by Area and Reason for not Using Contraceptives	71

SUMMARY

The research on women's participation in Primary Health Care was conducted in the Hluti and Matsanjeni areas of Shiselweni Region. It focused mainly on women as health care providers and users at two levels; the homestead and the Maternal and Child Health (MCH) Clinic. Primary health care as examined in this study is defined with both small letters, 'phc', and capitals 'PHC'. The former ('phc') refers to the level of the homestead, that is, health as it obtains in the every day lives of rural women and what actions they take when they themselves, or very young children in their care fall sick. The latter ('PHC') refers to the formal Maternal and Child Health (MCH) services that are provided at the clinics, and are an integral part of the PHC Programme in Swaziland.

The study population consisted of 185 women with children below the age of six in their care. They resided in two rural areas, one with a Rural Development Programme (RDP) and one without a RDP. It was hypothesized that women in the RDP would be more involved in 'developmental activities', via women's groups, and that this involvement would greatly enhance their health (and other) decision-making power within the home.

In-depth interviews with 53 women in the sample were conducted on the concepts of PHC, community participation in health, and Health for All by the Year 2000. All the 185 women in the sample were also asked to name the MCH services available, and

9

specifically to explain the relevance of vaccinations and weight monitoring, if these were mentioned by the respondents.

The in-depth interviews revealed that 68% of the women had never heard the slogans of PHC and HFA/2000. The remaining 32% were not certain what it all meant, and were sceptical as to the possibility of attaining the state of health for all by the year 2000. More than 90% of the 185 women were aware of at least 5 MCH services although some components were more well-known than others. For example, 90% mentioned vaccinations and weighing for women, whereas delivery services were mentioned by 37% and post-natal services by just 1%. Approximately 95% were familiar with children's preventive services. However, 87% did not know why children were weighed, and 85% did not know why pregnant women were vaccinated.

The hypothesis that women in the RDP area are more involved with women's groups was found to be untrue. In fact, more women in the non-RDP area were found to be involved in women's groups. Moreover, the majority of health care decisions concerning women and children in both areas were made by women. In this regard we found a relatively high utilisation of specific services such as, for example, vaccination of children (62% of the 288 children were found to be fully vaccinated at the beginning of the study). This suggests that in evaluating women's participation in PHC programmes, their involvement in family health at household level is relevant and should be taken into account. Not surprisingly,

their involvement at the clinic level was found to be limited to
the role of consumer. Careful planning is required if women are
to transcend this role and actively partake in the planning and
management of MCH services.

SWAZILAND

GEOGRAPHY, CLIMATE, POPULATION

The Kingdom of Swaziland is the second smallest country on the African continent after the Gambia. The country is bordered by the Republic of South Africa on the north, west, and south, whilst on the east lies Mozambique. The area covers approximately 6,700 square miles. From north to south it runs 120 miles, while from east to west it is 90 miles.

The Swazi people are a relatively homogenous group of people who share a common language and traditions. In 1986 the population was 712,131 (CSO 1988) representing an annual growth rate of 3.2% during the period 1976 - 1986. Approximately 47% of the population are less than 15 years of age, and about 24% are women in the age group 15 - 49 years. The male to female ratio is 89.2 to 100. Seventy seven (77%) percent of the population resides in the rural areas and 23% in urban areas.

The country is divided into four distinct ecological areas running almost parallel from north to south. These areas from west to east are; the highveld which has a cool moist climate and ranges in altitude from 6,000 ft. to 3,500 ft. Rainfall is between 1,016mm - 2,280mm year, and temperatures the range of 73°F (23°C) in the summer months (October - March) and 51°F (11°C) or below in winter above sea level. The subtropical middleveld has an altitude of between 3,500 ft. to 1,500 ft and is ideal for

farming. Rainfall is not as much as the highveld and is between 762mm - 1,143mm a year temps 79°C (26°C) 56°F (13°C). The third area is the lowveld which has a hot dry climate and lies between 1,000 ft and 500 ft. above sea level. The lowveld experiences very varied rainfall averaging between 508 - 890mm., temps 85°F (29°C) - 60°F (16°C). The Lubombo Plateau, said to be the rockiest of the four areas, lies on the eastern side of the country. The climatic conditions in Lubombo resemble the middleveld. Rainfall on the plateau ranges between 635mm-1,016mm.

There are four administrative regions, Hhohho, Manzini, Shiselweni, and Lubombo. Manzini region has 28.3% of the population, followed by Hhohho with 26.3%, Shiselweni with 22.8%, and Lubombo with 22.6%. Population density is lowest in Shiselweni and Lubombo regions, 18.5 and 16.3 persons per sq. kilometer. The Middleveld (Manzini) has the highest concentration of persons per sq. km. (43.4) followed by the Highveld (Hhohho) with 30.7 persons per sq. km.

Shiselweni region, where this study was conducted, is said to have the largest number of absentees (42%) as a result of out-migration to other areas in Swaziland, or to the Republic of South Africa in search of wage employment. The region is also the only one which has within it's borders the four ecological areas. The homesteads selected for this study are situated in the middle and lowveld areas of Shiselweni region.

Social Organisation.

Swaziland has no 'villages' as found in, for example, Tanzania or Uganda. Instead, the rural population resides in clusters of dispersed sometimes isolated homesteads. A homestead may comprise several households, tindlu or smaller mother-child units. The head of the homestead is usually a man.

ECONOMY

Swaziland has an open economy and is highly dependent on external trade. The country derives over 80% of its Gross Domestic Product (GDP) from exporting sugar, wood pulp, citrus and asbestos. In 1986/1987, Swaziland had a per capita income of \$US 854. Inflation in the same period was approximately 13%. Although considered a middle income country, and despite its appearance of wealth, a large proportion of the people especially in rural (and peri-urban) areas are poor.

HEALTH

Swaziland's health care delivery system is essentially hospital or clinic based with a bias towards curative medicine. In 1982 82% of the doctors and 50% of the nurses work in urban areas.

Health care is provided through a network of clinics, health centres, and hospitals run by the Government, Missions, Companies (mainly industrial) and private doctors. Non-governmental Organisations also provide some of the health services but the Government runs over 50% of all the health services. There are 7

government hospitals, 7 company ones, and 3 run by Missions. Of the 134 clinics and health centres in the country, 46 are government, 36 private, 32 Mission, and 20 belong to companies. Over 80% of the clinics are in the rural areas, and represent the backbone of the Primary Health Care System in Swaziland. Nurse-midwives are the backbone of the modern health care system, and make up over 70% of the health cadres directly dealing with patients. It is estimated that over 80% of the population is within 8 km of a health facility and clinics are almost evenly distributed throughout the country. However, they do not necessarily succeed in serving the largest number of people. In an effort to bring modern health care to the communities, the government began training community health workers in 1976. These workers, known as Rural Health Motivators (RHMs) at present cover a third of the country, and an evaluation of the RHM programme was recently completed (May 1989).

Another important source of health care for many Swazis is the traditional health care system. There are over 5,000 traditional healers in the country, and many of these are registered with the Traditional Healers Association. The possibility of integrating the two systems, modern and traditional, is being explored and one of the first attempts was a project in which a group of selected traditional healers and modern health workers got together, through a series of malaria and malnutrition (MOH 1984) workshops and given training in basic diagnosis and prevention of childhood diarrhoea and childhood diseases such

e.g. measles of whooping cough (MOH 1984).

Health Problems

Swaziland's major health problems fall into three categories: maternal and child health, communicable and environmental diseases, and, nutrition (MoH 1983). These health problems are largely due to poor environmental conditions including inadequate sanitary facilities and lack of clean and safe water supplies. Gastroenteritis, respiratory illnesses, tuberculosis, and problems associated with childbirth are all high on the list of leading causes of morbidity and mortality. Bilharzia and typhoid are said to be endemic. In the middleveld and lowveld, bilharzia affects 60 - 90% of the population. Drug resistant malaria is also on the increase.

Health Policy

In recognition of the health problems facing the majority of the Swazi people, the Ministry of Health (MoH) has stated as it's main policy objective, the improvement of the health status of all Swazis through the provision of preventive, promotive, rehabilitative and curative health services which are relevant (or appropriate), and accessible to everyone. In order to achieve its policy goal, the MoH has adopted the Primary Health Care (PHC) strategy which aims to bring health services to the people through their active participation.

INTRODUCTION

The Ministry of Health in Swaziland is committed to the goal of 'Health for All by the Year 2000'. To achieve this goal, the Ministry has adopted the strategy of mobilizing the populace for health in developing a comprehensive Primary Health Care (PHC) system (National Health Policy 1983). It is hoped that by so doing, health services will be brought nearer to the people, over 70% of whom live in the rural areas.

Participation is seen to a major component of the Primary Health Care approach to improving health status. Not only are individuals, families and communities required to participate in maintaining their own health, but also to undertake 'local grass-roots participation in the decision-making process.' (National Health Policy, 1983). Participation is seen to be essential to the success of PHC programmes.

The pivotal role of women to the success of PHC cannot be overstated. In many countries around the world, women are the majority in both the informal and/or traditional health care system and in the modern sector. In Swaziland over 65% of health care staff are women. Provision of Maternal and Child Health Services (MCH) is part of the core activities of PHC and women as mothers and guardians of children aged 0-5 year are expected to utilize MCH services for the benefit of the children and themselves. This involves making decisions to use the various components of the MCH package for both preventive and curative

care. A number of factors may constraint women from utilising available health services such as lack of knowledge of available services, geographical distance of the health facility providing the services and lack of cash resources to pay for transportation or clinic services. These factors influence the decision making process concerning which health care option to use if, for example, they themselves or their children became sick.

Although most of the research on women's decision-making in Swaziland has focussed largely on the agricultural sector (Sachs and Roach 1983; Carloni 1982; Nxumalo 1979; Tabibian 1983), it has highlighted one of the most crucial aspects of Swazi society, namely, women's subordinate (both traditionally and legally) position in society. As two authors on the situation of women in Swaziland have observed, efforts to ease women's burdens will only succeed if they change "...deep-set attitudes towards women which go to the very core of Swazi society" (Armstrong and Russell 1985, p.98).

The emergence of the mother as the primary decision-maker in health decision-making in Swaziland has been attributed to, among other factors, the increasing absences of the male homestead heads who have had to migrate away from the homesteads in search of wage employment. (Gort 1985).

However, Women's traditional roles as nurturers and providers of household needs such as food and water places them in the

forefront as far as health decisions are concerned because their decisions about their own and their young children's health falls within the realms of their 'traditional' responsibilities i.e. nurturing, caring.

Women in their roles as wives, grandparents, daughters and "heads of homesteads" will have varying degrees of influence in the homestead depending, among other factors, on their age and status. In their maternal roles, their health is intrinsically linked to that of their offspring. Women as mothers or guardians of young children spend a considerable amount of time tending to the health and other needs of the latter, such as breastfeeding, preparing weaning foods, and making decisions about the use of health care services.

A discussion of their health relative to issues such as family planning and utilization of MCH services, will have to therefore include health matters pertaining to children, especially the under fives.

OBJECTIVES OF THE STUDY.

The broad objectives of this study were;

1. To highlight the extent of rural Swazi women's participation in primary health care, and
2. To reveal or identify factors influencing women's decision-making in health.

The overall aim of the research is to utilise the findings in devising appropriate strategies for a) strengthening and improving the organisation and delivery of MCH services in rural Swaziland, and b) enhancing women's participation in the planning and delivery of formal health services, in particular, MCH services c) improving maternal and child health

The specific objectives were to study two groups of women relative to decision-making in health. These groups were as follows:

1. Providers of maternal and child health care at the following levels;

Homestead - Mothers and Guardians of children aged 0 - 5 years

Community - Traditional Birth Attendants.

Health Facility/Clinic - Nurses

Central Level - Women in decision-making positions i.e. Ministry of Health

2. Users of maternal and child health services at two levels;

Homestead - pregnant and lactating women, other women looking after children aged 0 - 5 years

Health Facility/Clinic - Women using maternal and child welfare services

MAIN RESEARCH QUESTIONS

The following five main research questions were formulated to focus and guide the research.

1. What are the traditional beliefs, attitudes and practices pertaining to maternal and child health? How do these influence the use or non-use of Maternal and Child Health (MCH) services?
2. In what activities within the household/homestead, and the community do women participate and make or influence decisions? Specifically, how are health and/or health related decisions within the household/homestead made?
3. To what extent do women as users of MCH services participate in clinic level activities other than in their capacity as service users?
4. What is the nature of the relationship between the (female) health staff and the users of MCH services? What are their attitudes towards each other? Do their perceptions of their roles in the provision and utilisation of health care differ?
5. To what extent were and are women as providers of MCH services involved in the decision-making process (planning, management, etc) in the provision of these services?

STUDY DESIGN

The study was designed to elicit responses from four levels of health care delivery. These were; I. Homestead Level, II. Community Level, III. Health Facility/Clinic Level, and IV. Central/Policy Making Level.

Table 1 outlines the main research questions in relation to the relevant level(s) of health care to which they apply.

1. Breakdown of Main Questions into Substudy level / Information Required / Instrument(s) / Target Population / Investigator

Question	Substudy Level	Information Required and Instrument(s) Used	Investigator(s)	Target Population
How are health and or health related decisions made within the "household"?	1. Homestead	Illness episodes - action taken, reason for action, Visits for preventive services. Questionnaire	2 Field Assistants Principal Investigator	- children 0-5 - pregnant women - other family members
	2. Homestead	Knowledge of available health services for women and children - both formal and informal	"	Mothers/Guardians of 0-6 years old
How are health and or health related decisions made within the "household"?	3. Homestead	(a) Knowledge, Attitude and of contraception decision to not to contracept Conjugal or couple communication concerning contraception and desired no of children - Questionnaire last 2 months women familiar with researcher, more relaxed and less shy answering intimate questions.	2 Field Assistants Principal Investigator	Target population of women in study homestead (incl. pregnant women)
	4. Homestead	Intra family decision-making on health and other matters - who decides what to cook / who's responsible - who controls financial resources	"	Target pop - Women Respondents
How are health and/or health related decisions within the "household" made?	5. Homestead	Number of Homestead members in paid employment - where/if money sent or brought back - to homestead/ How often - Questionnaire	2 Field Assistants Principal Investigator	102 homesteads in the 2 study areas (Respondent women in the study of other person in the homestead e.g. homestead head).
How are health and/or health related decisions made within the "household"?	6. Homestead	Women's Fertility History - number of pregnancies - number of living children - child deaths, and/or	2 Field Assistants Principal Investigator	- Mothers/Guardians of 0 - < 6 years olds - Pregnant women with no children

Question	Substudy Level	Information Required and Instrument(s) Used	Investigator(s)	Target Population
		miscarriages - Questionnaire		
tionally to the above:- Observations on overall condition of the homestead i.e. environmental hygiene, child care etc. were noted (Notes) for each visit when necessary. <u>Diaries</u> were also kept by the assistants and principal investigators on general issues discussed with the women in informal interviewing.				
In what activities within the community do women participate and make or influence decisions?	7. Community	Community activities in which are involved - how many of these activities are health or health related? - Interview schedule open end question - Observation (some participation) at women's group meetings (b) Informal interview of women's group leader(s). Tape recording of interview and note taking	2 Field Assistants (If possible, Principal Investigator)	Women attending community meetings and/or women's group meeting(s). Leader(s) of women's group(s)
In what activities in the community do women participate and make or influence	8. Homestead	- Women's Knowledge of local women's groups - Whether or not women are members of group(s) Questionnaire - Form II (a) Part B Nos. 10 and 11	2 Field Assistants Principal Investigator	- Mothers/Guardian of 0-6 years - Pregnant women
QUESTION health care options (options) for families rural areas?	9. Community	Existing health care option - traditional healers/herbalists etc - Rural Health Motivators - Mobile clinics (outreach) - Rural clinics - Hospitals - commercial outlets for (patent) medicine utilization of traditional medicine herbs, etc.) Questionnaire - Form II (a) Part B Numbers 12 - 19, Form II (a)	2 Field Assistants Principal Investigator	- Mothers/Guardians of 0-6 years - Pregnant women Health care staff (providers)

Question	Substudy Level	Information Required and Instrument(s) Used	Investigator(s)	Target Population
		Part A Informal interviews with Government/Mission health care staff at clinics and Regional Hospital Secondary sources for information on Shiselweni Region e.g. Planning Unit, MOH	Principal Investigator	
What are the traditional practices, beliefs and attitudes on maternal and child health?"	10. Homestead (and community)	<ul style="list-style-type: none"> - Pregnancy - child care - child spacing - child birth . Informal interviews using open-ended questions as guide for interviewer . Tape recording of whole interview . Note taking where necessary 	One field assistant hired specially for this part of the study (Principal Investigator) always presents	Older women or "Bogogo" (grandmothers) identified as TBAs via Form II (a) Part B No. 16
QUESTION do these influence use and/or non-use of CH services?" (to be interpreted within context of research findings)	11. Homestead	Utilization of (a) Traditional health care system (b) Clinic services for preventive, curative and delivery services <ul style="list-style-type: none"> . Questionnaire Form II (a) Part A (questions on illness episodes action taken, use of preventive services) . Observations of how pregnant women are treated in homesteads, what work they do etc . Diary keeping and note taking 	2 Field Assistants and Principal Investigator	<ul style="list-style-type: none"> - Pregnant women without children - Mothers/Guardians of 0 - <6 year olds

Question	Substudy Level	Information Required and Instrument(s) Used	Investigator(s)	Target Population
What is the nature of the relationship between the female health STAFF and USERS of MCH services?	12. Community Health facility based study	<ul style="list-style-type: none"> - Client/patient satisfaction or otherwise with services - Patient participation in clinic level activities - Why services being used i.e ante-natal, child welfare - Whose decision it was that woman/child attend clinic 	Principal Investigator with one Field Assistant	MCH staff - clinic MCH users - clinic at Maternal and Child Welfare Clinics
QUESTIONS "Do their perception of the roles in the provision and utilization of health care differ?"		<ul style="list-style-type: none"> - Health staff attitudes towards patients ability to participate in e.g. scheduling clinics - problems faced by service providers 		- Women in study homesteads
"To what extent do women users of MCH services participate in clinic level activities other than in their capacity as service users?"		<ul style="list-style-type: none"> . Questionnaires - Form V (a) Users Form V (b) Staff - Informal interviews/ conversations with women in study homesteads - Note taking/Diaries 		
To what extent WERE and ARE women as providers of MCH services involved in the decision making process (planning management etc.) in the provision of these services?"	13. Regional Level	<ul style="list-style-type: none"> - Organization and operation of MCH services at Regional and Central Levels - Historical development of health services in Swaziland with focus on MCH services development how women involved in it - Placement of Women in key decision-making positions within the MoH . Informal interviews . Secondary sources 	Principal Investigator	MoH staff - at Regional and Central Levels - Senior Medical Officer, Shiselweni - Regional Health Administrator - Hospital Administ
	14. Central Level MoH			

Question	Substudy Level	Information Required and Instrument(s) Used	Investigator(s)	Target Population
		<ul style="list-style-type: none"> - Organization of Health Care Delivery System in Swaziland - Historical Background of services (specific focus on development of MCH Services and women involved in this process) - Placement of women in key positions (policy-making, planning etc.) with MOH . Informal interviews using INTERVIEW SCHEDULE as guide . Secondary sources <ul style="list-style-type: none"> - Archives - MOH files - University e.g. (SSRU) - Ministry of Agriculture and Cooperatives - USAID - UNICEF 	Principal Investigator	<ul style="list-style-type: none"> - Health Planner, MoH - Medical Officer PHU, Mbabane - MCH Consultant PHU, Mbabane - Matron 1/C PHU - CCCD Co-ordinator - Director, Health Services - Director, Health Services - 1/C Health Education

METHODOLOGY

Given the enormous influence of the social, cultural, and economic milieu on the health of women and their families it was felt that the best methodology (or methodologies) was one which best takes into account these multiple influences. The range of topics covered in the study design calls for a methodology which is flexible enough to enable the researchers to identify the numerous factors impinging on women's lives. Furthermore, the methods used to collect information should allow the respondents (women) to talk freely and in their own words about the issues being investigated, and others that they may consider more important.

A multi-method approach was therefore selected for the study. The method highlights the level and extent of women's participation in primary health care, as well as the factors that influence their decision-making relative to health.

Both quantitative and qualitative methods were used in two types of studies; longitudinal and cross-sectional. These studies were conducted over a period of seven calendar months. Anthropological techniques, of observation, keeping diaries, indepth interviews, unstructured and semi-structured interviews, and participant observation, were utilised. Use of these techniques was facilitated by having 2 of the 3 field assistants, Swazi nationals, reside in the communities under study. A tape recorder was also used to record interviews with Traditional Birth

Attendants (TBAs), and 3 senior health personnel at Regional and Central levels.

Quantitative data was collected using (mainly) structured questionnaires (see Annexes).

One major longitudinal study was undertaken. This study looked at intra-family decision-making concerning action(s) taken when family members fell sick. The emphasis was mainly on illness episodes of children aged 0 - 5 years, mothers and or guardians of these children, and pregnant women without children.

Also investigated was the type of food consumed by family members, 24 hours prior to visits from the principal investigator and the field assistants, and how this was distributed.

The cross - sectional studies were on; knowledge, practice of contraception and couple/conjugal decision-making concerning fertility issues, PHC, HFA/2000 and Community Participation in health, homestead members in paid employment and remittances from them, women's knowledge of the growth chart, women's knowledge of MCH services and other health care providers in the community, and the homestead census.

The sub-studies were spread over the whole research period because some of the more 'sensitive' information (e.g. on contraceptive use) required the establishment of a good rapport between the researchers and respondents.

Note taking during each homestead visit was supplemented by diaries kept by the field assistants and the principal

investigator. Diary-keeping made it possible to record some of the content of informal conversations with women about issues that concern them. For example, it was possible to obtain women's attitudes towards health staff and opinions about staff efficiency in delivering MCH services through informal conversations in the relaxed atmosphere of their own homes.

Designing the Questionnaires and Interview Schedules

A total of 18 questionnaires and interview schedules were designed (see Annexes) after the main research questions were approved by the Ministry of Health (MoH), and informal interviews had been conducted with a few Ministry of Health officials (in Mbabane) concerning the topic under study. In addition, consultation of documents and various articles on women in Swaziland, and on health, clarified the issues posed by the main research questions. This in turn led to the formulation of specific questions related to each of the main ones. A necessary part of the process of formulating the specific questions was to liaise closely with the MoH in Mbabane so that the appropriateness of the questions, in terms mainly of the content, could be checked and if need be, refined. Additionally, it was important that if other areas of interest to the MoH were identified, they could be incorporated and investigated within the overall framework of the study.

Selection of Research Sites and Hypothesis/Assumptions

Given that one of the areas the research set out to investigate was women's participation in community activities, it was decided that since Shiselweni had a Rural Development Area Programme (RDAP), two areas would be selected, one within the RDAP and the other outside the RDAP. Map 1 shows the current Rural Development Areas in Swaziland.

Since RDAPs "...are theoretically based on the concept of mass participation in both decision-making and implementation of rural development plans" (Magagula 1978, p.462) the choice of two different areas would enable one to compare differences in women's participation in PHC, but more specifically, their decision-making relative to health matters. There were two general assumptions underlying the above and these were that;

a) women residing in Rural Development Programme Areas (RDPAs) would be more likely to participate in community affairs than women living in non-RDPAs.

