ASSESSING QUALITY OF CARE AND
RESPONSIVENESS OF HEALTH SERVICES FOR
WOMEN IN CRISES SETTINGS.

SWAZILAND CASE STUDY

Dr I. T. ZWANE, CONSULTANT FOR WHO

JUNE 2005
Acknowledgements

As author and principal investigator, I would like to express my acknowledgements to the invaluable support I and the research team received from the Ministry of Health & Social Welfare and World Health Organization. I would like to extend my sincere gratitude to research team members who worked with me at various stages of this project. These are Dr Isabella S Ziyane, Ms Eunice M Mabuza, both from the Faculty of Health Sciences of the University of Swaziland, and Ms Dudu Mbula Ministry of Health & Social Welfare for their assistance in formulating the research instruments. The WHO local office is also acknowledged for the support provided. Ms Dudu Dlamini WHO focal person for this study is recognized immensely for her support. The success of this study is an outcome of the commitment and tire-less efforts of the above-mentioned officers. The participation and contribution of the World Health Organization (WHO) during the preparations for the study is highly appreciated as well as the Tinkhundla, chiefdoms and service providers that were part of the study.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Clinics</td>
</tr>
<tr>
<td>ASRH</td>
<td>Adolescent Sexual Reproductive Health</td>
</tr>
<tr>
<td>CSO</td>
<td>Central Statistics Office</td>
</tr>
<tr>
<td>ESRA</td>
<td>Economic and Social Reform Agenda</td>
</tr>
<tr>
<td>FLAS</td>
<td>Family Life Association of Swaziland</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>HEU</td>
<td>Health Education Unit</td>
</tr>
<tr>
<td>HIS</td>
<td>Health Information System</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immune Deficiency Virus</td>
</tr>
<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education Communication</td>
</tr>
<tr>
<td>IMR</td>
<td>Infant Mortality Rate</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MI</td>
<td>Male Involvement</td>
</tr>
<tr>
<td>MOE</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>MOHA</td>
<td>Ministry of Home Affairs</td>
</tr>
<tr>
<td>MOHSW</td>
<td>Ministry of Health and Social Welfare</td>
</tr>
<tr>
<td>MTCT</td>
<td>Mother to Child Transmission</td>
</tr>
<tr>
<td>NDS</td>
<td>National Development Strategy</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>PAC</td>
<td>Post Abortion Care</td>
</tr>
<tr>
<td>REM</td>
<td>Rapid Evaluation Method</td>
</tr>
<tr>
<td>RHM</td>
<td>Rural Health Motivator</td>
</tr>
<tr>
<td>RHMT</td>
<td>Rural Health Management Team</td>
</tr>
<tr>
<td>RHU</td>
<td>Reproductive Health Unit</td>
</tr>
<tr>
<td>SB</td>
<td>Stillbirth</td>
</tr>
<tr>
<td>SHAPE</td>
<td>School Health AIDS Programme in Education</td>
</tr>
<tr>
<td>SNAP</td>
<td>Swaziland National AIDS Programme</td>
</tr>
<tr>
<td>SINAN</td>
<td>Swaziland Infant Nutrition Action Network</td>
</tr>
<tr>
<td>SDP</td>
<td>Service Delivery Point</td>
</tr>
<tr>
<td>SMI</td>
<td>Safe Motherhood Initiative</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TBAs</td>
<td>Traditional Birth Attendants</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>United Nations AIDS Programme</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WILSA</td>
<td>Women in Law in Southern Africa</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

BACKGROUND INFORMATION

The kingdom of Swaziland is located in Southern Africa and covers a surface area of 17,000 square kilometres. Swaziland shares borders with Mozambique in the east and the Republic of South Africa in the south, north and west. It is further divided into four administrative regions namely; Hhohho, Manzini, Lubombo and Shiselweni. Each region has an Administrator who is a political appointee and reports to the Deputy Prime Minister. The country is further subdivided into fifty five (55) administrative centres (Tinkhundla), under which there are about two hundred chieftancies. The Chiefs have control and authority of the country’s land. The legal system comprises a mixture of Roman-Dutch Law and the English Common Law and the unwritten Swazi Law and Custom. With a common language, culture and tradition, Swaziland is one of the few ethnically homogenous countries in Africa.

HIB/AIDS SITUATION IN SWAZILAND

Swaziland has been extremely affected by the HIV/AIDS pandemic. The prevalence rate among antenatal clients, as measured by the sentinel surveillance, has rapidly risen from 3.9% in 1992 to 38.6% in 2002, placing it among the worst affected countries in the world. The rapid rise has been consistent among the four regions, and is noted in urban as well as in rural areas. The worst affected age category among women appears to be the 20-29 year old, although the prevalence rate among teenage girls (15-19 years) was also extremely high (32.5%). Sero-prevalence data among men is scarce. A survey conducted among a high-risk population, namely sugar estate workers, in 2002 showed a similar high-prevalence rate of 37.5%. No population-based HIV sero-prevalence survey has ever been conducted in Swaziland. The Demographic and Health Survey (DHS) planned to be conducted in 2005, will include a biological component allowing a more accurate estimation of the population prevalence rates.

HEALTH CARE SYSTEM IN SWAZILAND

Health care at community level is ensured by the services provided by rural health motivators (RHM’s) whose duties include giving health talks, condom distribution, referrals, and advising communities on issues such as environmental sanitation, breastfeeding and general prevention of diseases. In addition to the formal health care services, traditional medicine is practiced through traditional healers/herbalists, etc.