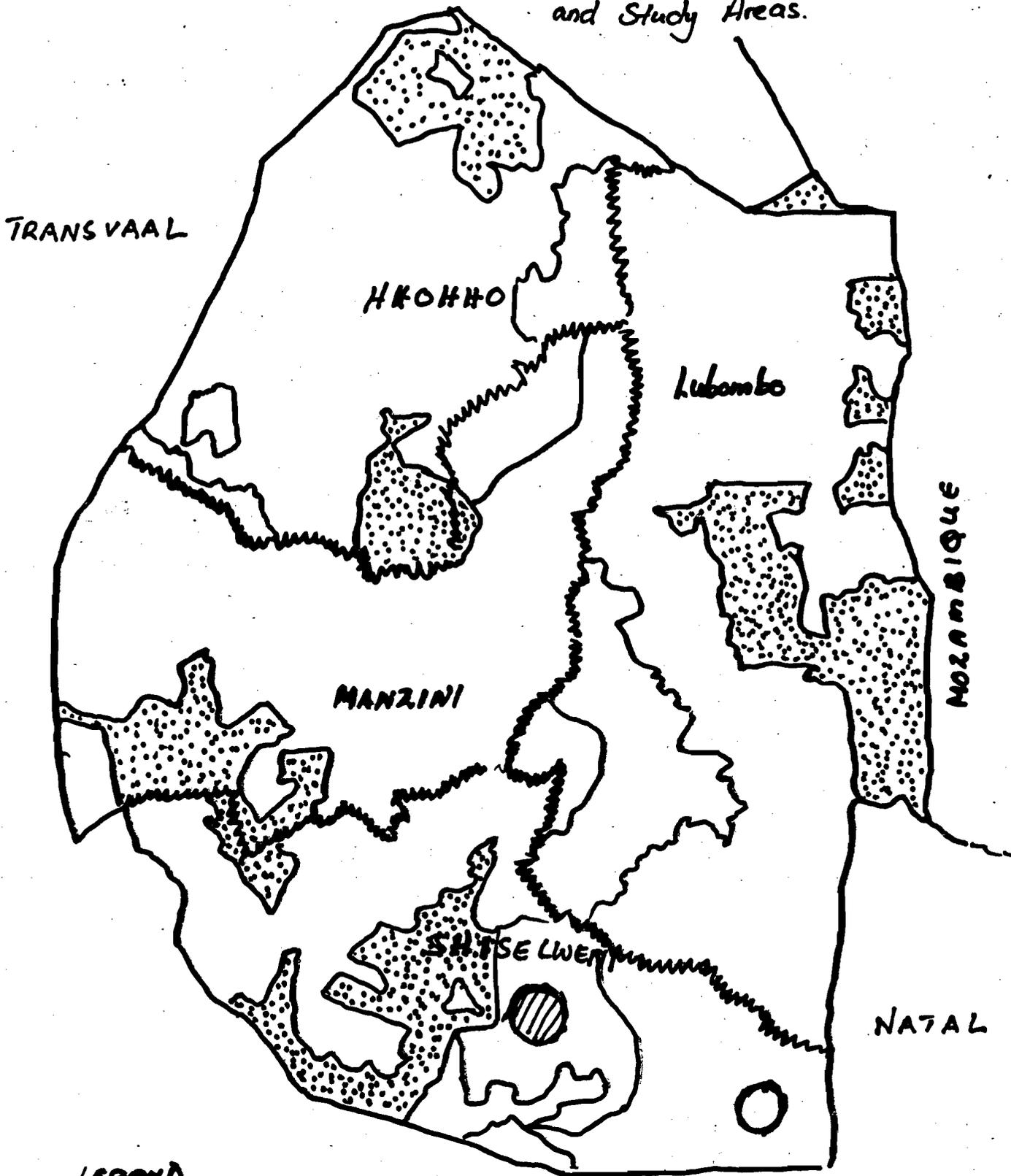
b) having had the opportunity to participate at the community level, women were then more likely to assert themselves when and if decisions were to be made within the home.

The Rural Development Area Programme: A Brief Outline.

The RDAP began in 1970 and is an attempt by the Swaziland Government to increase productivity and incomes of mostly subsistence farmers on what is known as Swazi Nation Land (SNL). This is land which is held in trust by the King for the Swazi nation and covers approximately 56.2% of the total land area of Swaziland. In 1982, the RDAP covered 51% of SNL, and the latter held 47% of the homesteads on SNL (UNICEF 1984).

19a

MAP 1 RDAs in Swaziland and Study Areas.



LEGEND

- International Boundary
- ~ Regional Boundary
- ▨ Existing Maximum Input RDAs
- ▭ Existing Minimum Input RDAs
- ⊙ Hluti Study Area
- Matsanjeni Study Area

Source: Ministry of Natural Resources, Land Utilization and Energy

There are 3 phases to the programme and these are;

Phase 1 - Planning. This entails drawing up a rough plan for development of infrastructures etc. in conjunction with members of the community and extension workers in the area acting as advisers.

Phase 2 - Minimum Input phase. Using the community plan (phase 1) the Ministry of Agriculture and Cooperatives works out detailed land use plans that are then returned to the community for approval. A project centre is also constructed and limited inputs are introduced e.g personnel to oversee the implementation of the plans.

Phase 3 - Maximum Input phase. Once the plans have been approved, the provision of inputs is expanded and a Project Manager and other officers needed to run and coordinate the programme are appointed (or designated).

There were 17 RDAPs as of June 1987 (when the Principal Investigator left Swaziland). Eleven of the RDAPs were Maximum-Input and 6 were Minimum-Input RDAPs.

Recruitment of Field Assistants:

The Central Statistical Office in Mbabane assisted in recruiting 2 of the 3 female assistants. The third assistant, who conducted the TBA interviews, was recruited in Shiselweni after field work had begun.

The main reason for selecting female assistants was that the study is female centred and women in the rural areas, especially, feel more at ease talking to a female interviewer. Homestead heads are also more willing to allow their wives and/or other female members of the homestead to talk to female rather than male researchers.

Training of Field Assistants.

The assistants were given a one week intensive training programme by the Principal Investigator. The programme covered the following; a general introduction to the purpose of the research, the instruments (especially the questionnaires) they were to use, and how to approach subjects for interviews.

Time was also spent going through each of the questionnaires, discussing questions that appeared unclear i.e open to more than one interpretation, and agreeing on the siSwati translations. It was important that the assistants asked the same questions in the same way.

A delay of a month was experienced before getting the final go-ahead from the Regional Administrator (the political head of the region) to begin the study. Given the already limited period in which the research was to be undertaken, this meant making a decision not to pilot test the questionnaires, but instead to go ahead with data collection and, if any changes were required, do them in the field. The longitudinal nature of the study made this a feasible choice.

Only question 3 on Form II(a) Part B was revised after the first round of homestead visits. The original question had read, "Who first told you about MCH services?". The question was interpreted by the women to mean the person who gave them specific information about the MCH services provided at the clinic and therefore answered 'nurse'.

Training of Field Assistants.

The assistants were given a one week intensive training programme by the Principal Investigator. The programme covered the following; a general introduction to the purpose of the research, the instruments (especially the questionnaires) they were to use, and how to approach subjects for interviews.

Time was also spent going through each of the questionnaires, discussing questions that appeared unclear i.e open to more than one interpretation, and agreeing on the siSwati translations. It was important that the assistants asked the same questions in the same way.

A delay of a month was experienced before getting the final go-ahead from the Regional Administrator (the political head of the region) to begin the study. Given the already limited period in which the research was to be undertaken, this meant making a decision not to pilot test the questionnaires, but instead to go ahead with data collection and, if any changes were required, do them in the field. The longitudinal nature of the study made this a feasible choice.

Only question 3 on Form II(a) Part B was revised after the first round of homestead visits. The original question had read, "Who first told you about MCH services?". The question was interpreted by the women to mean the person who gave them specific information about the MCH services provided at the clinic and therefore answered 'nurse'.

Homestead Sampling Procedure

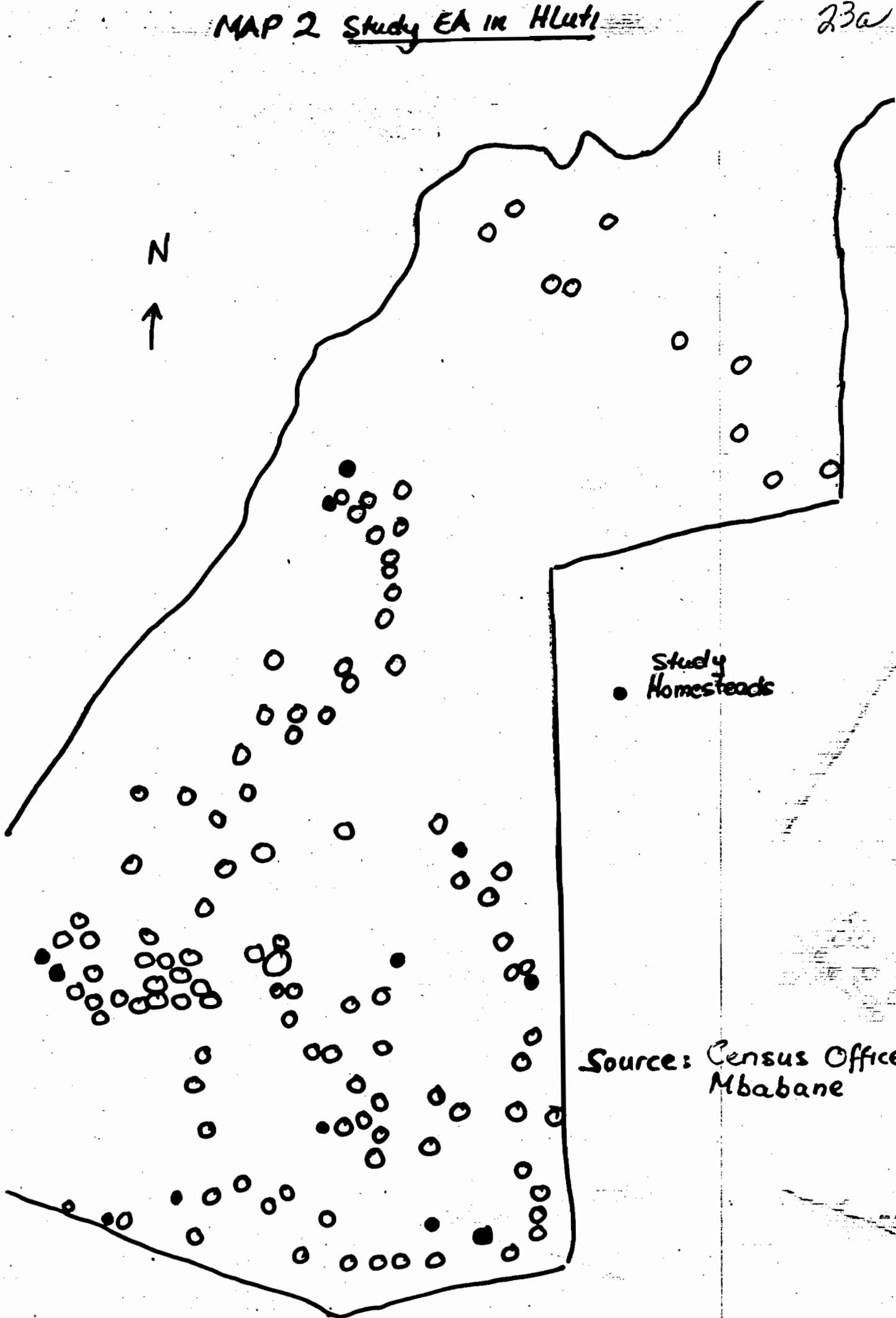
A map of Swaziland with the RDPAs delineated (Map 1) was obtained from the Ministry of Natural Resources and Land Utilisation. Arbitrary borders were drawn around areas designated Maximum-Input (Hlatikhulu area), Minimum-Input (Hluti area) and Non-RDPA (Matsanjeni area) all in the Shiselweni Region. This constituted the Sampling Frame which consisted of 34 Enumeration Areas (EAs). The EAs are areas with a given number of homesteads and population, demarcated by the Census Office to aid them in the last population census undertaking of August 1986. Of the 34 EAs in the Sampling Frame, 12 were Maximum-Input, 12 were Minimum-Input and 10 were Non-RDPAs.

Aerial maps of each EA were also provided by the Census Office showing all the homesteads (each had been given a number). The Census Office also provided a list of names of the Homestead Heads of the selected homesteads. The homestead, or umuti in siSwati (plural is imiti), is the basic survey sampling unit in Swaziland. The umuti consists of, usually, a group of houses whose residents may span three generations of one family. Homesteads are headed by the Umnumzane or homestead who is usually male. Map 2 and Map 3 show 2 of the EAs in which the study homesteads were situated.

With the assistance of the Central Statistical Office and the Census Office, a random selection of EAs was done. There were 6 each for the Maximum Input, Minimum Input and Non-RDA areas. Five

MAP 2 Study EA in Hluti

23a





homesteads in each of the EAs were randomly selected using a table of random numbers. This yielded a sample of 30 homesteads in each area, making a total of 90 homesteads. The 30 homesteads per study area were deemed adequate in terms of yielding statistically significant conclusions.

Selection of Study Population

The population with which the study was concerned was mothers and/or guardians of children aged 0-5 years, children aged 0-5 years, and pregnant women with no children. Those eligible for inclusion in the study were either one or all of the above groups found in any of the selected homesteads.

Preliminary Visits to Areas Selected for Study

Two preliminary visits to the selected areas were made three weeks prior to commencing the fieldwork. From these visits, some indication was obtained of the relative distance between the study areas as well as the distance between the selected homesteads within these areas. These visits revealed what a difficult undertaking this was, given the time schedule within which the research was to be conducted and the fact that funding allowed for only 2 full - time field assistants. The distances turned out to be too vast to allow adequate supervision and coordination by the Principal Investigator, as well as allow for a comprehensive collection of data. This necessitated the adoption of a different homestead selection procedure which would minimise the problems outlined above.

Revised Homestead Selection Procedure

From the logistics point of view, only two areas could be covered, one being a Non-RDA and the other within the RDAP. Of the RDP areas, the Minimum Input area (Hluti) was selected. The choice of Hluti made the supervisory tasks more manageable because the 'towns' of Hluti and Matsanjeni are less than half an hours drive from each other. The Principal Investigator was able to make alternate visits between the two areas, and with prior arrangement, the two field assistants could be seen on the same day to iron out difficulties and communicate experiences. The homesteads were selected after settling the field assistants in the two areas.

Selection Procedure for Matsanjeni Homesteads

There were 106 homesteads in the Matsanjeni EA. Separate pieces of paper were numbered from 1 to 106 placed in a bag. Fifty pieces of paper were then picked out of the bag. The homestead in which the assistant was to reside was added bringing the total to 51. Its inclusion provided an opportunity to observe (and even get involved in) homestead activities which would have been impossible in twice monthly visits to each homestead.

If one of the selected homesteads did not meet the selection criteria, then the assistant would move on until one was found.

Selection Procedure for Hluti Homesteads

In order to find a homestead willing to accommodate the field assistant for at least seven months, it was necessary to find

someone in the community who would be able to advise on which homesteads to approach. Assistance was therefore sought from the head of the local police station. On learning of the purpose of the study and the period it would take, the local police chief suggested that it would be better for the assistant to reside at Hluti clinic for two reasons;

one, being female, it was much safer for the assistant there. A spate of attacks on women in that area not long before our arrival made the police chief a bit wary of having the assistant reside in a homestead they were not too sure about. Two, the distance between the selected homesteads, and an infrequent bus service on which the assistant would have to rely would result in more time spent commuting between homesteads than with members of the homestead. Due to these considerations, it was decided to select part of the study population from the clinic. Women using MCH services were selected randomly using numbered cards that were distributed to women waiting to be seen for ante-natal, post-natal or child welfare services. A total of 25 women from 25 different homesteads were selected over a period of 9 days. Before selection could commence, the field assistant would greet the women, introduce herself and give a brief introduction to what she was about to do (and why) and ask for their cooperation. The women were also asked to put questions to the assistant if they felt unsure of the explanation. The nurse-in-charge was also on hand to introduce the assistant whenever possible.

For each of the women selected, the following details were noted down:- woman's name, name of the homestead head, area of

residence (i.e. neighbourhood or community name) and instructions on how to get to the homestead. The assistant would then tell the woman when she was going to be calling at her homestead.

Women were followed home and the nearest homestead to theirs, with children aged 0-5 years and/or a pregnant woman was also recruited into the study. This brought the total sample of homesteads to 42. In order to have a similar number of homesteads in both areas, 9 of the homesteads originally selected with the assistance of the Central Statistical Office were retained. These homesteads were almost halfway between Hluti and Hlatikhulu in the Ngololweni area, and represented homesteads with minimum access to static health facilities. The area in which these homesteads were situated was served by a rather infrequent mobile or outreach clinic service from Hlatikhulu General Hospital. There was also one bus running twice daily between Hluti and Ngololweni which meant that on the days the research assistant went alone (without the Principal Investigator), she had to ensure that she caught the bus on its return journey.

Clinic Based Study/Selection of Clinics

Four clinics, the ones most frequently used by the women in the study homesteads, were selected. Three were government clinics and one was a mission clinic. Two clinics had recently started operating MCH services daily but many of the clients still maintained the old schedule i.e. attending ante-natal and child welfare clinics on separate days. The other two clinics had been offering daily MCH services for sometime, but due to a sudden

shortage of staff, the schedule was altered temporarily availing MCH services thrice weekly.

Selection of Users

Because of the unpredictable nature of the clinic workload, and to ensure that each clinic visit by the researchers was adequately utilised, a criteria was set whereby random selection of clinic users would begin only after 3 or more women arrived. The procedure for introducing the researchers was similar to the one described above. At any one clinic visit, the Principal Investigator would be accompanied by at least one of the assistants. The user interviews were conducted in siSwati by the assistant, and the staff interviews in English by the Principal Investigator.

Data Collection

The homestead and clinic level studies were conducted over a 7 month period. The Principal Investigator resided in Hlatikhulu, where the Regional Hospital is situated, throughout the field data collection phase. From here, access to 'back-up' facilities for photocopying and for some of the typing, was made relatively easier than if she had lived in Hluti or Matsanjeni. However, this still meant travelling either to Manzini which is 76kms from Hlatikhulu, or 126kms to Mbabane for these services. The purchase of a vehicle before commencing data collection assisted enormously in minimising the time spent travelling to and from these towns.

The Principal Investigator commuted to the study areas daily for the first two and a half months of the study. The visits were on alternate days and involved participating in interviewing women, discussing problems with the assistants and offering support were required. Subsequent visits were made after not more than three days. Interview forms were collected from the assistants after every visit, checked and returned if information was missing. It had been calculated that in order to cover all the homesteads in a month, the assistants had to cover at least 4 homesteads per day.

Instruments Used

The questionnaires and interview schedules used are annexed to the report. The other instruments used were mentioned earlier. A total of 1,288 questionnaires and schedules were used.

Identification and Interview of Traditional Birth Attendants (TBAs).

This was done by asking women in the homesteads questions 15 and 16 on Form II(a) Part B. Seven women, all bogogo (grandmothers) who had their names mentioned more than once, were followed to their homesteads and a request was made for an interview. One gogo later declined to be interviewed. The 6 remaining bogogo were interviewed during 2 separate visits to their homesteads. An open-ended questionnaire, translated into siSwati by the assistant assigned to this part of the study, was used. All interviews were tape-recorded and were later transcribed then

translated into English.

Additional Questions for In-Depth Studies in 30 homesteads were formulated to guide the assistants in informal, more in-depth conversations/interviews with women in selected homesteads. Each assistant selected 15 homesteads mainly on the criteria that a certain degree of rapport, conducive to posing probing and 'sensitive' questions, had been established between the themselves and the respondents.

Problems Encountered During Field-Work

Although the initial idea was to visit each homestead twice a month, in practice, this proved impossible for the following reasons:-

1. The distances between homesteads were such that at times only 1 homestead instead of the projected 4-5 could be covered in one day.

2. Absence of key respondents. This necessitated re-visits to the same homestead which meant that covering 51 homesteads at least once took over a month.

3. Public holidays. During the Christmas period in December 1986, the assistants were away for nearly 3 weeks. Most of the illnesses during that period were therefore not recorded although attempts were made to ask respondents about illness when field-work resumed.

4. Unforeseen circumstances such as illness. One of the assistants also lost two close relatives within a space of two

months and had to go home for the burial ceremonies.

5. Drop-outs from the study. The head of one homestead fell ill two months after data collection was begun and moved to an inyanga's homestead (outside the study area). One mother and her 3 children were therefore 'lost' to the study.

6. Repeat visits to some homesteads to pose questions that were neglected during an earlier visit also contributed to some homesteads not being seen twice in a month.

Limitations of the Data

Given the scope of the study, and the complexity of the research topic, it was not possible to cover everything we set out to do. Some of the topics could have been dealt with more comprehensively. On the other hand, much of the data, most of it qualitative, has not been utilised. It was not possible, due to time limitations, to interview leaders of women's groups or local leaders such as chiefs. The substudy on the participation of health care providers (especially nurses) in the development of health services in Swaziland, but in particular MCH services was also left out. This warrants a separate study.

Illness Episode Data. The 'illnesses' were either a diagnosed illness (as a result of a clinic visit) or symptoms as reported by the respondents. Episode duration was not measured. It is possible that what may appear as two episodes of the same 'illness' may in fact be one episode of long duration. This is probably more true for women (adult) than children.

Because some of the responses are based on very small numbers, it is difficult to make generalizable conclusions. This may be one of the problems with longitudinal studies that combine quantitative and qualitative methods. The denominator keeps on changing resulting in, for example, lower response rates for the cross-sectional studies such as the one on fertility issues.

Data Analysis

Questionnaires II(a) Part A, II(a) Part B, and V(a) were post-coded at the London School of Hygiene and Tropical Medicine. Using the dBASE III Plus programme, the data was entered on a Personal Computer. Eleven data files were generated and for each one, the Scientific Programme for the Social Sciences, SPSS, was used to obtain descriptive statistics such as frequencies and cross-tabulations on the variables.

The qualitative information contained in the diaries, as well as the field notes was extracted from the notebooks and used whenever appropriate.

From preliminary analysis of the data, it was found that women in the two areas were more or less similar relative to e.g. health behaviour in terms of decisions to seek help when ill, hygiene, sanitation and child-care. For this reason, data for the two areas has been aggregated unless otherwise indicated.

RESULTS

HOMESTEAD BASED STUDY

Characteristics Of Study Homesteads

Age and Sex of Homestead Head.

Eighty six percent (86%) of the homesteads were headed by men and 14% by women. Half the female heads were over 60 years of age. In contrast, 27% of the male homestead heads were in the age group 40 - 49, 23% in the age group 25 - 39 and 22% between 50 -59 years of age. No ages were recorded for 3% of the heads.

Sex Ratio of Study Homesteads

The male to female ratio of the homesteads was 87:100. This ratio is slightly higher than the Regional (Shiselweni) one of 83:100, but nearer the national average of 89:100 (CSO 1988).

Homestead Composition

Approximately 66% of the homesteads had 9 or more members. The number of inhabitants per homestead ranged from 2 on the lower end to 44 on the other.

Main Source of Water

Just over eighty six percent (86.3%) of the homesteads relied on a river or stream for their domestic water supply. The rivers and streams were usually quite a distance from the homesteads and

often inadequate during the dry season. Quite often cattle and other domestic animals would be watered at the same source used to collect the household water supply. The remaining homesteads used taps (6.8%)¹, communal pumps (4.9%), and a well (2%).

Pit Latrines.

Seventy eight percent (78%) of the homesteads had no pit latrine or other form of 'toilet' for the disposal of human waste. The condition of the latrines in the remaining 22% of the homesteads was mainly poor to inadequate both in construction and hygiene. The inadequate water supply compounded the difficulties of trying to keep the latrines clean. There were a few homesteads that had begun constructing latrines but had given up for lack of support from 'central authority personnel' who had instigated the digging.

This lack of support was one reason for the scepticism as to the possibility of attaining the state of Health for All by the Year 2000.

Food and Cash Crops.

Vegetable Gardens.

Thirty four percent (35/102) of the homesteads had vegetable gardens. These homesteads included homesteads whose female members were involved with a 'self help' garden group, Zenzele. Part of the produce from these gardens was sold and the rest

¹ 3.9% had taps in their compounds and 2.9% fetched water from their neighbours taps

consumed by the homestead. The proceeds of the communal garden were shared out according to how much labour each woman member contributed.

Other Food Crops.

Ninety five percent, 95%, of the homesteads grew the staple crop, maize along with one or more of the other crops such as sweet potatoes (34.3%)², cabbage (22.5%), sorghum (17.6%), groundnuts (15.7%), Irish potatoes (11.8%), cow peas (3.9%) and beans (2.9%).

Cash Crops.

Thirty nine percent (39%) of the homesteads were engaged in cash crop farming. The majority of these homesteads were in Matsanjani (29/51 of the homesteads grew cotton whereas only 11 of the Hluti homesteads grew this crop with 3 growing tobacco).

Ownership of Cattle and Other Domestic Animals.

Sixty three percent (63%) of the homesteads owned cattle³, 48% owned goats and only 7% kept sheep. Nine homesteads kept donkeys and pigs. Poultry (chicken) were reared by 33% of the homesteads.

Of the 14 homesteads headed by women, 8 had no cattle. One homestead had 42 heads of cattle and the remaining 5 homesteads owned less than 20 cattle.

Homestead Members in Paid Employment

Approximately 71% (72/102) of the study homesteads had at least one person in paid employment. The majority, 70% (85/122) were

² In brackets are the percentage of homesteads growing that crop.

³ 12.7% had 6-9 head of cattle, 18.6% had 10-15, 9.8% had 16-20, another 9.8% had between 21-30, 7.8% had more than 30 and 3.9% had 3-5. Of those with more than 30 cattle, one reported having 100 and another, 600. The remainder had less than 90.

employed within Swaziland. Nearly 25% of those in wage employment were female. Thirty one percent (31%) of the workers were homestead heads.

Remittances To Homesteads

Only 4 (6%) of these homesteads reported not receiving any financial support from those working.

Almost all the homesteads with members in waged employment received (some) money from those working. Two homesteads, one with four working members and the other with five, received nothing.

The availability of cash to meet household needs may greatly influence the utilisation of health care services. However, one of the factors determining whether or not available cash is used for health care is women's access to it. Another factor may be how frequent cash resources are made available to the homestead⁴. Both these factors were investigated and it was found that in 72% of the homesteads, the homestead head controlled cash resources and had the final word as to how it should be spent. Eleven percent (11%) of these homesteads were headed by females. Only in 7% of the homesteads was joint decision-making reported, that is the husband and wife consulted each other on money matters. Wives were reported to have control over money in 6% of the homesteads, and in 4% of the homesteads, each individual retained the right over his/her money. In the remaining 11% of the homesteads, decisions concerning the disposal of homestead cash resources were made by a variety of individuals including sons, brothers, or husbands (not homestead heads) of the women in the study.

⁴. We did not, however, ask for the amount of money each worker brought or sent home. The 1978 Rural Homestead Survey estimated that almost three-quarters of cash income to the homesteads came from waged workers (de Vletter 1983).

Frequency Of Remittances

Nearly 65% (72/122) of those working made monthly remittances to the homesteads. Infrequent contributions⁵ were obtained from 12% (15/122) of the workers. Ten percent (12/122) had never sent money back, 6% (7/122) sent money about every 2 - 6 months, and one worker brought money once every year on his annual leave from working in the South African mines. Information was not obtained for 6% (7/122) of the workers.

Characteristics of Study Population

Women

The homestead census identified a total of 185 women as the main respondents for the study. One hundred and eighty three (183) were mothers and/or guardians of children under the age of six, and, 2 were pregnant women with no children.

Sixty two percent (62%) of the women resided in the Hluti area and 38% in Matsanjani. Slightly over 90% (167/185) of the women were biological mothers of the children in their care, 8% (15/185) were grandmothers and 2% (3/185) were said to be the children's aunts.

Age Distribution

Sixty seven percent, 67% (125/185), of the women were under the age of 35, 62% (78/125) of whom were in the peak fertility ages of 20 - 29 years.

⁵ Responses included, he/she sent money sometimes, only when he/she felt like sending money, and, whenever he sees anyone passing through here.

Table 2 HLUTI: % Distribution of Women by Age Group.(N=115)

Age Group	No. of Women	%
15 - 19	18	16
20 - 24	27	23
25 - 29	25	22
30 - 34	13	11
35 - 39	10	9
40 - 44	6	5
45 - 49	5	4
50 +	6	5
NA	5	4

Table 3 MATSANJENI: % Distribution of Women by Age Group (N=70).

Age Group	No. of Women	%
15 - 19	7	10
20 - 24	12	17
25 - 29	14	20
30 - 34	9	13
35 - 39	10	14
40 - 44	3	4
45 - 49	2	3
50 +	4	6
NA	9	13

Marital Status

Approximately 46% of the women were married and 41% were single. Nearly 5% were widows, 1% divorcees and about 5% had yet to complete the marriage formalities. Non-responses amounted to 2% of the total.

Education

Twenty seven percent (50/185) of the respondents were illiterate. Of this group, 8 said they had attended adult literacy classes run by Sebenta, the organisation running the adult literacy

programme. Forty three percent (43%) had received between 1 - 5 years of schooling, and 18% between 6 - 10 years. Less than 5% had received training after their secondary school education. All of the latter were teachers at the local primary and secondary schools.

There is a tendency for women to discontinue schooling while still at the primary level. Two factors appeared to contribute to this. The first was poverty. Many families could not afford to pay the school fees and the school building fund 'contributions', especially if they had more than one child of school age. The second factor was school-girl pregnancies. These not only interrupted the girls' education, but in the majority of cases completely destroyed their chances of continuing in school. The girls would now have new responsibilities that would inevitably draw on the already meagre homestead resources. Of our sample of 185 women, 41% (76/185) were single mothers, 20% of whom were illiterate and 43% with between 1-5 years of schooling. Furthermore, 34% were found to be either daughters, nieces, grand-daughters or sisters of the homestead head, under the age of 30.

The proportion of illiterate women in Matsanjani was higher than in Hluti, 36% as compared to 22%. Matsanjani also had a lower proportion of women with 8 - 10 years of schooling (4% compared to 13%). These differences can be partly attributed to the sampling procedure for each area rather than to differences in 'level of development'. All the homesteads in Matsanjani were

contained in one Enumeration Area (EA), whereas the ones in Hluti were spread over more EAs.

Women's Fertility Profile.

Thirty percent of the mothers and guardians had 2 - 3 living children. Twenty six percent (26%) had only one child, 19% had 4 - 5, 13% had 6 - 7 children and 11% had 8 or more.

Total Number Of Pregnancies

Thirty seven percent (68/185) of the women reported having more pregnancies than number of living children.

Miscarriages And Child Deaths

Fourteen percent (14%) of the women had experienced at least one miscarriage and the range was 1 - 4. Thirty percent (30%) had lost one child aged 0 - 5 years. Although the approximate age at death was recorded for only 44⁶ of the reported 66 child deaths, the majority (70%) had occurred before the age of one year, and 30% between the ages 1 - 3 years. The above figures are indicative of the poor health conditions prevalent in the rural areas, and the inadequacy of existing maternal and child health services.

Pregnancies During Study Period

Although only 2 pregnant women were identified when the study

⁶ This was due to the assistant in one area forgetting to either record or ask every woman the question on age.

began, 32 (17%) subsequently reported their pregnancies as the study progressed. This group of pregnant women provided an opportunity to observe women's use and/or non-use of formal antenatal services.

Children

Age and Sex Distribution.

When the study began, the target child population in the study homesteads was 288 children. An additional 27 children were born before the study was finalised thus increasing the potential sample of children to 315. The following table shows the age and sex distribution of the children at the beginning of the study.

Table 4 Distribution Of Children By Age (Months) and Sex. (Number & %)(N=285)

Sex	Age Group					TOTAL	--
	0 - <6	6 - <12	12 - 24	>24 - <37	37 - <72		
M	10 (3.5%)	15 (5.3%)	27 (9.5%)	41 (14.4%)	36 (12.6%)	129 (45.3)	
F	17 (6.0%)	13 (4.6%)	29 (10.2%)	51 (17.9%)	46 (16.0%)	156 (54.7%)	
TOT.	27 (9.5%)	28 (9.9%)	56 (19.7%)	92 (32.3%)	82 (28.6%)	285 (100.0)	

* 3 children did not have their sex and age recorded.

Most of the children were in the age groups 24 - <37 months (32.3%) and 37 - <72 months (28.6%). The target group for immunisation, or the 0 - <12 months made up 19% of the total. There was approximately 20% between the ages of 2 - 3, perhaps reflecting the mortality experiences of this group. Children become vulnerable to disease at this age because mothers have usually weaned them from the breast, and the weaning foods may be

inadequate. Malnutrition may follow and in turn exacerbate the childhood diarrhoea resulting from a combination of adverse economic and environmental circumstances common to most rural homesteads. Over a quarter (1/4) of the women reported having lost a child in the 2 - 5 year age group.

There were more female children than male, the former comprising just under 55% of the total. With the exception of the age group 6 - <12 months, female children predominated in all age groups. Fifteen percent, 15% (44/288), of the children were being looked after by a pregnant woman. All but one of these children were a year old.

Infant and Child Mortality.

Three (3) children, all were born at home, died during the study period. Two of them within 2 weeks of birth and one child at age 4 months. No other deaths were reported during that time.

Vaccination Status.

Using the child's health card to determine vaccination status, it was found that 62% (178/288) of the children were fully immunised. This proportion goes up to 68% if only those with health cards are included. Fourteen percent, 14% (39/288), had yet to receive their measles vaccine, and 4% (12/288) had not received their DPT3, polio and measles vaccines. Nearly 6% (16/288) had never been vaccinated and a little over 9% (27/288) did not have their health cards. Some of the children with incomplete vaccination records were said to have spent some time

with 'other' relatives (e.g grandmother) who had ignored or been too lazy to take the child for vaccination.

Table 5 Distribution of Children by Area and Vaccination(s) Received. Number & %. N=261 (Only children with Health Cards included)

Area	Vaccination(s) Received						TOT.
	All	BCG,DPT 1,2,3,Polio	BCG,DPT 1,2,Polio	BCG,DPT 1,Polio	BCG	NONE	
HLUTI	102 (64.0%)	27 (17.0%)	10 (6.0%)	6 (4.0%)	8 (5.0%)	6 (4.0%)	159 (100.0%)
MATS*	76 (74.5%)	12 (11.8%)	2 (2.0%)	2 (2.0%)	-	10 (9.8%)	102 (100.0%)

* Matsanjeni

The percentage of fully immunised children is unexpectedly high. A possible explanation may be that no (strong) 'cultural/traditional' barriers to immunisation exist for both children and pregnant women. The evidence from TBA interviews suggests that bogogo, who may be regarded as the 'keepers' of tradition, are aware of and appreciate the fact that modern health care services are able to protect children from diseases. In conjunction with modern health care (in the form of immunisation), traditional methods of protection (kugata, incising and applying medicines) are also used.

Children who were immunised by the age of 12 months constituted 64% of the children aged 6 - 12 months (52/81). When children aged 12 months are excluded, the percentage of children fully

immunised before their first birthday goes down to 43% (12/28)⁷. This figure is similar to the ones obtained from clinic data for the first six months⁸ of 1983 (41%), 1984 (43%), and 1985 (42%) (MoH 1985).

However, the percentage of children fully immunised before age one year in this study is higher than that obtained in the 1984 national immunisation survey which found only 24% of the children fully immunised. The survey also found Shiselweni Region to have the second highest number of fully immunised children (31%) after Rhohho (33.3%). Lubombo came third (18.6%) and Manzini last (14.5%) (MoH 1984).

Women's Knowledge Of Health Services

Maternal and Child Health Services including Family Planning are one of the 8 essential elements of the PHC approach. The major thrust of the PHC approach is the prevention of diseases and to this end, MCH services put great emphasis on immunisations of both pregnant women and children, as well as the monitoring of their weights. As part of the preventive services for women, family planning services are also offered.

In order to measure the participation of women in MCH/FP as consumers of services, this sub-study sought to first establish whether or not women were aware of services available for mothers

⁷ There were 28 children aged 6 - < 12 months when the study began.

⁸ This figure is based on projected births for the year.

and children, and then to test their understanding of what two specific services are for; vaccinations for children and pregnant women, and weighing or growth monitoring for children.

Of the 180 women responding to the question "Do you know about MCH services?", 96% (173) said they knew about the services and 4% (7) said they did not. The latter group included one woman who had never used health services because her husband did not believe in Western medicine and prevented her from seeking help from the modern health sector. The other women said they were aware of curative services but not services specifically for women and children.

When asked to name the services given at the clinic (which they named) the following responses were obtained;

Table 6 Distribution of Women Mentioning Specific MCH Service(s) (Number & %).

MCH Service	% Women	No. of Women
Children's Vacc.	95.0	171
Weighing/Children	94.4	170
Women/Weighing	93.3	168
Tetanus Toxoid	90.6	163
Delivery Services	37.2	62
Ante-natal	29.4	53
Nutritional Advice	25.0	45
Health Education	12.2	22
Family Planning	7.2	13
Children/curative servs.	4.4	8
Post Natal Services	1.1	2
Women/curative servs.	1.1	2

There is a high level of awareness of preventive services for both pregnant women and children, with over 90% of the women mentioning Tetanus Toxoid, weight monitoring for both women and children, and immunisations for children. However, less than 30% of the women mentioned ante-natal care and 37.2% mentioned delivery services. Post-natal services were mentioned by just 2 women as were curative services for pregnant women. Health education and nutritional advice were mentioned by 12.2% and 25.0% of the women respectively. Only 7.2% of the women mentioned FP although awareness of FP methods is high (see section on FP).

How Women First Heard About MCH Services.

Sixty two percent (62%) of the women learned about MCH services from their relatives. Mothers especially were the main source of information followed by sisters. More often than not, a mother would suspect that her 'un-well' daughter was pregnant and send her to the clinic 'to see what was wrong'.

Less than 9% of the women had heard about MCH services from nurses, usually when they went to the clinic for curative services, and less than 2% heard about it through the radio. Given the proximity of the study areas to the Republic of South Africa, most homesteads are more likely to tune into a Zulu (South African) radio station because the reception is better. Other reasons may be that the majority of homesteads do not have radios, or that women in homesteads owning a set may not have access to it. Another problem may be that the programmes about health, and especially those broadcast for a female audience may

not be scheduled to fit into women's leisure time. The cost of buying batteries may also possibly deter women from listening to the radio regularly.

Services for Children

Over 90% of the women were familiar with children's preventive services of vaccination and growth monitoring. Only 4% mentioned treatment of childhood illnesses as part of the services for children. A possible reason for this is the way clinic services are scheduled. At 2 of the 3 government clinics visited during the study, all curative services were provided in the afternoons. However, if a patient arrived for treatment in the morning while preventive services were in progress, she/he would be attended first. The provision of services at separate clinics gave the impression that curative services were not an integral part of the MCH package of services being offered.

Services for Women

Forty eight percent (48%) of 173 women could name at least 3 services, and the combination most frequently mentioned was ante-natal check-up, weighing and vaccination. Twenty percent (20%) of the women mentioned 2 services and 18% named 4. Only two women, both teachers, were able to name 6 and 8 services respectively.

Knowledge of What Specific Services are For Vaccinations for Children

Of the 171 women who mentioned child vaccinations, 94% (160) said they knew what they were for. Nearly 90% said protection of the child against diseases and 30% of these mentioned specific diseases such as polio, whooping cough and tuberculosis. Six percent (6%) did not know what vaccinations were for, and this group included women who gave incorrect responses such as, prevention of cholera, malaria and fever.

Vaccinations for Pregnant Women

Although over 90% of the (180) women knew of vaccinations for pregnant women, 85% of these either said they did not know what these vaccinations are for, or were found to be misinformed about the purpose of the injections. Some of the incorrect responses included beliefs such as protection against diseases like polio and tuberculosis, prevention of leg cramps and bleeding, and to help the child (foetus) grow properly.

Number of Vaccinations Required for (Maximum) Protection.

Forty seven percent of (47%) of the 171 women who mentioned children's vaccinations gave the correct number required for maximum protection against infectious diseases (5). If those who said 6 or more, or 'many' are included, then the percentage of correct responses increases to 57%.

It would appear that women are knowledgeable about the number of vaccines their children need and that this knowledge is translated into action as illustrated by the fact that of the 288 children seen when this study began, 62% had already completed

their vaccination schedule.

Although only 15% of those who mentioned women's vaccinations knew what they were for, 44% knew that 2 vaccinations were required. However, 32% mentioned only one vaccination, possibly as a result of having used the ante-natal clinic only once for preventive services during pregnancy.

Weighing or Growth Monitoring

To find out if mothers knew the function and utility of the growth chart, the following question on the growth chart was put to women who had their children's health card at home:

"Do you know what this (growth chart) is for? If (response is) YES, can you tell me what it is for?".

The response rate for Hluti was 54% (62/115)⁹ and 94% (66/70) for Matsanjani. All the Matsanjani women questioned said they did not know what the chart was for, and none remembered ever hearing the clinic nurses talking about it. In Hluti, 27% of the respondents (17/62) said they knew what it was for whilst 73% (45/62) did not know. The 'correct' explanations for the chart were as follows:

⁹ This was one of the problems encountered in trying to cover homesteads spread over a large area. The chances of not finding respondents at home in, especially in the cross-sectional studies, was relatively greater in Hluti than in Matsanjani.

<u>Function of Chart</u>	<u>No.</u>	<u>of</u>
<u>Women</u>		
To check if child is growing well	9	
To check if child is getting nutritious food/fed properly	4	
Shows when child is sick, "graph goes down"	1	
To check if child is in good health	1	
To check if child is gaining or losing weight	2	

When the samples from both areas are combined, a total of 111 of the 128 (87%) women did not know what the growth chart was for. In the Hluti area, it was found that 26 of the children had never had their weights entered on the chart although their mothers attended a mobile clinic, as well as took the children to a health facility when they fell sick. On enquiring from health staff why this was so, we were told that the mobile clinic was (sometimes) unable to take weighing scales along to the remote communities. As will be discussed later, factors associated with the health care delivery system are largely responsible for the inadequate coverage of some of the MCH services.

Women's Knowledge Of Traditional Birth Attendants (TBAs), Rural Health Motivators (RHMs) And Traditional Healers (TINYANGA)

Traditional Birth Attendants (TBAs)

One hundred and seventy seven (177) women, or 96% of the sample, responded to the questions "...are there any (TBAs) in this area?" and "Who usually helps women deliver if they have their baby at home?".

Fifty eight percent (58%) of the women said they did not know of

any TBA in the area nor did they know of a person who assisted women who delivered their babies at home. Forty percent (40%) knew of a TBA and responses for 2% were not recorded.

Rural Health Motivators (RHMs) Baqcugcuteli

An RHM is responsible for 40 homesteads in his/her community and, as front-line health workers, RHMs are expected to undertake, among others, the following tasks:-

- Assist in maternal and child health
- Identify and help solve community health problems
- Promote community participation in community development activities
- Teach, motivate, assist and organise the community to promote environmental sanitation
- Identify, teach, prefer and refer communicable diseases
- Promote adult literacy (Conolly & Dunn 1986).

Specific tasks in maternal and child health involve motivating and referring women for family planning services, and assisting in emergency home deliveries.

To test whether or not women in the study areas had knowledge of RHMs, the following questions were posed: "Have you heard of Rural Health Motivators? (If YES) Do you have one in your area?" and "Has he/she ever visited you?".

Nearly all the women in the Hluti sample (97%) had never heard of RHMs, and 69% in Matsanjeni. Those who had heard of RHMs (30%) lived within the catchment area of a clinic which had recently

trained a group of RHMs. However, none of these women had ever been visited by a RHM. This raises at least two issues concerning RHMs. The first issue concerns the process of identifying and selecting these workers, and the extent to which women are involved in this process. The second issue, related to the first, concerns the accountability of RHMs. If much of their work is MCH related, then theoretically RHMs should be accountable to women. What the above results suggest however, is that women may not be adequately involved in the selection of RHMs. The lack of 'community participation' in the RHM programme is said to be one of its main problems (World Bank 1985).

Traditional Healers (Tinyanga)

The response rate to the question, "Do you know any traditional healers in the area?", was 92% (171/185). Fifty six percent of the Matsanjani sample (39/70) said they knew of a traditional healer in their area, 41% did not, and approximately 3% gave no response.

In Hluti, 53% of the women knew a traditional healer in their area, 37% did not, and 10% gave no reply.

It appears then that a majority of the women knew an inyanga in their area. This suggests that tinyanga are relatively more accessible than modern health personnel because they live within the community, and are more numerous.

Women's Awareness of the Concepts of PHC, Health for All By the Year 2000 (HFA/2000) and Community Participation

PHC and Health For All By The Year 2000 - Have You Heard the Slogan?

Women in 30 selected homesteads, 15 in each area, were asked whether or not they had ever heard the slogan 'Health for All by the Year 2000'.

Fifty three percent (53%) of the Hluti women had heard the slogan through the radio, clinic, other women in their area, and read about it in the news papers. However, they were not sure about what it meant, and they expressed some reservation as to the possibility of achieving the state of health for all by the year 2000 mainly because of their environmental conditions. They had no pit latrines and lacked clean water. Apparently some people, who were understood to be from the Ministry of Health (MoH) (probably the local Health Inspector), had been around asking people to dig holes for pit latrines, promising them building materials. However, these MoH people had not been back since. The open pits were becoming hazardous and cattle were reported to have fallen inside and been unable to climb out again. An entry in the field assistants diary reads;

"....they say they don't think there will be health for all by the year 2000 if the people responsible (for helping them) don't care about them."

In Matsanjani, 87% of the women reported to have never heard the slogan. Three women said they had heard the year 2000 mentioned in connection with the coming of Jesus in that year, heralding the end of the world.

Community Participation

'Community participation' is another of the commonly used rallying cries for activities and/or services deemed necessary for the attainment of HFA/2000 . What then did women in these two areas understand by 'community participation in health'?

Without exception, all the 53 women with whom in-depth interviews were conducted stated that they had never heard of community participation in health, nor had they been involved in it. Their comments, and those of the field assistants, on the issue provide an insight into some of the factors constraining poor rural women from concerning themselves with communal health activities:

Jabu - "About community participation in health, in this area no one talks about health. You only think for yourself and your children. Hygiene is very far behind and as you can see, my homestead is full of papers and I'm coming from my fields and I'm very tired, I don't think I will sweep".

Thokozile - "...never heard of it (community participation in health). Our health is poor because we have to work very hard in the fields to get food. We don't have time to look after our health".

One of the field assistants, commenting in her diary after the interviews said:

"...they don't know about (community participation in health). No one participates...because the women in the community are not all friendly. They don't all listen to (other) women about health and some don't have the time for going to other women because they have many children, water is scarce and at the same time, they have to cook. They have so much work in a day so health is far behind".

The assistant's comment, apart from emphasizing the demand's on women's time also highlights an issue which has implications for

involving women, as a group, in community activities. The issue here is that of intra-gender conflicts. Although it has now been acknowledged that treating communities as homogenous entities, in terms of class and gender composition and interests, has been a contributory factor in some of the failed community participation programmes, the potential contribution of intra-gender conflicts to these failures has hardly, if at all, been examined.

Knowledge of and Involvement with Women's Groups/Organisations

Womens Groups

Women's participation in community affairs can be effected through activities which involve both men and women or, through groups which are exclusively female. It has been suggested that women's groups be utilised as entry points to health work based on the PHC approach (WHO 1985) because they have the following unique characteristics;

- they are traditionally supportive, motivated and interested in health care (linked with socially prescribed roles of women as health care providers);

- they are able to understand and carry out intersectoral activities basic to primary health care;

- they have a positive attitude towards voluntary work;

- their work in primary health care is seen as positive action, acceptable to the family and the community;

- they are based on, or form part of, long-standing networks, with family, cultural and intergenerational ties which are conducive to health promotion and disease prevention." (WHO 1987).

Knowledge of Women's Groups

The response rate to the question ; "Do you know any women's organisation in this area?" (Form IIa Part B, No.10) was 96% (178/185). Forty seven percent (47%) knew of a women's group and 53% did not.

Is Member of Women's Group

Those women who said they knew of a women's group were further asked if they belonged to it or any other women's group/organisation. Twenty three percent (23%) of the women who knew of a women's group belonged to it, 77% did not.

More women in the Matsanjani area (19/43) than in Hluti (2/41) were members of a women's group.

Groups said to exist in Hluti were, the Red Cross, a Market Group which was apparently formed on a cooperative basis, to encourage women to earn cash by selling vegetables. Chicken keeping (Tinkhuku), a Burial Society (Masingcwabisane) and a Revolving Fund (Umjikelezo).

The women involved with the market group were facing a water shortage because of draught. The vegetables had to be bought from Mhlosheni, then resold at the Market in the study area. This entailed expenditure on transportation (and of course time to travel there and back), something most of the women could not afford.

Matsanjani appeared to have more women who were members of a group. Three mentioned; Zenzele (self help group organised by

extension workers from the Ministry of Agriculture and Cooperatives), a handicraft and sewing group, and Lutshango. Over half of the women who belonged to a group were members of Zenzele and were involved in gardening vegetables. When the crops were harvested, some were consumed and some sold to homesteads whose female members did not belong to the group (Zenzele).

WOMEN AND HEALTH DECISION-MAKING

Who decided to have the children vaccinated?

Not surprisingly, the decision to vaccinate the children had been made by mothers in 89% of the cases. The involvement of the fathers in decisions to vaccinate children was very minimal as only 3 children were reported to have been vaccinated because their father wanted them vaccinated, and only one child whose parents made a joint decision to vaccinate the child. Grandmothers were the decision makers for 4% of children.

During informal discussions, a number of women were asked why they alone had decided to vaccinate the children. A number of them made the point that the fathers of the children did not concern themselves much with health matters and left all responsibility to the women.

Who Decides On Health Care Option When Women and Children are Sick?

It is widely believed that most, if not all, decision-making in Swazi families is the responsibility of the Ummuzane or Homestead Head. Since the majority of households are headed by men, the latter are regarded as barriers to women's action-taking.

However, as the examination of who decided to have the children vaccinated reveals, women made most of the decisions.

Women's Illnesses, What Action was Taken and Why.

There were 91 illness episodes reported by 66 women over a six month period, giving an average of 1.4 episodes per woman. Pregnant and lactating women¹⁰ reported 33% of these episodes. Thirty eight (38) of the women resided in Hluti, and 28 in Matsanjeni. More than half the women (46/66) reported only one illness episode, 15 reported 2, and 5 women reported 3 episodes. Most of the women (60/66), reported only one symptom per illness episode.

Table 7 Distribution of Illness Episodes by Type of Illness
(Number & %)

<u>Illness/Complaint</u>	<u>No. of Episodes</u>	<u>%</u>
Stomachache	14	15.0
Cough	12	13.0
Headache	8	9.0
Diarrhoea/Vomiting	5	6.0
Toothache	4	4.0
Sore throat	4	4.0
Sore breasts	4	4.0
Bleeding	3	3.0
Other	25	28.0
NA	12	13.0
TOTAL	91	99.0

¹⁰ During the study, a total of 34 women were known to be pregnant. Women with children 0 - 24 months were breastfeeding although most of the younger infants, ages 0 - 4 months, were on breast milk only.

Illnesses During Pregnancy

Twenty one (21/91) or 23% of the episodes were reported by pregnant women. The commonest complaint for these women was 'stomachache'. Half of all the complaints in this category belonged to pregnant women. Other problems associated with pregnancy included toothache (3/21), ante-partum bleeding (3/21) and headache (2/21).

Action Taken

The first choice for health care when women fell sick was the clinic or hospital (62.6%), followed by self medication using either (patent) medicines bought from a shop (9.9%), or traditional medicines (6.6%). The traditional healer was consulted for only 5 (5.5%) of the episodes. Two lactating women went to the traditional healer, one for 'high blood pressure', the other for headaches, generalised body weakness and unexplained fear (probably anxiety attacks). No action was taken in 11% of the cases.

Of the 21 illnesses reported by pregnant women, 67% (14/21) were taken to the clinic, home remedies using traditional medicines were used for three (14%) of the episodes and no action was taken in 4 (19%) cases.

Out of the 91 illness episodes, a second action was sought in only 2 cases. One woman reported going back to the clinic after getting no relief from the medication prescribed. Another sought the help of a traditional healer because the symptoms she was experiencing were judged to be indicative of 'illnesses' the

healer could deal with more successfully than modern health care providers.

Women's Health Care Options - Who Decides?

The decision to seek help was taken by women in 77% (70/91) of the illness episodes and by husbands in 8% (7/91) of them. In only 3 episodes was the decision to seek help taken by 'other' relatives such as the woman's mother.

Of the 10 illness episodes in which the decision for a particular health care option was made by someone other than the woman, only 3 of the decisions were said to have been influenced by the woman. The 'process' by which this influence was exerted involved either informing their husbands that they were ill and needed money to go to the clinic, or the decision as to what should be done was simply left to the husband.

Why was Particular Action Taken?

Responses to the question why a particular course of action was taken were obtained for 64 of the 91 illness episodes. Forty percent (40%) of the illnesses were perceived to be serious. If a symptom persisted, although not perceived as serious, the women would begin to worry and seek help (10% of the episodes that included persistent coughs or stomachaches).

Why no Action was Taken

The reasons given for taking no action varied from lack of money to go to the clinic and illness not being serious, to illness

getting better before anything could be done.

Use of Preventive Health Services by Pregnant Women.

Only 13 or 38% of the 34 pregnant women in the study used ante-natal services during the 7 months study period. For 5 of these women, it was their first pregnancy. A total of 15 visits were made, 14 for physical check-ups including blood pressure reading, and 1 for weighing only. Only 2 of the women had made 2 visits. None of these women mentioned receiving the anti-tetanus injection.

Eight women (62%) said they had used ante-natal services in their last pregnancy, and when asked why they had used the clinic the last time, 7 stated that they had gone to check if the baby was alright and 1 said she had gone to be weighed.

Education Level of Ante-Natal Clinic Users

More than half (7/13) of the women had between 1-5 years of school, 3 had completed 8 years, 1 was illiterate and another did not have her education recorded.

None of the 8 women (who had a previous pregnancy) had ever miscarried or experienced a child death.

Children's Illnesses, Action Taken and Why.

A total of 262 illness episodes were recorded for 177 children. Sixty three percent (63%) reported only one illness episode, 28% reported 2, 6% had 3 and 3% had 4 episodes.

The most commonly reported ailments were, coughs (26%), diarrhoea

(20%), skin rash (11%), and gastroenteritis (8%). The distribution of episodes by type of illness complaint are given in Table 8.

Table 8 Distribution of Children's Illness Episodes by Type of Illness. (Number & %)

<u>Illness/Complaint</u>	<u>No. of Episodes</u>	<u>%</u>
Cough	68	26.0
Diarrhoea	52	20.0
Body rash & Sores	37	14.0
Diarrhoea & Vomiting	22	8.0
Vomiting	14	5.0
Sore throat	10	4.0
Other*	50	19.0
NA	9	3.0

TOTAL	262	99.0

*includes chest pains, fever, toothache, eye and ear problems, headache and stomachache.

Action Taken

For 68% of the illness episodes, the clinic and/or hospital was the first choice of care. No action was taken for 15% (40/262), and self care in the form of patent medicines from the shops or traditional medicines was resorted to in 11% (30/262) of the cases. The remaining 6% used 'other' sources of care such as the traditional healer, as in the case of two children who were said to be possessed by evil spirits (they were said to cry at night, believed to be the result of evil spirits at work) and one child who had 'something on the throat'. The child was taken to a traditional healer, inyanga, who proceeded to prod the child's tonsils with some wooden instrument and apply medicine. The child, who was a year and a half old, was seriously sick for

nearly two months after the inyanqa's treatment. The mother of early this child had told the researchers at the beginning of the study that she did not believe in (the efficacy of) Western medicine.

The home remedies that were used included, warm water emetic and enemas for coughs; for diarrhoea, imbita taken orally or as enema (but usually a warm water solution is used instead of imbita), and home made sugar and salt solution for oral rehydration.

Dissatisfaction with the first source of health care leading to either a repeat visit or an alternative choice was reported for approximately 4% (10/263) of the episodes. Most of the cases (7/10) were taken to a clinic (either the one used when the child first became sick, or another clinic). In one instance the mother purchased some medicine from the local shop (the child was febrile), and 2 of the children were taken to traditional healers, tinyanqa, after clinic medicine failed to 'cure' them (these were the children mentioned above, who cried at night).

Why was Particular Action Taken?

Mothers and guardians who chose to go to the clinic and/or hospital reported that the reason why they selected these options first was because the illness was serious. This was the reason given in 52% of the cases taken to a clinic/hospital. The discomfort of the child without indication of the illness being serious coupled with the mother's/guardian's worry resulted in 21% of the episodes being taken to a modern health facility. This

discomfort was described in terms of the 'child not eating well', 'child was coughing until she/he wretched', 'child's crying and/or coughing keeping them awake at night'. Eighteen percent (18%) of the cases were taken to the clinic/hospital to alleviate the condition or get treatment. The infectious or potentially infectious nature of the illness resulted in 5% of the cases being taken to a modern health facility. The women were worried that other children might catch the disease, such as a cough or skin condition.

In the 2 episodes that were taken to the inyanga after clinic medicines failed, it was felt that modern medicine could not cure an illness thought to have been caused by supernatural forces, in this instance, evil spirits.

Why no Action was Taken (40/262 episodes)

For 28% of the episodes (11/40), women said they had no money to take the child to the clinic, whereas 23% (9/40) of the illnesses were judged to be not serious to warrant action. The remaining episodes, 15% (9/40) were said to have got better before anything could be done, or were still under observation, 13% (5/40). Still others were considered normal symptoms or conditions/complaints such as body rash due to the heat or diarrhoea when an infant is teething. The other reasons for taking no action were, lack of transportation when the child was ill (and decision had been made to take her/him to the clinic), weekend closure of clinic (and therefore no possibility of getting attention) and mother

not knowing why the child is unhappy/unwell¹¹.

Health Care Options for Children - Who Decides?

When health care was sought during an illness, the prime decision-maker in 64% of the episodes was the mother. Grandmothers made the decisions in 10% of the episodes, and fathers and grandfathers decided what should be done in 5% and 3% of the cases respectively.

When home remedies were used, the mother and grandmothers decided for 93% (28/30) of the cases. For 2 illnesses where medications were purchased from the local shop, grandfathers 'made the decision'. The women reported that they had no money and went to the child's grandfather to request help. Although these women responded in the affirmative when asked if they had influenced the grandfather's decision, it can be said that where money is required to pay for health care and women have no access to or control over it, their influence is minimal.

Children - Use of Preventive Services

A total of 58 clinic visits for preventive services were recorded for 50 children (26 male and 24 female), 42 of whom made 1 visit and 8 who made 2 visits. Seventy one percent, 71% (41/58) of the visits were for immunisation, 26% (15/58) for weighing (growth monitoring) and only 3% (2/58) for both weighing and immunisa-

¹¹ It was observed that the child was lethargic, and the cliniccal signs of malnutrition i.e. reddish fine hair, distended stomache, and was lethargic. Thus the mother's observation that the child was 'unhappy'. The child was also said to have a poor appetite.

tion.

WOMEN'S DECISION-MAKING CONCERNING FERTILITY ISSUES

Contraceptive Knowledge and Practice

The response rate for this substudy was 88% (162/185). Table 10 shows the distribution of women by knowledge of type (here defined as modern or traditional) of method, and current use by type.

Table 10 Distribution of Women by Knowledge of Contraceptive Method Type and Current Use by Type (Number & %).

<u>Knowledge by Type</u>	<u>Current Use by Type</u>				<u>TOT.</u>
	<u>None</u>	<u>Modern</u>	<u>Traditional</u>	<u>NA</u>	
Knows None	5 3.1%	- -	- -	- -	5 3.1%
Only Trad.	1 0.6%	- -	- -	- -	1 0.6%
Only Modern	109 67.3%	37 22.8%	- -	- -	146 90.1%
Knows Both	9 5.6%	- -	1* 0.6%	- -	10 6.2%
TOTAL	124 76.6%	37 22.8%	1 0.6%	- -	162 100.0%

*When asked to explain what the method was, the woman said she could 'feel' when the time was not right and therefore refrained from sexual intercourse with her husband.

Most of the women (97%), knew of a contraceptive method. The vast majority (90%) had knowledge of only modern contraceptives. Approximately 23% of the women with knowledge of modern contraceptives were currently using a method. This would appear to be a high user prevalence rate when compared to the national

Family Health Survey of 13% for rural Swaziland (MoH 1989)

All except one of the women using modern methods of contraception were on the 'pill'. That one woman was on Depo Provera.

Knowledge of Contraceptive Methods

There was no significant difference between the two areas (Matsanjeni 98%, Hluti 95%) whereas contraceptive use was higher in Hluti than in Matsanjeni. Table 11 shows the use of contraception by type and area.

Table 10 Distribution of Women by Area & Type of Method Used

<u>Area</u>	<u>Type of Method Used</u>				<u>NA</u>	<u>TOTAL</u>
	<u>None</u>	<u>Modern</u>	<u>Traditional</u>	<u>Both</u>		
Matsanjeni	49	8	0	0	-	57
	86%	14%	-	-	-	100%
Hluti	74	29	1	0	1	105
	70%	28%	1%	-	1%	100%

Number of Living Children and Use of Contraceptives

Thirty percent (30%) of the 162 women had 2-3 children and 27% had only one child. The following table give the distribution of women by number of living children and type of method used.

Table 11 Distribution of Women by Number of Living Children and Type of Contraceptive Method Used (By Number & %)

<u>Method</u>	<u>No. of Living Children</u>						<u>NA</u>	<u>TOTAL</u>
	<u>0</u>	<u>1</u>	<u>2 - 3</u>	<u>4 - 5</u>	<u>6 - 7</u>	<u>8+</u>		
Modern	0 -	11 6.8%	12 7.4%	10 6.2%	4 2.3%	0 -	- -	37 22.8%
Trad.	0 -	0 -	0 -	0 -	0 -	1* 0.6%	- -	1 0.6%
None	2** 1.2%	33 20.4%	37 22.8%	24 14.8%	14 8.6%	14*** 8.6%	- -	124 76.6%
TOT.	2 1.2%	44 27.2%	49 30.2%	34 21.0%	18 11.1%	15 9.3%	- -	162 100.0%

* With 10 children

** Pregnant for the first time

*** 7 had 8 children, 6 had 9 children, 1 had 12 children

Decision to Use Contraceptives

Women who said they were currently using a contraceptive method were asked who decided that they should contracept. Table 13 gives the distribution of women by decision-maker for use of contraceptive.

Table 12 Distribution of Women by Decision-Maker for Contraceptive Use (By Number & %)

<u>Decision-Maker</u>	<u>No. of Women</u>	<u>%</u>
Woman/Husband	14	37.0
Woman Alone	7	18.0
Woman/Boyfriend	8	21.0
Mother	7	18.0
Woman/Mother	1	3.0
Sister	1	3.0
TOTAL	37	100.0

Conjugal/Couple Communication

The question whether women have ever discussed with their partners the number of children they should have was put to 162 women. Of the 78 married women in the group, 53% (41/78) had never discussed with their spouses how many children to have, and 47% (37/78) had. Three of the (37) women refused to use contraceptives despite their partner's positive attitudes. Two of these women said they wanted support in old age, which they felt would be guaranteed by having many children. The third woman had used contraceptives before and said she 'nearly died' from using them. The rest of the women (34/37) had been refused permission by their partners. One of the women whose husband had refused to give her permission to use contraceptives admitted to using them secretly.

Of the 37 women, 27 (73%) had also discussed the number (ideal) of children to have. Some of the husbands' reasons for refusing included the desire to have many children, and the husband's concern over his wife's health (the 'pill' would make her more ill).

Of the unmarried women currently using contraceptives, half said they had discussed the matter with their boyfriends.

Why Men Agree to Women's Use of Contraceptives

Some of the reasons given by women as to why their husbands or boyfriends agreed that they use contraceptives included the desire to space their children, to have fewer and healthier children, and to stop when the desired number has been achieved.

It appears that conjugal or couple decision-making is common. There is however, a strong indication that mothers are influential in getting their daughters to contracept, as 18% of the users were told/advised by their mothers to use a method. The mothers' central role in informing, or at least directing their daughters to MCH services was mentioned earlier. Mothers' interest in their daughters' fertility behaviour has to be interpreted within the context of the lives of the majority of rural women. Quite a high proportion of the women were single mothers still residing with their parents. When they have a child, the responsibility of looking after it falls on the homestead head.

Reasons For Not Using Contraceptive Method

Women who were not contracepting (124/162) were asked why they were not using contraceptives. Responses were obtained from 92% (114/124) of the women. The reasons given are shown in Table 13.

Table 13 Distribution of Women by Area and Reason for Not Using Contraceptives (By Number & %).

<u>Reasons</u>	<u>Area</u>		<u>TOTAL</u>
	<u>Hluti</u>	<u>Matsanjeni</u>	
Made me sick	10 8.8%	0	10 8.8%
Husband said no	10 8.8%	5 4.4%	15* 13.2%
Boyfriend said no	10 8.8%	0	10 8.8%
Breastfeeding	7 6.1%	0	7 6.1%
Don't want to	8 7.0%	10 8.8%	18 15.8%
Want more children	6 5.3%	10 8.8%	16 14.0%
Cannot conceive	5 4.4%	4 3.5%	9** 7.9%
Have not yet decided	2 1.8%	5 4.4%	7 6.1%
Afraid of using it	3 2.6%	6 5.3%	9*** 7.9%
Don't know	0	3 2.6%	3 2.6%
Other reasons	5 4.4%	5 4.4%	10**** 8.8%
TOTAL	66 57.9%	48 42.1%	114 100.0%

*One woman said she drinks bicarbonate of soda after sexual intercourse as a contraceptive.

**Due to age or secondary infertility

***Not used to it, pregnant, never thought of it, afraid to ask at clinic, want to but don't know what to do, didn't know contraceptives were free at clinic, it is a sin(2), I am sickly, not staying with 'husband'.

Ideal Number of Children

The ideal number of children desired is quite high for the majority of women. In Matsanjeni, 20% (9/44) of the women who responded to the question on ideal number of children wanted six or more children, 22% (10/44) wanted 'many', 13% (6/44) wanted 5, 7% (3/44) wanted 4 and another 7% (3/44) wanted only 3 children. One woman said the ones she had were enough (6 children), and another said she could not conceive (she had a grown up child and was now looking after her niece, aged 5 years). Twenty seven percent (27%, 12/44) did not know how many they wanted.

The response rate for the question on ideal number of children was 91% (96/105) for Hluti. Women who did not know how many children they would like to have made up 24% of the respondents. Twenty two percent (22%) wanted from 1 - 3 children, 39% wanted 4 - 6 and 11% wanted 7 or more children, and 4 felt the children they had were enough.

Preferred Sex Ratio of Ideal Number of Children

Women in Matsanjeni indicated a preference for male children when they wished to stop childbearing after having 3, 4, and 5 children. Only one of the six women who wanted only 5 children indicated a preference for more female than male children. As the ideal number got higher, i.e. 6 and above, half the women wanted more female children, the other half wanted more male children. In Hluti, women tended to prefer male over female children if the preferred number was 1 - 3 children. For example, of those who wanted 3 children, 54% preferred male and 46% female children.

When 2 was said to be the ideal number, then one of each was mentioned. For the whole sample, only 14% preferred more female children than males, 30% wanted equal ratios, and 29% wanted more male than female children.

The continued desire for 'many' children should be examined in the context of the high infant and child deaths experienced by many women in their reproductive years. However, there does appear to be a real need for contraception as reflected in the fact that 47% of the married women questioned about this issue said they had discussed it with their husbands.

Evidence from this sub-study does indicate that women have the least decision-making power or influence over an issue that directly affects their health. Those working to promote the acceptance of contraception will have to look carefully at all the issues involved such as, women's experiences of infant/child deaths and miscarriages, the extent to which couples discuss these matters, and men's attitudes towards contraception.

TBAs AND THEIR BELIEFS, ATTITUDES AND PRACTICES PERTAINING TO
MATERNAL AND CHILD HEALTH CARE: Their possible influence on the
utilisation of MCH services.

1. Introduction

In Swaziland it is estimated that although 70% or more of pregnant women visit a clinic at least once before giving birth, only 10% receive the complete course of tetanus toxoid injections. Maternity services do not fare much better either and less than 50% of the births are said to take place at clinics and hospitals. This section, based on interviews with 6 Traditional Birth Attendants, examines some of the traditional beliefs and practices that may be influencing the utilisation of formal maternal and child health services. Knowledge of what TBAs believe, what they do, how much they know relative to their work, how their practices may be influencing the health of mothers and children, and the problems they encounter, will no doubt assist in planning appropriate MCH services.

2. Pregnancy

2.1 Who is Informed When Pregnancy is Suspected

The first person to be told that a woman is or may be pregnant depends to a large extent on where she resides. For unmarried women living at their parents homesteads, the woman's mother is the first to know. Usually mothers become suspicious when their daughters complain of feeling ill, and because they are familiar with pregnancy symptoms, they will know the woman is pregnant.

before pregnancy is confirmed.

Knowing who is first told about a woman's pregnancy is important because that person may be influential in directing the woman to appropriate sources for pre-natal care. For example, the majority of women in the study stated that their mothers were the first people to inform them about the MCH services.

This fact opens up new possibilities in terms of identifying 'target' groups for health information and education, as well as devising strategies for the latter.

2.2 Taboos and Customs Observed

One of the traditional requirements, once pregnancy was confirmed, was for the woman to cease having sexual intercourse. It was /is believed that this allows the foetus to develop properly.

Pregnant women are also advised not to engage in activities that will bring harm to the unborn child or themselves. For example, attending funerals is prohibited because of its association with 'spirits' (the other world) and the state of 'pollution' (see especially Ngubane 1977, for an extensive discussion on the Zulu concept of pollution in death and birth). Climbing a tree when fetching firewood in the forest, or climbing a house to put thatch on the roof is believed to frighten the unborn child and leads to birth defects. Although it is difficult to see how these activities in themselves can lead to physical disability, the advice to desist from e.g climbing trees makes sound sense. Accidents may happen and the woman may injure herself and/or

miscarry.

MISCAR:

It is also believed that difficult deliveries may be caused by pregnant women peeping through doors. This belief can be seen as an attempt to explain complications of childbirth that TBAs are usually incapable of dealing with (see later sections).

2.3 Food for the Pregnant Woman

2.3.1 Food she can eat

According to the TBAs, pregnant women are allowed to eat just about any food available. Some of the foods said to be eaten by expectant mothers are in fact what is normally eaten by everyone. These foods include sinambatsi, a mixture of pumpkin and maize meal; tinhlubu (ground nuts), tinhlumaya (cow peas), emasi (curdled sour milk), emahhewu, a local drink prepared from maize. As well as the above foods, pregnant women eat wild fruits such as blackberries which grows in the low-veld during the summer months.

The generally unrestricted diet of pregnant women can be partly explained by the belief that whatever the mother eats protects the baby from disease (later section) and partly by the limited choice of food available for most families anyway. No special food is prepared for a pregnant woman unless she has a craving for certain foods (and provided it can be obtained).

2.3.2 Food she cannot eat

Certain parts of a slaughtered animal, for example the liver, must not be eaten as it is believed that these will adversely

affect the foetus (and the woman). They are also advised not to eat inembe (made from fermented maize) because it may start premature labour or lead to a spontaneous abortion.

There does seem to be disagreement, however, over which other foods should be prohibited for pregnant women. For example, one TBA said she knew of people who did not approve of women drinking emasi or eating eggs. As far as the milk was concerned, she could not understand why expectant mothers should not drink it, because as she put it,

"...even the elderly Swazis like to see her (the pregnant woman) drink milk..."

Another TBA said liquor is not allowed for pregnant women although it was recognised that when pregnant, a woman might develop a craving for alcohol.

2.4 Work During Pregnancy

Pregnancy does not exempt a woman from work unless she is feeling weak or sick, in which case she does light work around the homestead. Pregnant women are expected to go to the fields and plough (within limits), weed harvest, collect firewood, cut the grass for thatching roofs, fetch water and cook just like other women. It is recognised however, that unlike non-pregnant women, they may be less strong and will therefore require frequent rest breaks when working. Pregnant women should not over-exert themselves or undertake tasks that might be injurious to themselves and the unborn child (section 2.2). Jobs that require a lot of strength such as ploughing and planting should not be

attempted by a pregnant woman who is feeling unwell, or who is unfit. However, doing nothing at all is discouraged because inactivity is believed to lead to difficult labour and childbirth. Consistent work throughout pregnancy was said to keep the woman fit and also minimise labour pains.

3. Pre - Natal Care

The TBAs do not offer any form of continuous care for pregnant women unless they have some knowledge about traditional medicines and other forms of treatment for pregnant women. A woman who is feeling unwell is usually referred to a Traditional Healer (Inyanqa, pl. Tinyanqa). There are tinyanqa well versed in women's health problems. One of the TBAs we interviewed was also an inyanqa. She had in her possession a variety of roots, tree bark, herbs and other medicaments that she used in treating a whole array of complaints, including those associated with pregnancy.

3. A Few Problems in Pregnancy and How They are Managed

What causes the problem and How is it Cured

3.1. Swelling of Hands and Feet (Oedema)

Three factors believed to be responsible for this condition were mentioned by four of the six TBAs. These were, the weight of the baby, impure blood and swollen 'nerves' (blood vessels) leading to poor blood circulation.

Two of the TBAs said they did not know the cause, nor did they know of the medicine, muti, used to cure it. One TBA said;

"Sometimes she swells and when she delivers you find that the baby is still-born which means the baby was also sick".

The other TBA said that in her youth, it was rare for women to have this complaint. She said they only experienced it during childbirth if they knelt for too long.

The TBA-cum-traditional healer displayed some of the medicines she used for pregnancy related illnesses, such as swelling. The names were given in siSwati and these were umhlahlo, umuzi, umyawoyawo and lihala (no attempt was made to find out the botanical names). These were all in bark form and are boiled and the liquid is drunk by pregnant women. The umhlahlo is said to also relax the muscles and is given to women to make childbirth easier.

Certain tree leaves are also used to relieve the swelling caused by 'impure blood'. The leaves are boiled and the water, while still hot, is then used to wash the feet, legs and hands.

If the woman is immobilised because of the swelling, the inyanga is called to treat her at home. This clearly illustrates the advantage tinyanga have over modern health care workers. Not only are the former more accessible because they usually reside within the community, but they are also prepared to visit the homes of those who cannot come to them.

3.2 Vomiting

Vomiting is considered normal if it only happens after a woman has eaten food which disagrees with her, or food she does not

like. Excessive vomiting is said to indicate two things; that there is something wrong with the woman's digestive system, or she is possessed by evil spirits. The woman is referred to an inyanga.

3.3 Bleeding (Threatened Miscarriage)

Bleeding while pregnant is said to result if the baby descends before it is due to do so. Again, there are traditional healers who are well known for treating threatened abortions or miscarriages. One of the medicines used to arrest the bleeding is said to work by "lifting the baby (back) up (into the womb)" and is known as umkhweto.

3.4 Dizziness

Dizziness is attributed to a variety of reasons such as hunger, standing or sitting for too long, and twins. Home-made remedies may be given to alleviate the dizziness, or the inyanga is consulted.

3.5 If The Baby is Not Moving in The Womb

If the baby's movements are infrequent, it is believed he/she will be a lazy person. Nevertheless, the baby is expected to move about at least once or twice before dawn. Prolonged inactivity is alarming, and the inyanga is usually consulted. It is believed that the baby may be unwell, or that the woman is bewitched. If witchcraft is suspected, the woman is given muti (traditional medicine) in order to find out if what she has conceived is

'human' or an 'animal'. It was said that if the woman has conceived an animal, it will be aborted. The woman may also be given herbs or animal substances (inyamatane) to burn and inhale. The smoke is said to stir the baby and restore its movements.

4. Methods of Protection for The Mother and the Unborn Child

For the unborn child, the food the mother eats is believed to offer protection. All the TBAs said there were no traditional medicines to prevent diseases. This apparent absence of a 'traditional' concept of disease prevention may partly explain why so few women actually receive Tetanus Toxoid injections. However, a contributory factor may be ignorance of what the injections are for as illustrated by the results on the knowledge of available services.

5. TBAs' Knowledge About When the Baby is Due

Although TBAs cannot calculate the precise date of delivery, they recognise certain physical changes in the woman that indicate imminent delivery such as, for example, the 'look' on a woman's face, her body odour, and the 'dropping' of the stomach. These observations are only possible if the TBA is in close contact with the pregnant woman, for example if the woman belongs to the TBA homestead. Usually, however, TBAs who deliver women in the wider community are summoned when labour begins.

6. Child- Birth

6.1 Preparations for the Baby' Birth

Women are expected to start collecting and storing items such as clothes for the baby (in some other parts of Africa e.g. Tanzania, it is considered bad luck to collect baby clothes etc. before the baby is born), cooking utensils and firewood well before they are due to deliver. A rope may also be mounted inside the hut (on beams) for the woman to hold onto when giving birth.

6.2 Place of Delivery/Birthing Position(s)/Instruments/Equipment Used

Delivery usually takes place in the traditional kitchen or the grandmother's hut, unless some other hut within the homestead is selected for that purpose. The traditional position adopted while giving birth is to kneel down with legs apart and the hands holding the knees. Many women delivering at home still adopt this posture although others may choose to lie on their backs. A few women (members of the homestead or neighbours) may be present when labour begins, and they assist the woman by physically supporting her when she begins to push. If the woman is alone, she holds onto something stable such as a rope if it has been installed in the hut.

Not all TBAs have special instruments or equipment to help them in their tasks. Two TBAs said they take soap with them, as one said,

"to use for washing my hands so as to prevent germs. Everything has to be clean...".

Another TBA said she took a plastic sheet which she placed on the floor for the woman to kneel on while delivering. Otherwise, TBAs expected to find almost everything else they required at the expectant woman's homestead.

Cutting the Cord

The following instruments are used for cutting the umbilical cord; razor blades, grass, reeds, and when these are not available, pieces of broken glass are used. Although the use of broken bottles was reported as past practice, there is no reason to suppose they are no longer used. Many of the rural homesteads are poor and TBAs may find that the only easily accessible 'instrument' for cutting the cord is a bottle.

Although razor blades are mainly used for cutting the cord, there is some evidence to suggest that they are also used for episiotomies when childbirth proves difficult (see below).

The cord is cut after the placenta has been expelled, but exactly when and where it is cut depends on the individual TBA. The accounts of cord cutting do, however, suggest that neonates are at risk of haemorrhaging;

"...You measure (the cord) by the length of the baby's knee and then you cut....After the blood has oozed out, I then cut it again...where it ends...."

"...If the blood is still flowing heavily, then you hold the umbilical cord and blow on it, then put the baby to sleep (i.e. let the baby rest)".

Hygiene

As a result of the researchers introducing themselves as "people from the Ministry of Health", the TBAs were at pains to stress that they washed their hands before delivering a baby, and also used clean or new razors. One TBA said she used a razor,

"... because an old one affects the baby. Whether (the woman) is from my family or not, I use a new razor still covered in its paper".

The same TBA was defensive when asked if reeds were washed before being used;

"Why should I wash the reed, does it have mud? Since it was picked it was never used. It was just stored or used for thatching...."

No doubt the TBAs were conscious of the fact that we were concerned about their practices and the contribution these may be having on maternal and infant morbidity and mortality. In fact, one TBA claimed she had been asked by some Ministry of Health (MoH) nurses to stop delivering babies in the homesteads. This explained why she was at first reluctant to be interviewed, believing that we had come to check on her.

6.3 Dressing the Cord

To arrest the bleeding, the cord may be tied with cotton thread, or a coin is placed on the stump after some ointment has been applied. It is believed that the coin helps to close the wound. A piece of cloth is then wrapped around the baby's waist to hold the coin in place.

Also used to nurse the umbilical stump are the leaves of a tree

known as ipiliti, or dry soft sand. The leaves are dried and then crushed, and when applied on the stump, they keep it dry and help it heal quickly. The sand is ground then sprinkled onto the cord stump. The 'nipple' of a pumpkin provides another source of powder for dressing the cord. The 'nipple' is burnt, then ground into a fine (black) powder. Animal fats are also prepared as ointment for the cord. All these preparations are said to aid in removing the remaining part of the umbilicus and drying (healing) the cord.

7. What TBAs Do When Faced With Difficult Deliveries

7.1 Prolonged Labour

Prolonged labour is believed to result from the baby still being attached to part of the mother's body, the umilele. To overcome this problem, different types of medicine are given to women. The umhlalo is said to relax the muscles and is usually taken over a long period of time, maybe four months before the baby is born. The other medicinal preparations, that speed up the labour process, work immediately and are taken when labour begins.

When TBA Efforts Fail

The inyanga may be called in the hope that he/she can advise on what to do also tell them what may be preventing the baby from coming out. Medicine from animals, tinyamatane, is burned and the expectant mother is made to inhale the smoke. Family elders are also sometimes asked to beseech the ancestors to intervene.

However, not all women in the rural areas use these medicines and /or seek the assistance of traditional healers. Those who languish for a long time in labour may be taken to the clinic or hospital if transport is available. Someone in the community with a car may be approached to take the woman to the nearest clinic.

7.2 Inkonjane - The Swallow (Bird)

One other cause of difficult deliveries is believed to be a cavity within the woman's vagina, in the shape of a bird, the swallow. In siSwati the cavity is called inkonjane after the bird. It is believed that the baby becomes trapped in the inkonjane on its descent into the birth canal, and may go back into the womb. This condition can lead to the death of both the mother and the baby. To prevent this eventuality, the TBAs are forced to incise the vagina to enable the baby to emerge. Another solution to the problem of inkonjane, reported by one TBA, was to put her hands on the woman's navel and press hard to force the expulsion of the baby. (Expectant women peeping through doors was also said to cause difficult deliveries).

7.3 Breech Births

When faced with a breech presentation, TBAs usually hold the baby's legs and pull or place their hands into the vagina and help the baby out that way. One TBA claimed that there was always someone present and experienced who would know what to do.

Not all TBAs are confident to deal with such problems however, as the following comment shows;

" This condition of a reverse-coming baby is difficult....I just run away because I don't know how I can turn (the baby) back or reverse it...(the baby) can die...I don't know how to push my hand into the womb".

7.4 Retained Placenta

The placenta is expelled almost immediately after the baby is born, especially if the woman has been taking some of the traditional medicines mentioned earlier. If, however, the placenta is retained, the woman is given a bottle or a calabash and told to blow hard into it. This action usually expels the placenta. If this fails, the placenta is extracted manually. One TBA reported washing her hands first then smearing them with soap to facilitate insertion of the hands into the vagina.

Some TBAs use their feet to press the stomach just above the navel. Animal skin may be rotated around the birthing hut in the belief that this will result in the expulsion of the placenta.

If this fails, the skin is tied to the woman's leg and everyone waits for the placenta to come out.

Apart from the placenta, there is the 'extended placenta', called umjobajoba, which is believed to block the woman's blood supply and may cause death if left behind. Only one TBA believed that a retained placenta was caused by some disease.

7.5 Post-Partum Haemorrhage

One of the causes of haemorrhage following child-birth is said to be retained pieces of placenta known as liphukuphuku. Some TBAs used home-made traditional remedies to arrest the bleeding, others called the inyanqa. One TBA said she did nothing when women bled heavily because;

"...people are not the same. Some bleed heavily and others do not. But the bleeding eventually stops on its own...(after the placenta has been removed)".

What is Done to stop The Bleeding

Before a woman is referred to the nearest clinic, TBAs first try all they can to arrest the bleeding. One TBA reported using a plant called gobo, which grows on river banks and resembles a pumpkin. The plant is crushed then cooked together with another known as jikitsa intsama. When the mixture has cooled down, it is used as an enema to, as the TBA put it, "cool down the blood". It is possible that these plants have similar properties to ergometrine, used in hospitals to speed up the clotting mechanism in newly delivered mothers. The anal application of such preparations probably leads to their rapid absorption into the blood system. Another TBA reported giving women a mixture of sugar and their own blood to drink.

8. Post - Partum Care

8.1 Seclusion Period

Mother and baby are expected to stay in the hut where the birth took place for a period of time. TBAs reported seclusion periods of varying lengths, from a week to 5 months. The most common determining factor appeared to be when the umbilical cord had dropped off or the umbilical stump had dried. A newly delivered woman, umtedlane, is only allowed outside in the evenings to wash and go to the toilet. She is believed to be in a 'polluted' state or 'unclean' and must not cook for men or share eating utensils, and must also avoid touching anything belonging to a man. The belief is that their virility may be affected. She is also believed to be dangerous to herself and the baby.

A female relative may be there to help out but if not, the woman does all the chores herself. Some women may remain in seclusion until post-partum bleeding stops.

A factor which may be curtailing the period spent in seclusion is the changing family pattern. The extended family residing within a single homestead is gradually being replaced by 'nuclear' families. In such a family;

" The woman does not stay for a long time inside the house because she needs so many things (and there is no one to do things for her). So after the umbilical cord has dropped off and she has polished the floor of the hut with cow-dung, she is free to go outside..."

Although some women may prefer to deliver at home because tradition requires that they remain in seclusion after delivery, this does not appear as important a factor as distance and the

lack lack of delivery facilities, in contributing to the (still) high percentage of births taking place in the homesteads. Women interviewed in connection with this issue in the homesteads felt that the lack of transportation and the (geographical) distance of clinics and hospitals were the main constraints.

8.2 Care of the Newborn Baby

8.2.1 The Premature Baby

Although babies born prematurely in rural homesteads may have fewer chances of survival than babies born in urban areas, traditional methods for looking after premature babies exist, and from the TBAs accounts, appear to work well.

One of these methods is to incubate the baby in goat skin after first smearing it's skin with animal fats. These kept the skin soft (and warm). This process is called kuphala. The head is left uncovered to enable the baby to breastfeed. The goat-skin is left on the baby for 'about nine months'.

The second method involves placing the baby in goat tripe, covering the head and body and only leaving "...a small opening so that the mother can breastfeed". The tripe rots quickly and must be changed frequently. The tripe dressing is discontinued after about 3 months when the baby's neck and head have become firm.

The third method is to use a plant called emayonjana which is ground into fine powder and then smeared on the baby's head. The rest of the body is covered with red ochre (believed to have

protective powers). The baby and its mother are confined in-doors until " the baby had grown".

Not all TBAs know about these methods and some will refer the mother to the clinic or hospital. Others do nothing because they believe that babies born prematurely will not survive.

A potentially dangerous practice, to both mother and baby, was reported by two of the TBAs. This involved pushing the baby back into the womb. Tinyanga were said to do the same when called to try and delay the birth. If this was unsuccessful, the baby would eventually die.

8.2.2 When a Baby does not Cry Immediately After its Birth

A number of things are done in order to make a baby utter its first sound. First, the mucus, ludzendze, is removed from the baby's mouth and cold water is poured on the baby. If that does not work, tinyamatane may be burned near the baby (smoke is believed to revive the baby). A kitchen mat called sitsebe may be held next to the baby and air blown over it.

A baby who is silent when he/she is born does not cause undue worry, provided he/she is breathing. The TBAs said the baby is left to rest as it may be tired.

8.2.3 Breastfeeding

All the TBAs stated that babies nowadays are breastfed almost immediately after their birth whereas in the olden days,

breastfeeding would begin after the umbilical cord had dropped off. However, the TBAs reported that mothers usually extract the colostrum first before the baby is put to the breast. Furthermore, it was reported that soon after birth, the baby is first given inembe, or a mixture of water and soot (from beams in the hut), light maize porridge, or only water. Soot may also be rubbed on the nipples before the baby is put to the breast.

8.2.3.1 Refusal to Breastfeed

Babies who refuse to breastfeed are given inembe or cow's milk. Others are taken to the inyanga or the clinic. One TBA reported that some babies had their throats 'cleaned' (she was not asked how this was done) because they were suspected of having diphtheria.

Refusal to breastfeed and mothers inability to establish lactation may result from not putting the baby to the breast immediately it is born. But as the above evidence suggests, babies are fed other 'foods' before they have even tasted breast milk and this may result in rejection of the breast.

8.2.3.2 Inadequate Supply of Breast Milk

If a woman has an inadequate milk supply, she contacts the person (usually an inyanga) who was giving her timbita (sing. imbita) when pregnant. Certain plants that exude milky substances are collected, burnt and the smoke inhaled by the woman. Other forms of treatment include taking steam baths (widely used for a number of ailments), and making incisions on the skin into which muti is

smearred. The mothers are also given a lot of liquid food to encourage milk production. They are also advised to rub the nipples in order to clear the lacteal (milk) ducts.

8.2.3.4 Length of Breastfeeding

Breastfeeding may last from between one year to three years, with two years said to be the average. Breastfeeding was said to provide food for the baby as well as protecting it from diseases.

"... the baby was weak and sickly, that would mean he/she was not breastfed adequately".

9. Still-Births And Neonatal Deaths

When a woman loses children soon after their birth, it is believed that she suffers from luhlanga, a disease said to kill newborn babies. An inyanga known for curing luhlanga is consulted. One TBA gave the following account of her own experience with this disease;

"...I gave birth to boys and they died because there was no inyanga to help me. I discovered that my children were being killed by luhlanga, not that someone was bewitching them. Luhlanga was on my private part and I would scratch until blood would come out. But I did not know what it was. I was eventually told by an inyanga ... (through my husband)... what was killing the children... After smearing cow-dung on the floor, the child starts crying, vomiting and has diarrhoea. Sometimes the baby would cry until the following morning or cry for a few days until on the last day it died".

The TBA attributed the illness to the insumpe (growth or lump), on the mother's genitals, which "...knocks the baby on the head and (the baby) becomes sick".

From the above description however, and also from the preceding sections, it appears that organisms from the soot, inembe, and/or cow milk may be carrying bacteria which, on contact with the

newborn's stomach, results in severe gastroenteritis. The cow-dung in turn may lead to tetanus because at the time when it is freshly smeared on the floor, the umbilicus has not completely healed. The possibility that luhlanga may also be a venereal disease cannot be ruled out. However, studies are needed to establish what these conditions are and what causes them.

10. Protection for the Newborn (Against Diseases)

Although there is a belief that breastfeeding can and does protect babies from disease, it does not prevent 'evil spirits' from making the baby ill. Protection in the form of timbita and tinyamatane are therefore sought from the inyanga. No other form of preventive traditional medicine was mentioned. One TBA said diseases cannot be prevented by traditional medicines. She went on to say that,

"...at least you people can now give babies injections and they will help them...You see this child (sitting with her) has not finished his injections and I will have to take him to hospital (to have his injections) so as to keep (him/her) healthy".

This suggests that there is no apparent 'traditional belief barrier' preventing women from immunising their children. This is borne out by the results on children's vaccination status. Over 60% of the 288 children aged 0 - 5 years were fully immunised.

11. Some Infant and Childhood Illnesses

11.1 Stomach Cramp or 'Umbilical Cord Pains'(Colic)

One TBA noted that babies suffered from this condition until they were six months old. The baby is either treated by TBAs or referred to the inyanga.

One of the treatments for colic involves the application of enemas made from prescribed herbs. Enemas are believed to remove whatever may be causing the colic, described by one TBA as 'short

strings'. It is possible, given the less than ideal sanitary conditions in the rural areas, that the children she has seen are also suffering from worm infestation.

Sometimes, incisions are made around the baby's navel, and muti is then smeared into the cuts. The baby may also be given imbita. The plants that provide the medicines are called mshwilandle and sigadlana. The latter was described as a plant with small ball-like fruits (thus the name sigadlana or small balls). The sigadlana can also be worn as a charm around the baby's waist.

11.2 Libala (Cradle Cap)

This condition, identified by a red spot on the baby's scalp, is believed to be extremely dangerous and may lead to death if not treated immediately it is noticed. The baby is taken to an inyanga who makes small incisions on the scalp and applies muti. Apparently some tinyanga are well-known for 'curing' libala.

11.3 Diarrhoea (Umsheko)

There are 3 traditionally recognised forms of childhood diarrhoea, umsheko, which is believed to result from natural causes, and kuhabula, and inyoni or umphezulu whose origins are supernatural (Green 1984, Green 1985). These last two types of diarrhoea are believed to be more life threatening than the 'ordinary' umsheko.

The TBAs reported using a variety of plants to control the diarrhoea. These were said to harden the stool (therefore stop the diarrhoea). The name of these plants were given as; mqwaba,

incosi, lihlule ('blood clot', taken orally), lintulwa, umqudvuqudvu (which is ground and mixed into the child's food), inkokhokho, umqanu (or marula), umvanqati and umtfolo (wattle tree). One TBA reported using crushed tomatoes, administered anally, to treat a 'disease' which caused children to discharge 'green stuff'. The colour of the faeces indicated that the child had inyoni.

Causes of Diarrhoea/Treatment

Although TBAs were not specifically asked what they believed caused childhood diarrhoea, 2 causes were mentioned.

Luhlanga (see above), which presents as a rash on the genital organs of either the mother or father of the child is believed to cause diarrhoea. Treatment involves (the inyanqa) massaging the baby before giving him/her an enema treatment.

Teething was also said to cause diarrhoea.

All the 6 TBAs said some of the medicines are applied through the anus, to clear the baby's insides, or given orally. A small quantity (maybe a teaspoon) of the same medicine which is used as enema, or a different one, may be given to the child to drink or is mixed into his/her food.

When traditional methods of controlling diarrhoea fail

Only 2 of the 6 TBAs said children are taken to the clinic if local methods of controlling diarrhoea fail. One of these 2 said children are given medicine which is taken orally and they are

not supposed to be given food;

"...(the medicine) is in a bottle and should be drunk until the baby gets better".

This comment suggests that there may be a misunderstanding, on the part of mothers and grandmothers in the homesteads, of how oral rehydration solutions should be used e.g. ^{not} withdrawing food from the child.

Two of the TBAs stated that the traditional medicines usually worked. One TBA said the inyanqa is consulted, to probably diagnose the type of diarrhoea the child may have and offer the appropriate treatment. The sixth TBA said she wouldn't know what to do and the would eventually die.

It appears that the beliefs as to the origin of the diarrhoea, (thus the different types), and confidence in the traditional methods of dealing with it result in many children either succumbing to its effects, or being referred/taken to the clinics when their condition has deteriorated.

BEST AVAILABLE COPY

12. Birth Spacing and How to Prevent Pregnancy

12.1 To Space Births

Sexual relations after the birth of a baby are said to resume after 3 - 6 months, although the TBAs said they cannot tell a man what to do in his own house (i.e. sexual relations may resume even earlier). The 'ideal' time was for the mother to wait until she had recovered from the birth and the baby could sit up or

crawl. One TBA said the woman has to look and see if the baby 'looks more like a human being (and people appreciate him/her)'. For women to ensure that they do not get pregnant, they must 'sleep like young girls' during intercourse. This entails having sexual intercourse while lying on their side. It is believed that the 'missionary position', with the man on top of the woman results in pregnancy because the sperms swim up into the womb easily. The TBAs stressed the importance of the man and woman discussing 'what to do' in order to avoid pregnancy. Coitus interruptus was also mentioned as a way of avoiding pregnancy.

It was, and to a lesser extent still is, considered shameful for a woman to fall pregnant while the baby is still breastfeeding. Once pregnancy is suspected, breastfeeding stops. The milk is considered unsafe for the baby, and "he/she does not grow very well (and) becomes a sickly child.." although it does not always affect the child.

12.2 To Prevent Pregnancy

Apart from the TBA-cum-traditional healer, all the TBAs said the only way women could in the traditional way avoid getting pregnant, was total abstinence (as they put it, practicing self control), or resort to 'sleeping like young girls' with their partners. The TBA-cum-traditional-healer claimed to be able to 'turn the womb' as, she said, they do in hospital to prevent pregnancy. She was reluctant to discuss how this was done and added that she is usually reticent when asked to do it.

One TBA ^{said} childbearing stopped automatically after a certain age (that is, when a woman is 'past' the child-bearing period).

From one TBA account, it appears that 'sex education' from the parents/grandparents was the norm in traditional society. They were told, when they reached adolescence, that when they fell in love with a man,

"...he would do many things to you and (the mother) would specify which things you should agree to do and which ones you should refuse to do..."

Nowadays, few young girls are told about the consequences of sleeping with a man. From the homestead based study, we were told by the majority of the women that they were not told by their mothers about a) menstruation, or b) how babies are conceived.

13. How Some Of The Traditional Beliefs and Practices May Be Influencing the Utilisation of MCH Services and Maternal and Child Health

13.1 Informing the Mother When Pregnancy Suspected

The mothers of pregnant women appear to be influential in referring women to the MCH clinics. The majority of women in the sample found out about MCH services from their mothers. Although the motive for referring their daughter(s) was to confirm the pregnancy, nevertheless the implication is that modern health workers are regarded as being more capable than TBAs in ascertaining pregnancy. Confirmation of pregnancy may be one of

the reasons some women attend ante-natal clinics in the first trimester. It was observed for example, that only 13 out of 34 pregnant women in the sample visited an MCH clinic during the study period. Significantly, 8 of these were primigravidae.

13.2 Pre-Natal Care

Pre-natal care is provided rather informally by TBAs, and usually if requested by a pregnant women. Sick pregnant women are referred to tinyanqa unless TBAs have knowledge of traditional medicines.

Beliefs about what causes conditions such as oedema and dizziness, two of the signs indicative of serious obstetric complications (e.g. Population Reports 1988), were investigated. The TBA responses suggest that many at risk women may not be using ante-natal services for these conditions because they are considered 'normal', or they are considered treatable with traditional medicines e.g. cleansing 'impure blood' in the case of oedema. Many women are not aware that dizziness or swelling of hands and feet is potentially life threatening.

Another risk factor, bleeding from the vagina (ante-partum bleeding), was recognised as a serious condition (indicating a potential miscarriage). However, traditional healers apparently known for handling the condition are contacted. Only when attempts to arrest ante-partum bleeding fail are modern health facilities contacted. It cannot be assumed, however, that all women utilise the services of the tinyanqa. It is probable that

some pregnant women sit and 'wait out' the problem. A few women in the homesteads reported that their families had now become true Christians i.e. were saved, and no longer consulted tinyanga. Another reason given was that they no longer trusted tinyanga because they sometimes duped their clients by giving them 'dirty' muti which did not work, yet they charged perhaps a cow for it.

The pervasive belief that unless she is ill, a pregnant woman does not have to be seen by a health professional influences the utilisation of the preventive service component(s) of ante-natal services. Despite the high percentage of pregnant women visiting clinics at least once during pregnancy, there is no information as to whether the services sought are mainly curative or preventive. The evidence from this study would seem to suggest that a high proportion of pregnant women use ante-natal services for curative care and/or just confirmation of pregnancy.

BEST AVAILABLE COPY

The relative inaccessibility of MCH clinics is another factor strongly influencing utilisation of both ante-natal and delivery services. The long distances to be covered are not conducive to 'ordinary' clinic visits for preventive health care even if some women are motivated to attend clinics. One of the major complaints about the clinics was that they are too far away. Related to the above point is the finding that there is no traditional practice of 'immunizing' expectant women against diseases of 'natural origin'. However, Green's (1984) study of traditional healers in Swaziland found that pregnant women

consulted tinyanqa for protective medicines against diseases such as 'lipulete' (plate). This was said to be a disease, of recent origin, which obstructed the womb at the time of delivery. The mode of application of the medicines given was via incisions made around the naval and the back.

There is a high level of awareness among women of the modern preventive services offered at MCH clinics. However, the significance of the services is not well understood. For example, although more than 90% of the women knew that pregnant women were given injections (tetanus toxoid) at the clinic, 85% did not know for what purpose. This lack of knowledge about why the injections are given can be attributed to health personnel neglecting to provide this information. For example, one of the criticisms levelled against the MCH services by women in the homesteads was that the nurses do not teach them what purpose certain things, such as the weight chart, serve.

Child-Birth

Given the scattered and isolated nature of many rural homesteads, the lack of, or an inadequate transportation network, the inadequate or lack of delivery services at the clinics, and the easy accessibility of TBAs and/or other female relatives, home births appear to be the only viable and practical option for many rural women. The practice of routinely taking traditional medicines to accelerate the birthing process means that even if women are willing to give birth at a clinic or hospital, they may

not be able to get there (because of distance) soon enough for the baby to be delivered. Some women reported having given birth to one or more of their children unassisted. One of the 34 pregnant women in the sample related how on her way to give birth at the clinic, she felt the baby coming and had to quickly divert to her sister's homestead (which happened to be nearby) and have the baby there instead.

Thus while women may be motivated to have their babies in modern health facilities (because they believe they will be given better care), they may not always succeed in their attempts to get there. Of the 27 children born during the study, only one was born in a health facility. The mother was still at school and, because it was her first baby and she had the motivation, she chose to deliver at the regional hospital some 94kms away.

CLINIC BASED STUDY

Introduction

The study of both providers and users of MCH services at the clinic level sought to answer the following main questions:

1. To what extent do women as users of MCH services participate in clinic level activities other than in their capacity as service users?

2. What is the nature of the relationship between the (female) health staff and users of MCH services? What are the attitudes towards each other? Do their perceptions of their roles in the provision and utilisation of health care differ? (That is, do the users see the providers as being somewhat different from them, and vice versa).

The clinic study also investigated who made the decision that the users come to the clinic.

The Clinic Sample

Clients/Patients

Sixty three (63) women and 1 man were interviewed. Twenty six (26) women had come for ante-natal services, and 37 women and 1 man had brought the children aged 0 - 5 years to the child welfare clinic.

Twenty of the ante-natal had come only for weight monitoring (weighting). Two (2) women had come for both weighing and treatment for non-specific ailments, and 4 for curative services. Of the 41 children seen, 66% (27) had come for treatment and 34%

(14) for preventive services (weighing and/or vaccinations).

Staff

Only nurses in-charge of the 4 clinics visited were interviewed. All four were female. They were state registered had been working at their respective clinics for about 2 years.

All 4 nurses had also qualified as midwives but had no special qualified in maternal and child health. Although all the clinics offered family planning (FP) services, only one of the nurses had been trained in FP. A clinic survey by the MoH in 1984 found that only 13% of the Government nurses and 11% of those working in Mission facilities had qualifications in Public Health and MCH (MoH, 1984).

Use of MCH Services - Who Decides?

Child-Welfare Services

Seventy nine percent (79%) of those who had brought children to the child welfare clinic said they themselves had made the decision to come. One child was brought by his young aunt (about 12 years of age) who said the child's mother had decided that the child be taken to the clinic for weighing and vaccination. Three women (8%) said the child's grandmother had decided, 2 reported that the decision was taken by the child's father, and one woman said the decision was taken by herself and the child's grandmother.

Ante-Natal Services

The majority of the women attending the ante-natal clinic (88%) made the decision to attend themselves. Over 90% had come for weighing. Two (2) women had been told to attend by their mothers, and I said she and her mother felt that she should attend the clinic.

Reason(s) for Utilising MCH Services

Although a variety of reasons for deciding to use clinic services were given, the most basic one was the desire 'to be well'. For example, most of the children had been brought for curative services and the parents were concerned that their children get better or regain their health. The clinic was seen as the only place to provide a cure. Treatment was sought for the following ailments; diarrhoea (37%), Vomiting/cough/fever (18.5%), Fever (15%), Body rash/Sores (11%), Other (18.5 %). The latter category included swelling or growth on the leg, no appetite, newborn with thrush in the mouth lithumba, and worms/blood in the faeces.

Preventive Services - Children

Some mothers bringing their children for vaccination and growth monitoring said they did so because they had been told by the clinic nurse to bring babies born at home for vaccination. Others mentioned protection against diseases and to monitor their child's health and growth. It can only be assumed that these mothers had already seen the benefits of using the services because the majority had two or more children, and over 90% had

used MCH services at that particular clinic before. It is notable, however that the majority of the children (66%) came for curative services. The motivation to save the child's life when he/she is ill is greater than the motivation to prevent the illness by e.g. completing the vaccination schedule.

Ante - Natal Care

The reasons given for attending ante-natal clinics were as follows:

- The nurses told them to come for a checkup and get a clinic card when pregnant which would make it easier for them to receive attention if they went for hospital deliver ...27% (7/26)
- To ensure that the baby growing inside was protected against diseases and/or was growing well, and the mother was alright ...38% (10/26)
- Not feeling well ...15% (4/26)
- To establish/confirm how many months pregnant she is ...8% (2/26)
- Others ...12% (3/26)

Of these 3 women, one used to go to private doctors but they charged too much, another said the clinic nurses checked them without asking them why they had come¹, and the third one said she had used the clinic since her first pregnancy and continued to utilise the services so that she would not get any problems

¹ The woman explained that the nurses at this clinic did not make them feel as if they were being bothered. Instead of being asked 'why have you come?' it would have been better to perhaps say e.g. 'how can I help you?'. The approach used by some nurses was felt to be unsatisfactory.

when giving birth.

Most of the women, 38%, were interested in ensuring that they themselves, and their unborn babies were well. Nurses also appeared to have influenced ante-natal attendance by informing the women of the necessity and importance of obtaining the clinic card.

Participation in Clinic Activities

Clinic Committees

Three of the clinics, all government, had Clinic Committees which were more or less functioning. Two of these committees had female members apart from the clinic nurse. Women who attended MCH clinics did not attend committee meetings. One nurse said sometimes general meetings are called and everyone is invited to attend as for example when the clinic fee has to be raised.

The committees were initially formed by local communities that wanted to construct a clinic through self-help efforts. They were disbanded once the clinic was built. There is at present an attempt to revive the committees and charge them with overseeing preventive activities within the communities such as latrine construction. The key person on the committee as far as health issues are concerned is the clinic nurse, and the success or failure of these committees is largely dependent on the interest the nurse has in its functions.

In the 3 clinics with a committee, the impression obtained from the interviews was that at present the committees' main function is to collect the clinic fee. The money thus collected was used for the maintenance of the clinic, for example to pay the cleaner or a security guard. The fee was between 20-30 cents, and was paid by the patients on each clinic visit. The charge for consultation at a clinic, in 1986-87, was 1 Lilangeni.

Women Patients/Clients Involvement in Scheduling Clinic Sessions and Staff Transfers

From interviews with clinic staff it was apparent that the concept of active patient participation in clinic affairs was quite new. No one had mentioned the subject to them before but were unanimous in lauding the idea of for example having the patients/clients determine what hours were most convenient for the clinics to open. The nurses also agreed that it would be better if clinic users felt they had the power to change staff they were dissatisfied. As one nurse put it, "If they (the women) are not happy (with the services or staff), they will stay at home".

The clinic user's role however, was totally confined to that of 'passive consumer'. When the women using MCH services were asked if they had been to the clinic for anything other than the services, the response was a resounding no. In fact, they appeared surprised at the question (and the suggestion) that the clinic could be used for anything else apart from (mainly).....

curative care (health facilities are regarded as 'treatment' centres).

Relationship Between Staff and Patients

Women at the clinic appeared to take every passive role and treated the staff with much defence. The relationship, not surprisingly, was very much one of servers (the staff) and served, although the latter took the subservient role.

Client/Patient Satisfaction with Services Offered

Complaints About the Services

The 63 women were asked whether or not they had complaints about the services offered. Eighty nine percent (89%, 56/63) said no. Of the 7 (11%) women admitting to having complaints, 2 said they had told the nurse the complaint, 2 had mentioned it to friends, 1 to her family, and 2 had told no-one.

A subsidiary question on what was good and/or bad about the clinic produced a better response (30%, 19/63). The things felt to be bad about the clinic were;

- The clinic was too far away (6/19)
- Shortage or lack of drugs (4/19)
- Too few staff (3/19)
- Nurses don't give injections
- No maternity services, told to go back home, nurses tired
- Opens late and closes at 4pm
- No delivery beds
- No transportation to take us to government hospital to deliver

- Nurses don't tell us how many months pregnant they are

Complaints from Patients to Staff

There was no formal procedure at the clinics for hearing patients' complaints. Clinic staff said they learnt about these indirectly via discussions of general problems with individual patients. Informal conversations with women in the homesteads revealed that they would welcome a place where they could voice their dissatisfaction with clinic services. There is however a reluctance on the part of many women to make their grievances public. A possible reason could be that they do not want to offend the nurse by confronting her personally (and thus incurring her dis-pleasure.

The complaints the nurses have received from the women include the distance of the clinic and bus routes from the homesteads, lack of attention at night when they are ill and turn up at the clinic, and long waiting queues. The latter is of particular concern to the women because they have to depend on infrequent bus services.

Many of the complaints have not been acted upon because the nurses have no control over the situation. For instance, where the clinic has no working generator, patients cannot be seen at night. Nurses were also concerned about their own security when opening their houses at night. Not all the clinics could afford a night watchman.

Clinic staff were also asked about the problems they face the clinic. These are detailed below.

Clinic Problems Mentioned By Nurses Interviewed

Clinic

Problems

Matsanjeni

- Clinic Building too small, no lights, no water, problem with rats, no transport, no telephone, no security especially at night- have had a few break-ins.

Hluti

-Patients coming at night - security fears
 - Shortage of delivery equipment, for resuscitation
 - Problem of transportation for patients- ambulance delays (comes from Hlatikhulu), no lights - generator not repaired yet, use candles, torch is broken - cannot check IUDs.

Our Lady of Sorrows

- Need extra staff - heavy workloads- staff overworked but no money to pay salaries for extra staff.

Lavumisa

- No store room, examination room too small
 - Clinic building too small
 - No dark room for eye examinations
 - Problem with security - no guard so doors not opened at night when patients come unless they are accompanied by a policeman known to the nurses
 - No accommodation for a security guard even if one were employed.

With staff shortages, queues remain long unless the minimum staffing requirements for the clinics are reached. This is a matter for the MoH and not the clinic nurse. In addition to the above problems, clinics experience shortages of essential drugs and equipment, or lack them altogether. This in turn impedes the provision of effective services by the nurses. At one of the clinics for example, physical examinations of women coming for family planning services could not be conducted because there were no speculums.

How services Can be Improved - Clients/Patients Views

When asked if they thought the services at the clinic could be improved, 70% of the women (44/63) answered yes, 25% (16/63) said they did not know, and 5% (3/63) said the services were alright as they were.

Over half of the respondents (52%, 23/44) felt that the provision of delivery facilities, in the form of delivery beds, waiting houses for expectant mothers, and delivery wards at the clinic (in-patients beds), would greatly improve the MCH services. None of the clinics offered delivery services except in emergencies. Even then, the lack of adequate facilities and equipment, especially when faced with difficult deliveries, puts tremendous strain and responsibility on the nurse in charge. At one of the clinics for example, there was no telephone, an essential for a clinic which depends on the ambulance from the Regional Hospital some 90km away.

The other suggestions for improving MCH services were;

- Upgrade the clinic to a hospital (32%)
- Increase staff-especially doctors (32%)
- Provide In-patient beds (16%)
- Provide milk/clothes for the children (%)9
- Provide (working) telephones (5%)
- Provide adequate drug supply (5%)
- Build better toilet facilities (2%)
- Provide water pumps (2%)
- Provide milk for pregnant women (2%)
- Nurses should explain what the drugs prescribed are for (2%)
- Nurses should tell pregnant women whether or not baby is in the right position (2%)

How Services can be Improved - Staff Views

The four nurses interviewed felt that the only way services at the clinic(s) could be improved was to address the problems identified by themselves and the patients. In addition, 2 of the nurses felt there was a need for refresher courses and 'specialist' training in, for example, family planning.

Reasons for Preferring Non-Government Clinic

Women utilising the Mission clinic were asked two additional questions:-

1. What (was) good about the clinic?
2. Why have you com so fare (for those known to have by-passed a government clinic or clinics)?

One of the main reasons for using the Mission clinic was the reception the women received when they arrived there. Of the 18

women sampled from the mission clinic, 56% (10/18) said the nurses "talk(ed) nicely" to them, 22% (4/18) that they are told when their babies are due and 17% (3/18) believed the drugs given were more effective (respondents could give more than one reply). A woman who had by-passed 3 government health facilities said she only uses the latter for minor ailments.

Summary

The clinic study confirmed what had already been revealed by the homestead study and that is that Swazi women are the primary decision makers in health. The majority of the children seen at child welfare clinics had been brought for treatment.

Numerous problems beset health facilities and these affect utilisation primarily because the staff are impeded from providing 'effective services' for lack of equipment and adequate clinic space. Distance to the clinic and the lack of delivery facilities for expectant women can be seen as major inhibiting factors to the utilisation of modern maternity services.

Women's involvement at the clinic was confined to the role of passive consumer.

The Mission clinic was found to be more popular than the other 3 clinics because the 'quality' of care, as measured by staff behaviour towards the patients and availability of drugs/equipment, was seen to be better.

DISCUSSION AND CONCLUSIONS

Homestead Based Study

One of the objectives of this study was to highlight not only the extent of women's participation in health care within the family, but also the influences on their health decision-making. The study design allowed these objectives to be reached. Women were found to make the majority of health decisions (e.g to use a clinic or home remedies) concerning themselves and children aged 0 - 5 years. Such decisions were seen as being within the realm of women's responsibilities which generally includes childcare.

The decision to use a health facility depended on the perceived severity of the illness. This was the reason for 40% of the 62/91 women's illness episodes for which a response was given to the question why a particular course of action was taken. Fifty two percent of the children's illnesses taken to the clinic or hospital were perceived to be 'serious'. Lack of money appeared to be the main reason for not taking any action (for both women and children). Without a ready source of cash, women were unable to act even if they believed that the illness warranted the attention of a (modern) health worker.

The majority of women interviewed at the child-welfare clinics (79%), and ante-natal clinics (88%) alone decided to come to the clinic. In both the homestead and clinic studies, the illnesses

reflected the poor environmental and sanitary conditions¹, in particular lack of safe water supplies, that plague most of the rural areas.

To be able to measure women's participation² in the formal health care system, it was necessary to first establish whether or not the potential participants, in this case the women, knew exactly in what they were expected to be participating. If women are to accept that MCH services are an essential and vital element in the promotion and prevention of diseases, they must first know what services are offered, and secondly, understand their function or purpose. This study not only tested women's knowledge of MCH services, but also their understanding of the functions of two important components of MCH, namely weight monitoring (for children) and immunisation (for both children and pregnant women). It appears that women are not provided with sufficient information and/or explanations about the various MCH services for example, tetanus toxoid injections. It is only if women understand the utility of these services that they will be more motivated to utilise them. However, provision of relevant information concerning MCH services has to take place in tandem with efforts to remove utilisation barriers at the health service level. These barriers include inadequate staffing levels at rural

¹ Of the 91 illness episodes (women), 15% were 'stomachaches' and 13% 'coughs'.

² Participation is broadly defined to encompass both 'use' of service which is usually said to be 'passive' participation, and 'involvement' which entails patients/clients taking part e.g. in planning their services.

health clinics and insufficient or total lack of provision of services that cater for the health needs of women such as delivery beds. The problem of distance also needs to be addressed. Both staff and patients/clients mentioned it as one of the main problems affecting the utilisation of MCH services.

It appears there is an information gap concerning RHMs which has to be dealt with urgently especially in the areas farthest from a static health facility. Information and/or publicity about the RHM training programme and the rationale for having such a cadre, must be disseminated well before plans for selecting and training someone from the communities are executed. Because the bulk of the work done by RHMs involves women, their opinions should be sought concerning this cadre.

Women's participation in primary health care at both the homestead and health facility levels needs to be informed participation. The latter calls for new lines of communication, especially from the side of health workers. Health education messages must go beyond the clinic level and into the communities and people's homes. If women's participation in primary health care is to have an impact on health status between now and the year 2000 (particularly their own and that of their children) it is imperative that a dialogue be established between modern health workers and the beneficiaries of the services they provide. For women to effectively participate in 'phc' and 'PHC', services (such as water, transportation) and

infrastructural improvements (roads) are required. Many of the reported illnesses were related to environmental sanitation and water availability (gastroenteritis, 'stomachaches'). Since it is obvious that the health sector alone cannot bring about improved health status, the active involvement of other sectors in the planning activities of the Ministry of Health, for Primary Health Care, should be considered an urgent priority.

Women should be viewed as concerned participants, because they are, by and large, the primary providers of health care for their families. This implies that communication between health care providers and women should be a two-way process. Health workers should not only convey messages that they hope and desire to be understood, but they too must try and comprehend messages from the people they are serving. To this end, community and home visits by health workers should be emphasized, especially during training.

The organisation of women into groups at the grass-roots level is weak. It was claimed by one informant that husbands prevented their wives from joining women's groups because they believed the women would use this as a cover or excuse for meeting their lovers! Nevertheless, women expressed a desire for some sort of group,

"...where they can speak of their problems and (learn how) they can stop diseases in their area".
(Research Assistant's Diary)

Another reason why women do not organise themselves more frequently into groups is the existence of differences between women which render communication between them difficult. This was clearly brought out in the homestead study where many of the women reported never visiting their immediate neighbours, or only occasionally.

The apparent popularity of the Zenzele group stems from the fact that it offers women an avenue through which they can meet their families food needs as well as the need for some cash income. The handicraft and sewing group also provided women with an opportunity to make money but unfortunately, it was short lived. The person organising it, an expatriate (she provided the raw materials and found a market for the finished products) moved away and the group folded.

Although women saw the need for some income generating activities, they did not necessarily realise it through a women's group. For instance in Hluti, 9 income generating activities were identified ranging from beer brewing, to knitting jerseys that were sold in the Republic of South Africa. For women's groups to become a viable tool for PHC work, they must first address problems facing rural women. One of these problems is the lack of financial resources to meet family needs for food, health care and children's education. Women whose husbands were unemployed worried continuously about where their children's school fees would come from. Some women were married to men who drank heavily and refused to prepare the land (plough) for planting, and others were deserted by their partners, and had to fend for their

children alone. Although many of the problems cited were experienced by many women, each woman worked alone, rather than in a group, in finding a solution.

The existence of a Rural Development Programme did not result in the promotion of women's participation 'in development' through women's groups. In fact, more women in the non-RDA than in the RDA were members of a group. A possible reason could be that being only at the 'minimum-input' phase, the benefits of the programme had not yet been felt. However, the needs of women (as a special group) were not one of the things the programme set out to address: The benefits to women were to be a 'spin-off' of community development resulting from the programme (Swanepoel & de Beer 1983). In general, welfare issues (e.g. improved health, quality of life, availability of food) in the RDP were secondary to the concern over 'economic' development. As in many programmes that do not involve the supposed beneficiaries from the beginning, the Rural Development Programme in Swaziland has been criticised for not addressing the problems of the poor, many of whom are women³.

³ Of the 204 rural homesteads studied by Guma & Neocosmos (1986), 16.2% were headed by women. Of these, 22.5% were classified as 'poor'. Relative to the RDP, similar proportions of poor homesteads were found in the non-RDA (32/156) and RDA (8/43).

de Vletter has argued that the RDP in fact succeeded in raising the standard of living not through increased agricultural production, but (by displacing rural (male) labour) through wage earnings which increased homestead income. Carloni (1982) in her study of women farmers in the Northern RDA found that for maize production, increased input of e.g. tractors did not lead "to increased maize output, but merely to the maintenance of current levels of output with less male labour" (Carloni 1982, p.22, see

In so far as education was concerned, there were no significant differences in terms of knowledge of MCH services, vaccination of children, knowledge of the functions of weight monitoring and immunisation, and health behaviour generally, between women who were illiterate, and those who had spent a number of years in school. Motivation⁴ must therefore be seen as one of the important factors influencing the utilisation of available health services. The provision of information about the services, either through family members, neighbours, or the clinic is also important.

Although the knowledge of modern contraceptive methods was high among the women in the study, less than a quarter reported they were currently using a contraceptive method. Although this figure is higher than the current user rate for rural Swaziland (13.1%)⁵, it does not really tell us how long the women had been using the method, or for how long they continued to use contraceptives.

Two of the reasons advanced for so few women in the developing world using contraceptives are a) that women are not motivated to use them, and b) large families are still preferred (Acsadi &

also Sachs & Roach 1983 on the same point).

⁴ Women want to see their children healthy regardless of educational level. They will therefore want to make use of those services that will bring 'good' health (curative and preventive).

⁵ Based on women 3,279 women aged 15 - 49 years interviewed for the national Family Health Survey 1988 (Ministry of Health Swaziland, March 1989)

Johnson Acsadi 1984). However, motivation to control or regulate fertility arises out of a given context and/or personal experiences. In the rural areas where this study was undertaken, the socio-economic conditions are far from ideal. The majority of the people are barely subsisting, and the burden of responsibility to look after family welfare falls on the women. Evidence from this study also strongly suggests that the experiences of many women in their reproductive period are not conducive to a desire to control fertility. A high pregnancy wastage rate, as well as the loss of children in the 0-2 year age group may possibly be inhibiting women from being interested in using contraceptives. Thirty seven percent (37%) of the women in the study reported having less children than pregnancies. Fourteen percent (14%) of the women had experienced at least one miscarriage. One woman reported having 4 miscarriages. This is clearly indicative of the poor, and/or inadequate, pre-natal care women receive within their families (e.g better nutrition) and from modern health facilities.

Another factor which may be influencing the use of modern method of contraception is the changing social environment where traditional sanctions relating to pre-marital pregnancy no longer operate (the 'old' customs etc have been discarded but no structure with similar functions has been created). One of the reasons for this is that grandmothers, who traditionally had the task of educating young girls about sexual matters, no longer have absolute control and/or influence over the young. In 'traditional culture', youngsters were apparently taught that

pregnancy outside marriage was shameful, and from what the TBAs said, girls were told how pregnancy could be avoided (although whether or not these methods worked is impossible to tell). Nowadays, many children are away at school, and may not even reside with their grand-parents. Most of the women in this study reported that they were never told about menstruation, or how babies are made. Forty four percent, 44%, of the respondents were single women.

Scarcity of health resources such as personnel, delivery beds and equipment, and the geographical inaccessibility of the clinics all appear to be major factors influencing the utilisation of maternity health services (as well as other MCH services). Given these facts, the possibility of training and upgrading the skills of TBAs should be given serious consideration. However, TBAs (and older women - bogogo, in the homesteads) ought to first be consulted in order to find whether they are interested in being trained (Alakija 1984) and what they consider to be their needs in terms of improving their skills and knowledge. The six TBAs interviewed for this study indicated that they would not mind being given more knowledge (about how to better help pregnant women) by health personnel⁶ but they felt they were too old to undergo any training. It is also imperative that women in their childbearing period be involved in discussions about TBAs

⁶ i.e they wouldn't mind learning from them.

generally and TBA training in particular⁷.

Traditional Birth Attendants and other bogogo within the homesteads currently provide health care and advice for most of the expectant women in the rural areas. They have accumulated a wealth of knowledge about traditional maternal and child health care which ought to be utilised by modern health care providers when for example, planning health education messages. An essential prerequisite to the above is to first delineate TBA practices and beliefs according to which ones are beneficial and which ones are harmful.

The fact that TBAs' knowledge, beliefs and practices may vary, as regards pregnancy, childbirth and the care of newborn babies, means that generalisations cannot be made about their work, or the influence these practices and beliefs (may) have on maternal and child health. However, an important issue raised by the examination of TBA beliefs and practices is the extent to which these beliefs and practices are contributing to the maternal and infant morbidity (and mortality). Relative to the latter, some areas of concern have been identified and these are ;

- a) health problems during pregnancy and how they are dealt with by TBAs
- b) the level of hygiene during childbirth, especially when labour is obstructed
- c) the instruments used for cutting the umbilical cord and 'medicaments' for dressing it

⁷ Since these are the consumers (potential and actual) of TBA services, they may identify areas in TBA knowledge and practice that could benefit from some form of training.

- d) 'episiotomies' performed by the TBAs
- e) TBAs competence in dealing with complications such as breech deliveries, post-partum haemorrhage and retained placenta
- f) care of pre-term infants

There is an urgent need to first investigate traditional beliefs and practices concerning maternal and child health as a starting point towards improving maternal and child health as well as strengthening the MCH services.

Clinic Based Study

Staff/Patient Relationship

Although the relationship between staff and patients at the MCH clinics was observed to be cordial, staff were nevertheless regarded as belonging to another 'class' by the majority of rural women. The most obvious reason for this was that nurses are more educated and therefore 'different'. The other reason was that the nurses, being government employees, are usually posted to clinics not situated in their home areas, and are therefore 'strangers' in the communities in which they work. Their contact with the homesteads was minimal, partly because their training and therefore work orientation focuses on static clinics (the visits depended on how much time the nurse had to spare, in other words the clinic workload), and partly because they lack transportation to enable them to conduct home visits (those who are motivated). It is only at the mission clinic that home visits were reported to be a regular feature. The scattered nature of the homesteads made it impossible for the nurses to cover homesteads that were

very far away from the clinic.

Apart from the usefulness of home visits in detecting cases that require hospital or clinic attention, such as tuberculoid (T.B.) cases, malnourished children, and expectant mothers, home visits can be a vehicle through which some relationship may be established between the clinic nurses and women in the homesteads. If nurses can be seen in the homesteads regularly, perhaps the image of them as people belonging to a separate class may begin to change.

Because nurses are perceived as being a group apart, this creates a barrier to communication between themselves and women using MCH clinics. One of the women we interviewed in the homestead sample explained that in their area, people belonged to different classes. Those who were 'better off' (of a higher class) could chat with the nurses but those who were poor (lower class) could not. This attitude, based on how the women assessed their economic status in relation to the nurses, may partly explain the reluctance by women to air their grievances/complaints to the nurses.

Although Rural Health Motivators (RHMs) may fill the need for a formally trained health worker^e within the community, this still does not resolve the problem of health workers, nurses in

^e RHMs cannot surely be expected to undertake tasks that full-time health workers find difficult like for example, visiting 40 homesteads within their catchment areas? In a study of community financing of RHMs, Connolly and Dunn (1986) found that the RHMs in the study areas had very little routine contact with 'members of the community'. There are obviously numerous reasons for this but the question of accountability must come first.

particular (and by implication the clinic), being regarded as external to the community.

There is clearly a need to establish better relationships between clinic users and clinic staff that are conducive to participation of users in the management of clinic activities, such as scheduling clinic sessions. What is required is continuous dialogue between users and providers about not only problems that affect them individually, or as families, but also problems that the users associate with the health care delivery system. Knowledge of these problems would greatly assist health workers in their efforts to improve clinic services.

RECOMMENDATIONS AND AREAS FOR FUTURE RESEARCH.

The present study has uncovered a whole range of issues relating to women and their participation in health care which need to be addressed if women are to benefit from current efforts to promote PHC in Swaziland. These issues fall into two broad areas; primary health care within the homesteads and the community levels, and, Primary Health Care at the clinic level (the formal health care delivery system). The following recommendations are made to reflect the issues raised at the two levels.

Recommendations

1. The Ministry of Health, through the Primary Health Care Committee, should seriously consider a working definition of 'Primary Health Care'. A clarification of what is meant by PHC, in the Swazi context would greatly assist in the planning and evaluation of 'PHC' activities in the country.
2. The Ministry of Health, through the Primary Health Care Committee, should closely examine the concept of 'community participation' and what it means in the Swazi context relative to women and men. In this regard, attention is drawn to the need for a gender-oriented approach to planning and implementation of health and other services.
3. The Ministry of Health should examine the possibility of working with women's groups in the communities as channels for, not only health messages from 'above', but also (most

importantly) learning what women consider to be their priority problems. Although few women in the study belonged to a group, a number of groups, serving different needs, were identified by the study. Knowing what groups exist and what their functions are could be a beginning to a better understanding of the potential for mobilising women within the community for health related activities.

4. The Lutshango Lwaka Ngwane, the national organisation for Swazi women, should engage in discourses with all women's groups, both formal and informal, with a view to establishing a (better) platform for women to voice issues that concern them as women. Many women in the homesteads indicated the desire for 'group' through which they could air their views about the hardships they face in their daily struggle to maintain their families. Other women were experiencing problems with their partners, especially lack of financial support.

Although the Lutshango is the umbrella organisation for Swazi women, most of the women in the study felt that the organisation was there merely for purposes of mobilising women's labour whenever it was needed by (especially) the chief (to cut thatching grass).

5. Health education campaigns should address themselves to the question of men's involvement in family health, and in particular, the health of women and young children. Specifically, the substudy on the knowledge and use of contraceptives has

indicated that women have minimal decision-making power over an issue which directly affects their health. Continuous health education campaigns for men (including adolescent boys), on the importance of family planning for mother and child health, should be given serious consideration.

Relative to maternal health, women in the homesteads stated that men needed to be told of the harmful effects of strenuous work on pregnant women.

6. There are problems with the MCH care delivery system (as indeed with the health care delivery system as a whole) that necessitate the exploration of alternative ways of delivering health care for mothers and children. Having an MCH programme, essential as it is to the PHC schema, is not a panacea to the problems facing women and children. But, given that MCH services are there for the benefit of the women and children, a necessary step towards improving the services is to know what women think of the services and how they think services could be improved. The recommendations are therefore that;

a) Periodic, homestead based studies be undertaken to assess women's perception and evaluation of the care provided at the clinics. These could be undertaken along with clinic based studies, but it is felt that homestead based studies will include the opinions of women who do not use formal health care services at all, and those who use them infrequently.

b) One of the functions of the Clinic (Health) Committee should be to hear and note complaints about the clinic services, with a view to feeding this information to the Regional and Central levels. The clinic level study has indicated that a need exists for a platform for MCH service users to air their complaints. The necessity for health workers and planners to know the level of satisfaction and/or dissatisfaction with existing services (from the clients themselves) cannot be overstated.

c) Home visits be made an essential criteria for judging the work performance of health workers in the rural areas. During the study, many women made it known that they needed some instruction on 'good health practices'. Visits to the homesteads would enable the health workers to assess the practicality of the health education usually dispensed at the clinics. They would also be in a better position to offer women advice which is relevant to their (home) circumstances. These visits would also minimise the communication barriers that exist between health workers (nurses) and MCH service users.

d) All efforts be made to consult women in the community before health services that have them as the main beneficiaries are established. Particularly pertinent to this point is the training of RHMs. Because most of the RHMs' work concerns women, the latter should be informed about the rationale for training such a cadre well before selection of the trainees begins. Women should also be the primary participants in the selection process for RHM

trainees. In this way, the RHMs will be accountable to the women they are serving, rather than to their supervisors, the clinic nurse. Furthermore, it is important that women's opinions/attitudes about the whole idea of having such workers be heard.

7. In order to better evaluate the coverage of MCH clinics and programme performance (in terms of objectives and targets), health workers posted to rural clinics should be provided with basic statistical information about the areas they are serving such as the number of homesteads in the clinic catchment area¹, and, the population by age and sex. This information should be updated on a regular basis. This type of basic information will be very useful for planning homestead visits, and in assisting nurses to set targets for e.g. immunisation coverage (for both mothers and children).

8. The Ministry of Health should consider undertaking research on TBAs, their beliefs and practices, and how the latter are affecting the health of pregnant women and infants.

¹ This point cannot be better stressed than the finding of the clinic study undertaken by the Ministry of Health in 1984. The catchment area of the clinic was not known by the rural clinics visited (MoH 1984).

Areas For Future/Further Research

1. Women's Knowledge of Health Services /PHC /Community Participation

Surveys in other regions could be undertaken to establish if the results of the substudies on women's knowledge of health services, PHC, and Community Participation are generalisable. The importance of such surveys cannot be overstated. If the Ministry of Health is committed to the goal of Health for All by the Year 2000, it is imperative that the groundwork for establishing how much women (and people in general) know about this goal be undertaken first. The surveys would also provide some baseline data from which to evaluate future developments.

2. Traditional Beliefs and Practices

Research to find out which of the beliefs and practices can be incorporated into topics for health education. For example, if women routinely seek the services of tinyanga to protect themselves against ipulete and inkonjane, then these diseases can be used as examples to promote tetanus toxoid injections for pregnant women.

3. Maternal Health

In order to convince women that fertility regulation is beneficial to their health and that of their children, a number of problems will need to be addressed. The most immediate are problems relating to experiences of child loss and miscarriages. Research is therefore required into the frequency and causes of

miscarriages. This research would determine (among other things);

- the general nutritional level of expectant women
- at what stage miscarriages occur e.g. first, second trimester
- the incidence of pelvic abnormalities
- the incidence and prevalence of toxæmia and associated factors
- the effect of workloads on maternal health
- the incidence of (foetal) congenital abnormalities

4. Mental Health

Without doubt a lot of women are under considerable stress as they struggle to maintain their family's welfare. A woman who has numerous demands on her cannot be expected to provide a harmonious, loving and tolerant environment for her family. Research is therefore required to establish to what extent the demands and expectations on women are affecting their mental health.

5. Infant/Child Health

Research is required to determine the incidence and prevalence of neonatal tetanus. This research should address the following questions;

- How many deaths are due to tetanus in a given area?
- How are TBA practices contributing to morbidity and mortality due to tetanus?
- Of the infants dying from tetanus, how many have mothers who have received the tetanus vaccine.

REFERENCES

Acsadi, G.T. & Johnson-Acsadi, G. (1984). "Perspectives of Family Planning in Developing Countries - Some Lessons Learned from the WFS." International Planned Parenthood Federation, London, Sept. 1984.

Armstrong, A. & Russel, M. (1985) A Situation Analysis of Women in Swaziland. United Nations Children's Fund & Social Science Research Unit, University of Swaziland (UNICEF/SSRU), February 1988.

Carloni, A.S. (1982) "Social Analysis of An Agricultural Investment Project With Emphasis On The Role of Rural Women: A Case Study On The Credit and Marketing Project For Smallholders in Swaziland." Prepared For Training In Agricultural Project Preparation' (TCP/RAF/0107) Population Documentation Centre, ESH Division, FAO, Rome.

Connolly, C. & Dunn, L.H. (1986). Development of Appropriate Methods for Sustaining Rural Health Motivators. Social Science Research Unit (SSRU). Research Paper No. 20, March, University of Swaziland.

CSO (1988) Highlights on the Results of the 1986 Population Census. Swaziland Government/Central Statistical Office, Mbabane.

de Vletter, F. (1983) "The Swazi rural homestead: A case study of subsistence wage dependency and misguided rural development". Paper presented at the Second Carnegie Inquiry into Poverty and Development in Southern Africa, April 13 - 19, 1984. Carnegie Conference Paper No.285.

Gort, E. (1985) "Health Care Selection in Rural Swaziland." Papers presented to the American Anthropological Association 1985.

Guma, X.P. & Neocosmos, M. (1986) "Some Aspects of Poverty Among Swazi Rural Homesteads" Research Paper No.23, October. Social Science Research Unit (SSRU), University of Swaziland.

Magagula, G.T. (1978) "Rural Development Area Programmes: The Case of Swaziland." Journal of Southern African Affairs Vol. 3(4), pp. 433-470.

MOH (1985) Immunization Update - Health Planning Unit.

MOH (1984) Clinic Survey Report and Recommendations. Health Planning Unit, Mbabane, & Health Planning and Management Project International Assistance Programs Inc. New York, New York.

MOH (1983) National Health Policy. Ministry of Health, Mbabane.

Nxumalo, K.B.T (1979) The Survey of Roles, Tasks, Needs and Skills of Rural Women in Swaziland 1978/1979. Government of Swaziland, Ministry of Education and UNICEF.

Sachs, C & Roach, C. (1983) "Women and Agricultural Production on Swazi Nation Land". Swaziland Cropping Systems Research and Extension Training Project, Center for Women in Development, South-East Consortium for International Development, Washington D.C.

Swanepoel H. J. & de Beer F.C. (1983) "Community Participation Swaziland's Rural Development." Africa Insight Vol. 13(2).

Tabibian, N. (1983) "Swazi Women's Income Generating Activities". Division of Extra Mural Service, University of Swaziland/Centre For International Education, University of Massachusetts.

UNICEF (1984) Report on Swaziland. January, Maputo.

WHO (1985) Women, Health and Development. A Report by the Director General. WHO Offset Publication No. 90. World Health Organisation, Geneva.

WHO (1987) The Role of Women's Organizations in Primary Health Care with Special Reference to Maternal and Child Health Including Family Planning. Report of an Inter-regional Meeting, 23th-26th November 1987, Jakarta.

Alakija, W. (1984) "Method of Child Delivery in Benin City and its Environs" Journal of Tropical Pediatrics Vol. 30 Feb. pp. 48-49.

Homestead Head or other senior or responsible person

PARTICIPATION OF WOMEN IN PHC - SWAZILAND

Date of interview / / 19

HOMESTEAD IDENTIFICATION
(First Visit Only)

1. AREA

MIN-RDA

NON-RDA

2. ENUMERATION AREA NUMBER

--	--	--	--	--	--	--

3. HOMESTEAD NUMBER

--	--	--	--

4. NAME OF HOMESTEAD HEAD AGE

--	--

5. M

F

6. OTHER HOMESTEAD MEMBERS

6.1

ADULTS AGE 15 OR OVER			
NAME	M/F	AGE or APPROX.	Relationship to Homestead Head
1			
2			
3			
4			
5			
6			
7			
8			

HOMESTEAD IDENTIFICATION
(First Visit Only)

6.2

CHILDREN AGE UNDER 15 YEARS				
	NAME	M/F	AGE in years months if 0-5	Relationship to Homestead Head
1				
2				
3				
4				
5				
6				
7				
8				

7. Total Number Males

8. Males Aged 15 and Over

9. Total Number Females

10. Females Aged 15 and Over

11. Total Number Children Under 15 years

12. Total Number Children 0-5

13. Number of houses/Rondavels/huts

14. Number of cattle Goats Sheep Other(s) _____

15. Do the cattle belong to you? Yes No

16. If No, find out how many belong to him/her. (write down number or state in words what respondent says)

17. Crops grown: Maize Sorghum Peanuts Irish Potatoes
 Sweet Potatoes Tobacco Cotton Cabbage

Others (Specify) _____

18. Do you have a vegetable garden? Yes No

19. If Yes, who is mainly responsible for it?

20. When the crops are harvested from the vegetable garden, what do you do with them? Don't know Sell some of them Sell them

Use them for ourselves Other(specify) _____

21. If sold (in part or all), who keeps the money?

22. Where do you get water for home-use?

Rain River Stream Tap Where is tap?.....

Other (specify) _____

23. Does the homestead have a latrine(s)? Yes No or other form of toilet? If other specify _____
 (Interviewer, please check if said toilet exists).

PARTICIPATION OF WOMEN IN PHC-SWAZILAND

Date of interview ___ / ___ / 198__

Illness Recall Form/Use of Health Facilities

1. Homestead Number

2. Name Homestead Head

3. Person for whom form is filled in

(a) Pregnant woman

Name

(b) Lactating mother

Name

(c) Child aged 0-5 M F

Name

4. If (c) Relationship of [child to] interviewee:

- Mother
- Grandmother
- Sister
- Aunt

Other (specify)

5. Complaint:
- Diarrhoea
 - Vomiting
 - Diarrhoea/vomiting
 - Cough
 - Chest pain
 - Other (specify)

6. What was done about it?

- (a) Nothing if (a) Why?
- Went to (b) Clinic Name
- (c) Hospital Name
- (d) Health Centre Name
- (e) Traditional Healer Specify type
- (f) Home remedy(ies) Name
- Why?
- (g) Other (specify)

7. Why did you go/or take child to (b) (c) (d) (e) (g) _____

If answer is (b) to (g), who made the final decision?

- (a) Self (b) Husband (c) Homestead Head
- (d) Brother (e) Brother-in-law (f) Grandmother
- (g) Grandfather (h) Sister (i) Other(specify)

8. If answer to No. 7 is not (a) ask, "Did you in any way live & say in deciding what to do?" Yes No

If yes, what did you do?.....

If No how was decision reached? (Please write down as best as you can interviewee's account of how decision was made)

.....

9. Visited (clinic/hospital etc. specify).....

10. Reason. Immunizations Ante natal other (specify).....

ANNEX 3

FORM II (a) PART B

Mothers of children 0-5 yrs

Pregnant and/or lactating women

Guardians of children 0-5 years

PARTICIPATION OF WOMEN IN PHC-SWAZILAND

Date ____ / ____ / 198__

Name of Homestead Head.....

Homestead Number

Name of Interviewee.....

To be asked on first visit to homestead (all in sample)

1. Do you know about health services for mothers and children?

Yes No If yes, where can you get them from?
(Name of health facility)..... Dont know
N/A

2. (If yes,) Can you name any of the services given?

Mothers
Ante-natal

Children
Weighing

Vaccinations
(Immunization)

Vaccinations
(Immunization)

Weighing

Treatment
(specify) _____

Health education

Nutritional advice for
pregnant women

Other (specify) _____

Mothers

Children

Delivery	
Post-natal	
Family Planning	

Treatment (specify) _____

Other (specify) _____

3. When did you first hear about these services?

4. Do you know what the vaccinations are for? Yes No

If yes state for (a) Child

(b) Pregnant woman

5. If immunizations/vaccinations mentioned, ask how many (and tick)

	1	2	3	4
(a) a pregnant woman needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) a child needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4

6. Of the children aged 0-5, have these children been vaccinated?

Yes No Dont Know N/A

If yes (tick which is mentioned/shown on immunization card)

Vaccinations Received

<u>Name of child</u>	BCG	DPT I POLIO	DPT II POLIO	DPT III POLIO	Measles
1					
2					
3					
4					
5					
6					
7					

7. If the children have been vaccinated, who decided to have them vaccinated

8. (Ask mothers of 0-5) When you were pregnant with Name
 Did you go to the Clinic/ Hospital/ Health Centre?

Yes No Dont know Cannot remember

If yes what did you go for?

9. (If woman currently pregnant, ask) Do you go to the clinic now that you
 are pregnant? Yes No N/A

If yes, what do you go for? (or if she says she did go, what did she go
 for?).....

10. Do you know any women's organizations in this area?

Yes No N/A

If yes which? Lutsango Zenzele Other (specify).....

11. (If answer in 10 is yes ask) Do you belong to any organization (or to this organization?) Yes No N/A

If yes what are the activities of your organization?.....

12. Which is the nearest clinic?.....
 Dont know N/A

13. Do you know any traditional healers in the area? Yes No NA

14. (If yes) what type are they (e.g. Inyanga, sangoma)..... and how do they heal people?..... N/A

15. What about traditional midwives, are there any in this area?
 Yes No Dont know N/A

16. (If No or Dont know) Who usually helps women deliver if they have their baby at home?.....

17. Have you heard of Rural Health Motivators? Yes No
 Don't know N/A

18. (If yes) Do you have one in your area? Yes No
 Don't know N/A

19. (If yes) Has she/he ever visited you? Yes No N/A

PARTICIPATION OF WOMEN IN PHC-SWAZILAND

Date of interview ____ / ____ / 198__

INTRA-FAMILY DECISION-MAKING

(First visit only)

Health Related Decisions

1. Homestead Number
2. Name-Homestead Head.....
3. MIN-RDA ; NON-RDA
4. Interviewee (name).....
5. Relationship to Homestead Head: Only wife First wife
2nd wife Daughter Mother Mother-in-law
other (specify).....
6. Does homestead have vegetable garden? Yes No N/A
7. What is grown?.....
8. Who is mainly responsible for it?.....
9. Whose idea was it to have the garden?.....
10. What do you do with the vegetables?.....
11. (If vegetables sold in part or all) Who keeps the money from the sales?
..... Why?.....

- 12. What is the money used for?.....
- 13. When someone in the house is ill and has to be taken to the clinic, or to the traditional healer, or medicine bought for them, who generally decides about the money to be spent?.....
- 14. What about money for buying for example sugar, salt or clothes, who controls that? (If they say homestead head, ask, what if he/she is not there?).....
- 15. Who is responsible for cooking?.....
- 16. Who decides what to cook?.....
- 17. When the food is ready, how is it shared?.....

OBSERVATIONS:

- 18. Notes to be made each time on the following:
 - 18.1 **Cleanliness** around the homestead, who does the cleaning? Who directs the cleaning?
 - 18.2 **Childcare** Who looks after the children 0-5 years? (Write down your comments about everything you observe e.g. feeding, are hands washed, or plate etc.).....
- 19. On each visit make sure you observe who is working on the vegetable garden if there is one, or if it is the garden for maize etc. and generally what is going on in the homestead especially with the women and children.....
- 20. If there are new items purchased, whether food, clothing etc. who decided that such an item was required, but if difficult to ask observe and write down comments later.

PARTICIPATION OF WOMEN IN PHC-SWAZILAND

Date ____/____/198__

INTRA-FAMILY DECISION-MAKING

Health Related Decisions (Subsequent Visits)

1. Homestead Number

2. Name-Homestead Head

3. MIN-DRA ; NON-RDA

4. Vegetable garden

4.1 Who is tending it?.....

4.2 Sale of Vegetables: Have vegetables been sold?

Yes No N/A

4.3 (If yes) Who kept the money from the sale?.....

4.4 Has the money been used? Yes No N/A

4.5 (If yes) What was it used for?.....

5. Illness in the family

5.1 Has anyone in the house been ill? Yes No N/A

5.2 (If yes) Name of person.....

5.3 Was person given home remedy (describe it).....
 taken/went to traditional healer
 taken/went to clinic/hospital
 bought medicine from shop

5.4 How much money was spent? (approximate amount).....

5.5 What was it spent for? Medicine from shop
 Medicine from traditional healer
 Fee for traditional healer
 Transportation
 Other specify _____

5.6 Who decided that money should be spent for this?.....

6. Food distribution If following were eaten yesterday, who got the most, least and none?.....

6.1 Vegetables (state which vegetable and who got most).....

Who got the least?.....

Who got none?.....

6.2 Meat/beef Who got the most?.....

Who got the least?

Who got none?.....

6.3 Meat/chicken Who got the most?.....

Who got the least?.....

Who got none?.....

6.4 Milk (Emasi) Who got the most?.....

Who got the least?.....

Who got none?.....

6.5 Other?

Who got the most?

Who got the least?

Who got none?

PARTICIPATION OF WOMEN IN PHC-SWAZILAND

OBSERVATIONS/ (Participation) at Women's MEETINGS

NB: After this meeting please make appointment to interview group leader(s)

1. ENUMERATION AREA NUMBER

--	--	--	--	--

2. Name of AREA.....

3. Name of Women's group.....

4. Date of Meeting ___/___/198___

5. Does it have a "leader" (i.e. President, chairperson etc.)?.....
Yes No

If yes who is it

6. Proceedings

6.1 Topic(s) discussed (a)..... (b)..... (c).....

6.2 Who brought it up? (a)..... (b)..... (c).....
(Chairperson, individual woman etc.).....

6.3 Do $\frac{1}{2}$ or more of the women take part in discussions or are they mainly listeners? $\frac{1}{2}$ or more take part
 $\frac{1}{2}$ or more mainly listeners

6.4 Does it appear that some identifiable women are more listened to, or that they are "influential" in the meeting? Yes NO

6.5 Describe proceedings and explain what you mean by answer in 6.4
.....
.....

6.6 How did this group start? (ask group leader or person who was member from beginning)

PARTICIPATION OF WOMEN IN PHC-SWAZILANDWOMEN'S GROUP LEADER(S) INFORMAL INTERVIEW
(TAPE RECORDER)

1. ENUMERATION AREA NUMBER

--	--	--	--	--
2. NAME OF AREA
3. DATE ____ / ____ /198 ____
4. Could you please tell me your name and a little bit about yourself?
5. What is the name of your group?
6. How did it start?
7. How many women were in the group when you started?
8. What are the groups' activities?
9. (If nothing on health mentioned) Do you do any activities related to health?
10. (If yes to number 9) what are these activities?
11. (If not mentioned in answer to Number 10 Has your group been involved in building latrines, setting up water taps or wells?
- (If yes ask) Can you tell me a bit about the (latrine building) (water taps) (well (s) or any other related activity if any?
12. What do the husbands and men of this area think of your group?
(Do they think it is a good thing? Have they ever made any comments to you about it?)

13. Are there any other groups/or is there a group or activities in this community in which women take part? (That is, activities which involve everyone). (If yes) please name them?
14. What is usually discussed in these groups/meetings/(or if activities what are they)?
15. Do women speak up if matters concerning them are brought up, for example digging wells, building a clinic?
16. In your group, can you say there are some women who are more active and/or vocal than others? (If yes) Can you tell me who these women are? (Their names and name of Homestead Head if they are not the Heads.)
17. (a) Finally, Do you think your group's activities have made/or will make any differences in the lives of the women in the group?

(b) Have the activities made any differences to/or contributed to the community? (If yes) How?
18. If health activities have been mentioned, how have these made any differences? (ask item by item)

ANNEX 8

FORM IV
Regional Level
Tape Recorder/Notebook

PARTICIPATION OF WOMEN IN PHC-SWAZILAND

INFORMAL INTERVIEWS WITH REGIONAL STAFF

1.

DATE	INTERVIEWEE	MEMBER, REGIONAL HEALTH MANAGEMENT TEAM		M/F	REG. HOSP.	PHU	OTHER
		YES	NO				
	Senior Medical Officer						
	Matron, Regional Hospital						
	Matron, Public Health unit						
	Regional Health Administrator						
	Other (specify) _____						

2. MCH SERVICES

2.1 Could you tell me how the MCH services in Shiselweni Region are organized?

2.2 What services are offered for (a) mothers (b) children?

2.3 How many health facilities in this region offer MCH services?

2.4 How many of these are (a) company (b) mission (c) private (d) government

2.5 How often are these services provided? i.e daily, weekly?

155

- 2.6 Do you have mobile services? How many? How often are they run?
Who runs them?
- 2.7 Who is responsible for dispensing MCH services at clinic level?
- 2.8 Is this person trained in MCH?
3. Do you have staff meetings to discuss specifically MCH services and the problems and/or other issues that staff may be encountering?
4. What are some of these issues/problems?
5. (If yes) How often do you have meetings?
6. Who decides on the scheduling of services?
7. If there are certain issues requiring a decision, for example, what days to immunise the children, who is likely to decide?
8. Are the clients/patients involved in any activities at the clinic/hospital/HC? If yes what activities?
9. If there are complaints concerning the services provided or about the provider (e.g. nurse) is there a person or a place the patients/clients can go to? If yes who or where?
10. What are some of these complaints?
11. Do you think, the MCH services in Shiselweni need improving? How?
12. What is your role in MCH services?
13. When is your next staff meeting? Is it alright if I came along?

14. Could you tell me a bit about other health care services within the communities, that is, apart from the government, mission and company ones? Can we start with
 - (a) traditional health care services (healers, midwives, herbalists)
 - (b) Self care
15. How many Rural Health Motivators do you have in this Region?
16. What is their main function/duty?
17. Do they get any training in maternal and child health? What specifically?
18. How long is the training?
19. What has been the reaction of the communities to RHMS?
20. Could you tell me a bit about the position of women in rural areas i.e. their status?
21. It is said that women in Swazi homes are not allowed to make decisions, or rather, that they defer to their menfolk. How true is this?
22. What of decisions concerning health matters e.g. a child is sick, has diarrhoea, or the woman is sick? Who decides what should be done? Could you talk a bit about this please?

PARTICIPATION OF WOMEN IN PHC - SWAZILAND

Client/Patient Satisfaction with Services

- 1. Date _____/_____/_____ 198__
- 2. Name of Clinic.....
- 3. Area
- 4. What are you here for?

MOTHERS

Ante-natal

Treatment

CHILDREN

Weighing

Vaccinations (TT)

Other (specify)

Vaccinations

Weighing

Health Education

Other (specify) _____

Nutritional advice
for pregnant women

Delivery

Post-natal

Family Planning

- 5. Is this your first visit to this clinic? Yes No N/A
- 6. When did you start coming to this clinic?

108

7. Who decided that you should come (or start coming) to the clinic?

Myself

Husband

Mother-in-law

Mother

Other (specify) _____

8. Why did you/they make the decision? Dont know

N/A

9. Where do you live?

10. Have you been to any other clinic(s) for these services?

Yes

No

N/A

11. (If Yes) Which one(s)?

12. Do you have any complaints about services here?

Yes

No

13. (If Yes) Have you told anyone about them?

Yes

No

14. (If Yes) Who have you told?

Clinic Nurse

Other (specify) _____

15. Is there anything you think is not right/good at this clinic?

Yes

No

Dont know

16. If Yes, can you tell me what is not good about it?

ShorLage/No Drugs

Too far

Shortage of staff

Other (specify) _____

17. Do you think services in this clinic can be improved?

Yes No Dont know

18. If Yes How?

19. If No why not?

20. Have you ever come to the clinic for anything else apart from the MCH
or other health services Yes What? _____

No

PARTICIPATION OF WOMEN IN PHC - SWAZILAND

HEALTH STAFF ATTITUDES TOWARDS PATIENTS

1. Date ____/____/198 ____

2. Name of clinic

3. Area

4. Interviewee

Registered Nurse	<input type="checkbox"/>
Nurse Assistant	<input type="checkbox"/>
Nurse/Mid-Wife	<input type="checkbox"/>
Other (specify _____)	

5. Sex

Female	<input type="checkbox"/>
Male	<input type="checkbox"/>

6. Facility

Government	<input type="checkbox"/>
Mission	<input type="checkbox"/>
Company	<input type="checkbox"/>
Private	<input type="checkbox"/>
Other (specify _____)	

161

7. What MCH Services are offered here?

SERVICE	TICK if offered	NUMBER OF TIMES PER WEEK				OTHER (SPECIFY)
		DAILY	ONCE	TWICE	3 TIMES	
Child Immunization						
-Antenatal						
Delivery						
Health education						
-Weighing children						
Post-natal						
Family planning						
Other (specify)						

8. Are you trained in MCH? Yes No

9. For how long have you been working here?

1 month 1-3 months 3-6 months 6-12 months
 1 year - 1½ years 1½ years - 2 years 2 years

10. What is the average daily attendance for MCH Services

10 ; 10-20 ; 20-30 ; 30-40 ; 40-50
 Over 50 (Please note down number _____)

162

11. Do you have a clinic committee? Yes No N/A

12. Who are the members?

13. What is its main function?

14. Do the women who use MCH services come to the meetings?

Yes No N/A

15. (If No) Why is that? Dont know They are not interested
N/A Other (specify) _____

16. Do you think women patients should be involved in

(a) Scheduling clinic sessions? Yes No Dont know N/A

If Yes why,

If No why not?

(b) Deciding whether to transfer a nurse if they are dissatisfied with her? Yes No Dont know N/A

If Yes why?

If No why not?

17. Do you visit homes in this area? Yes No N/A

If yes how often?

18. What is the reason for the visit(s)?

19. Are there any COMMUNITY health activities in this area?

Yes No Don't know N/A

20. Are you involved in these activities? Yes No N/A

21. How many women in the community are involved?

22. Is there anything you think is not right/good at this clinic?

Yes No Dont know N/A

If yes what? No drugs Too far Other (specify) _____

23. Have you ever had complaints about the services here?

Yes No N/A

If Yes from whom?

24. What is done about the complaints?

25. Do you ask the patients to tell you any complaint they have about the services?

Yes No N/A

26. Do you think services in this clinic can be improved?

Yes No Dont know N/A

27. If Yes how?

28. If No why not?

29. Do you have staff meetings? Yes No N/A

30. If yes, how often do you meet?

31. When is your next staff meeting?

32. Can you tell me some of the problems you have or have had while working at this clinic/in this area? (e.g. with clients, with the community, lack of equipment).

.....
.....
.....

ANNEX 11

FORM VI

"Bogogo" or
grandmothers

PARTICIPATION OF WOMEN IN PHC - SWAZILAND

TRADITION/PRACTICES/BELIEFS/ATTITUDES ON MCH

-
1. Enumeration Area Number -----

 2. Homestead Number -----
 3. Name of Homestead Head
 4. Name of Interviewee
 5. Age of Interviewee
 6. Date ____ / ____ /198__
 7. PREGNANCY
Can you tell me broadly about pregnancy in Swazi culture?
 - 7.1 When do you tell the mother-in-laws that you are pregnant?
 - 7.2 Usually, whom do you tell first?
 - 7.3 Is there anything that is done when it is known that you are pregnant?
 - 7.4 If there is anything given to the pregnant woman for protection of her and the unborn baby, what is it? And how does it help her and the unborn baby?
 - 7.5 If the woman is given some medicine for rubbing or drinking, how long does it take for the medicine to work? Can you explain more about it?
 - 7.6 Is there any food which pregnant women are not supposed to eat according to Siswati custom? If yes, which one?
 - 7.7 According to Swazi custom which foods is she supposed to eat?
 - 7.8 What sort of things is the pregnant woman not supposed to do? Why?
 - 7.9 Are pregnant women allowed to work like any other women around the homestead?

165

- 7.10 If she does not feel well, what is normally done?
- (a) When she vomits?
 - (b) If she bleeds?
 - (c) If she gets dizzy?
- 7.11 Do pregnant women come to you for help?
- 7.12 What do you do with a women who falls pregnant yet she still has a young child?
- 7.13 Traditionally, what do you do for a woman who cannot feel the baby's movement?
- 7.14 If a pregnant woman gets a miscarriage, how long is she supposed to stay before falling pregnant again?
- 7.15 If a pregnant women swells (hands and feet), what is usually done? What causes the swelling?
- 7.16 Nowadays, as you know, workers from Health Centres advise pregnant women to to visit the clinics regularly once they know they are pregnant. Do you think it's a good idea or a bad idea? If it's good, why? If it's bad, why?
8. CHILD - BIRTH
- 8.1 How do you know that it is time for a pregnant woman to deliver?
- 8.2 Those women who deliver babies at home, or those who cannot get to hospitals or clinics in time, who helps them when delivering the babies?
- 8.3 Does the woman who is going to help the pregnant woman deliver the baby know what to do?
- 8.4 Do you make any preparations before going to deliver the woman? Can you tell me about it?
- 8.5 What happens when a woman is delivering? How does she position herself when delivering? What do you use for cutting the umbilical cord? Is there anything you put on the baby's umbilical cord? If the woman bleeds heavily, what do you do?
- 8.6 If the woman has difficulty in giving birth or if the baby

FORM VI

"Bogogo" or
grandmothers

comes out with feet first, what do you do?

- 8.7 Would you like to be taught by the nurses and the doctors other methods of delivering babies? What things would you like to be taught? If you do not want to, why?
- 8.8 How long after the birth of her baby does a woman wait before having sexual intercourse with her husband?
- 8.9 For how long is a baby breastfed?
- 8.10 If a baby has naval cramps (colic) or has a spot on the head (libala), what is done to cure it?
- 8.11 If a baby doesn't like breastfeeding, what is done?
- 8.12 How long does a new-born baby stay in the house before being taken outside?
- 8.13 How long does the mother of the baby stay in the house before going outside?
- 8.14 Is a woman who has recently delivered allowed to enter the kitchen?
- 8.15 In which house does a woman usually give birth?
- 8.16 If a baby has been born and the placenta hasn't come out, what do you do?
- 8.17 If every time a woman delivers babies they die, is there anything done according to Swazi custom?
- 8.18 What do you do if a woman gives birth to a pre-mature baby?
- 8.19 If a woman gives birth to girls only, can anything be done for her to get boys?
- 8.20 If a woman fails to deliver (prolonged labour), what is normally done to help her?

9. CHILDCARE

Can you tell me about the caring of young babies?

- 9.1 When does the mother start to breastfeed the new-born baby? Is there anything else given to the baby besides breast milk? At what age do babies start eating other food? What

FORM V

"Bogogo" or
grandmothers

sort of food is given to the new- born baby?

- 9.2 What is given to babies to prevent them from diseases and bad spirits? Can you explain more about it?
- 9.3 These days we are encouraged to take our babies to hospitals and clinics so that they can be immunised against certain diseases. Do you think it is a good or bad thing? If it is good, why? If it is bad, why?
- 9.4 If a baby has diarrhoea, what is done? (according to Swazi customs)

10. CHILD-SPACING

- 10.1 If a woman does not want to fall pregnant again, are there traditional ways of preventing pregnancy? Could you tell me more about them?

INFORMAL INTERVIEWS

1. History - political organisation, Shiselweni, selected EAs
2. Geography - of Region, of selected EAs
3. Resources - farming, mines, ranching etc
4. Social amenities in areas under study e.g. schools, shops
5. Women's organisations, women's "activities"

PARTICIPATION OF WOMEN IN PHC-SWAZILAND
INFORMAL INTERVIEWS and SECONDARY SOURCES

1. Organization of MCH services nation wide, health policy:
2. Historical background of MCH services, and health services as a whole.
3. Interviews with staff
 - 3.1 MOH Headquarters: Planning Unit (and obtaining relevant published material)
Director Health Services/Deputy Director
Chief Nursing Officer
Personnel Unit
 - 3.2 Public Health Unit: MCH Consultant
Matron I/C
CCCD co-ordinator
Immunization Campaign
 - 3.3 Institute of Health Sciences: Specifically training curriculum for nurses on maternal and child health, home visiting, primary health care and "community participation"
 - 3.4 Health Education Unit: Relevant documents on MCH, Nutrition, etc. also visual aids produced for this.
4. Ministry of Agriculture: Nutrition, women's health related activities.
5. National Archives: Development of health services especially MCH
6. Donor Agencies: Voluntary agencies - particularly activities in Shiselweni. USAID, UNICEF Church organisation, etc.
7. University of Swaziland: SSRU, Sociology Department.
8. Questions: (MCH/FP Consultant, Medical Officer, PBC, Matron I/C PHU, I/C CCCD, I/C Immunization Campaign)

- 8.1 What MCH activities are being undertaken?
- 8.2 What does the programme entail?
- 8.3 How is it funded?
- 8.4 Is there sociological/anthropological research going on within the programme?
- 8.5 When did MCH activities start? When did they start in programme form?
- 8.6 What services are offered and how are they organized e.g. daily?
- 8.7 What are attitudes towards MCH/FP (child spacing) of women, and men?
- 8.8 What of demand of FP?
- 8.9 At organizational level, how many women are in top position? Are these decision-makers? Can staff list for PHU be obtained, also outline of individual duties.
- 8.10 Who is/are policy maker(s) on MCH issues?
- 8.11 Traditional Medicine: What effect/influence has this had on uptake of MCH/FP services?
- 8.12 What activities are undertaken under Public Health Unit?
- 8.13 How do you view your role here, not as a nurse/health worker, but as a woman in Swazi society?
- 8.14 How many women working on coordinating committee, and how many look at matters concerning MCH?
- 8.15 How often do you have staff meetings?
- 8.16 What are some of the things discussed?
- 8.17 Which of these come up frequently at meeting?
- 8.18 Can you tell me about this programme/project?

8.19 Do you involve women at the grassroots level?

What form does this involvement take?

8.20 What is the role of clinic nurses in MCH services?

9: National Archives:

9.1 Documents containing reference to health services, particularly services for mothers and children.

9.2 How did colonilists view health of women and children?

9.3 How many women/what women/involved in developing MCH services?

9.4 Documents on matters affecting development of health policies.

9.5 Documents specifically for Shiselweni District (now Region)

9.6 Other documents which may throw some light on development of health services in Swaziland.

9.7 Newspaper reports of problems, developments etc.

ANNEX 14

KNOWLEDGE AND PRACTICE OF CONTRACEPTION

Homestead Number and Name of Homestead Head	Mother of Children (Name)	Religions Affiliation (what church do you belong to)	Are You Married?						
			Yes				NO		
			Church	DC's office Registry	Traditional (Libovu)	Other (e.g. married to late husbands' brother)	Single	0	
47 Samson Phakati	Ntombie (d)	Apostolic Church							
19 Maphonyi Ndinisa	Jabu (d-in-law)	None				Just living with in-laws			

Do you know about FP		If YES, are you using any contraceptive			If <u>yes</u> who decided that you should use contraceptives? If decision was a joint one tick (✓) both e.g. "Myself" and "husband"					
Modern	Traditional	Yes	No	If yes which?	Myself	Husband	Boyfriend	Mother	Sister	Other (specify)

If <u>No</u> why are you not using any contraceptives					How many children would you like to have? Please indicate (F) for females and (M) for males						
Don't want to	Husband said NO	Boyfriend said said no	Want more children	Other reasons reasons	1	2	3	4	5	Don't know	Other
				Has not thought about it					2(F) 3(M)		
				I drink bicarbonate of of soda after intercourse					3(M) 2(F)		

ANNEX 1-5

SHORT FERTILITY HISTORY

AREA _____

* Relationship to homestead head.

Homestead Number (Name of Homestead head)	Mothers with or Guardians of Children aged 0 - 5	Number of Living Children	Total Number of Preg- nancies	Comments
56 (Ndlela Hlophe)	Zangle (w) † Gugu (sister-in-law)	3 7	5 9	. one miscarriage . child died at 2 years 2 children died at 2 years

FOR SELECTED HOMESTEADS FOR IN-DEPTH INTERVIEWING/OBSERVATION

1. What do women think of women's (their) situation (in Swaziland)?
2. Have they heard of "Health for All By the Year 2000" slogan? What of Primary Health Care? What do they think of it? What does it mean to them? Is it possible that there will be "health for all by the year 2000"?
3. General hygiene on the homestead - washing of clothes, bathing, sweeping yard etc., disposal of rubbish etc.
4. Women's problems - general but also their health problems, what are these?
5. Relationship with their spouses/mother-in-law.
6. Food distribution - also what is regular food i.e. what is cooked daily.
7. Do women think they should be given say in organizing health services for e.g. staffing and scheduling when clinics should be held?
8. When they have problems at clinic, (either with nurse or someone/something else) where do they lodge their complaints? Would they like to have a (facility) place where complaints about health services (and other problems) can be aired?
9. Community Participation in health - what does this mean to them?
10. When someone in the home is sick, especially children, and has to be taken to a (a) traditional healer, (b) clinic, (c) hospital, who decides? How is the decision reached? Through consultation with homestead head? Other relatives? Or does the woman decide, then go ahead i.e. take action?

11. In cases where she decides, does she tell her husband/or homestead head?
(As way of information only)
12. What about food - who decides when meat should be bought, or cow/goat/sheep slaughtered? What of other foods?
13. Women's "informal" networks
 - who are their friends?
 - when they have problems who do they call on - neighbour? relatives? etc.
14. Relationship between mother-in-law and daughter-in-law (makoti)
 - How powerful is the Mother-in-law?
 - How does makoti get on with mother-in-law?
 - Can she call on her for advice when problems arise between herself and her husband for example? Give specific example e.g. no money to feed children
15. Role of the church in women's lives
 - Are these used as occasion for social inter-action? What networks exist within church setting? Why do they go to church?
16. Where do the women come from? i.e. Are they residing in their home areas?
17. Does the land belong to them?
18. How do they spend their days? i.e. work done, visiting etc.

HOMESTEAD MEMBERS IN PAID EMPLOYMENT

(Homestead Head or other family member(s)
working away from home)

AREA _____

Homestead Number (Name of Homestead Head)	Person(s) working away / Name	Place of work (Name)	Does he/she send or bring money back? How often?
16 (Casbert Jele)	None	-	-
92 (Mashwibi Maziya)	Mashwibi Jabu Muzi	Johannesburg Manzini Johannesburg	Sends every 4 months Sends every month Never

ANNEX 18

DO MOTHERS KNOW WHAT THE CHILD'S WEIGHT CHART (Road-To-Health) IS FOR

Do you know what this (weight chart) is for?
If Yes, can you tell me what it is for?

AREA _____

* Relationship to homestead head

Homestead Number (name of Home- stead Head)	Mothers or Guardians of children aged 0 - 5 (name)	Yes	No	Comments (other)
03 (Myna Khanya)	Annah (d)* Mhlangile (d) Maggie (sister in law)	✓	✓ ✓	To check whether the child is growing well.

ANNEX 19

a. RESEARCH TEAM

NAME: Jean Rutabanzibwa-Ngaiza
Principal Investigator
Doctoral Candidate:
Evaluation and Planning Center for Health Care
London School of Hygiene & Tropical Medicine

NAME: Nohlanhla Mazibuko
Research Assistant (Hluti Area)
Secondary School (3 Years)
Previous work: Interviewer,
National Manpower Survey

NAME: Buzile Dladla
Research Assistant (Matsanjeni Area)
Secondary Schooling (2 years)
Previous Work: Interviewer,
National Manpower Survey

NAME: Celiwe Nkonyani
Research Assistant (TBA Interviews)
Secondary Schooling (3 Years)
Previous Work: Shop Assistant
Married with 3 Children

b. Journal Articles

Within the next six months, I plan to work on and submit for publication articles on: TBAs and their work in Swaziland, and Women's Decision-making concerning Fertility Issues. These will be submitted to Studies in Family Planning and Health Policy and Planning. However, your assistance in identifying other journals to which I can submit the articles will be greatly appreciated.

c. Evaluation of Experience as Part of Maternal Nutrition and Health Care Program.

It has been a great privilege to be part of a program which puts women's health issues first. The support from ICRW enabled me to 'finalize' the work which began in September

179

1985. More importantly for me, I was able to return to Swaziland and present the findings to the Ministry of Health. A one day seminar to present and discuss the findings, with about 70 invited participants is scheduled for July 10th 1989.

Twelve months in the life of a researcher can either appear like years, or only a few months. More often than not, one feels there is never enough time to explore the crucial questions! The twelve months with with the MNHCP has been no exception. Although the analysis was more or less on schedule, my other commitment, (the thesis!) meant that analysis of some variables focusing specifically on women (as opposed to mothers and children). e.g. food consumption data, has not been possible. However, the information will be incorporated into a future (planned) article on food distribution in Swazi homesteads.

The requirement that researchers submit a quarterly report has a disruptive effect on the work in that one has to put everything aside and concentrate on compiling a report. Perhaps half yearly reporting would be better.

Financial Constraints

Unfortunately, when the request was made for funding, the anticipated inflation rate was well below what is actually became! For instance, transportation costs were estimated at 40 Pounds per month but were but were in fact 50 Pounds. I had therefore to request permission from SAREC (Sweden) to use the remaining funds from the grant I received from them (1985/87), to supplement my monthly allowance. Fortunately, the request was granted.

To minimize worries and allow researchers to concentrate on the task at hand, the Program might consider having an 'emergency' fund to which requests for assistance can be made.