The country has both private and public health facilities distributed around the country. The country’s health care delivery system is divided into three main levels namely the
clinic, which is the first level of contact and a primary health care unit, the health centres (HC) and the public health units (PHU), which is the second level of contact, and the hospital, which is the last level. About 80% of the total population resides within 8 km radius of a health facility. Antenatal care is offered at clinics as part of the services offered at the out-patient department and at health centres, PHUs and hospitals as part of the services offered at the maternal and child health department. More than 90% of pregnant women are reported to make contact with the ANC services at least once during pregnancy (Swaziland Community Health Survey, 2002). The health care programmes in Swaziland are coordinated at the central level by the Ministry of Health and Social Welfare (MOH&SW) and at regional level by the regional health management teams.

PURPOSE AND OBJECTIVES

The following were set out to:

1. identify local organizations providing health and social services to women
2. Determine key constraints/ challenges to women’s access to health and basic services
3. Recommend components of a health assessment tool that would be considered locally relevant and useful
4. Formulate concrete recommendations for action to increase women’s access to health and related social services for women in Swaziland

METHODOLOGY

The target population for this study was all women of child bearing age (15-49 years) living in Swaziland with the exception of those who were in special institutions such as prisons, mental health institutions, schools and universities.

A multistage sampling approach was used in this study as follows: Two of the four regions of Swaziland were selected using HIV prevalence in both urban and rural geographic settings. Enumeration areas were selected using the 1997 Census Enumeration sites. From the EAs households were selected using the circular systematic sampling method. Within households systematic random sampling was carried out to identify eligible women. Where there was only one eligible woman in a household, that person would be interviewed.

Sample size determination

Sample size was determined using the HIV/AIDS prevalence rates in the two selected study regions. These are Hhohho and Lubombo. These regions represent both urban and rural geographic settings of Swaziland. Lubombo region is typically rural. Sample size determination was calculated based on the national rural and urban HIV prevalence as indicated in the 8th Sentinel Survey (2002). The prevalence for the rural areas was reported to be 32.7% and 35% for urban settings. The formula adopted for the calculation of the sample assumed a normal distribution. The desired 95% confidence
interval for this difference of 2.3% was set to be between 5% to 25% giving a standard error of 5%. The sample size in each group was calculated using formula
\[ N = \frac{p_1 (100-p_1) + p_2 (100-p_2)}{e^2} \]
4475.7/25 = 179 women in each region. Oversampling was done to yield a total of 500 women.

**TRAINING OF FIELD WORKERS**

After the team was formed field workers had a two-day training on the study survey. Tools used for data collection were pretested at Ludzeludze Inkhundla which was not included in the study sample.

Interviews were conducted with women, family planning clients (exit interviews), maternity women (exit interviews), focus group discussions with women, and Heath care providers (nurses). Only one team collected data from the two regions.

**DATA HANDLING AND ANALYSIS**

Colour coding was done to distinguish data from each of the two regions that were studied. After each interview data was checked for accuracy and completeness. All questionnaires were kept in a safe cabinet to ensure that privacy and anonymity of participants was maintained. Data was analyzed using a computer software package, SPSS for descriptive statistics. Data from focus group discussions was analyzed using content analysis.

**LIMITATIONS OF THE STUDY**

The exclusion of women aged below 15 years and those above 49 is a limiting factor because needs identified in this sample cannot be generalized to apply to all women in Swaziland. Additional limitations arise from the fact that the time allocated to the study was very limited. This was coupled by inadequate funding for the study. Consideration of time and funding should form the basis for quality studies.

**KEY FINDINGS**

**OBJECTIVE 1 To identify local organizations providing health and basic social services to women**

Several organizations in Swaziland provide health and social services in Swaziland. These organizations include the following: Family Life Association of Swaziland (FLAS), Swaziland Action Group Against Abuse (SWAGAA), Women and Law (WLSA), Ministry of Health & Social Welfare, Social Welfare programme. Findings from analysis of these organizations indicate that services for women are diverse but uncoordinated. Women in rural areas do not know where to go for protection. This was as a result of lack of publicity of these organizations as most of them are located in urban
areas. Need for civic education was expressed as a means to get women educated about issues affecting them as a group.

**OBJECTIVE 2** To determine key constraints and challenges to women’s access to health and basic service.

Interviews were conducted with women and health workers.

**ECONOMIC FACTORS**

Women in this study were of low socioeconomic status as only 8.5% were in gainful employment. The majority (70.9%) earned their living through sale of fruits and vegetables, selling of clothes (hawkers) and some (20%) were just ordinary housewives and unemployed depending on their husbands for their livelihood. Women’s dependence on men makes them vulnerable to HIV and other STIs as these women do not have the power to negotiate for safer sex.

**SOCIO-CULTURAL FACTORS**

In Swazi culture married women remain legal minors. Marital power recognizes men as head of family and the wife’s position is a perpetual minor. Group rites are mainly defined in family, kinship and clan arrangements defined in patriarchal terms. Findings from this study indicate that group decisions over individual decision making prevail as only 14% of the women reported that they make decisions on their own. For the remaining 84% decisions within households are made by husbands (45%), fathers-in-law (5%), mothers-in-law, and grandmothers (2%).

**PHYSICAL BARRIERS**

Majority of women (70%) reported to rely heavily on public transport (at a cost) to get to a health facility. A nearest facility was viewed as near if it was within 8kilometres radius, far if it was more than 10kilometre radius of walking. Thirty two percent (32%) of the women reported that distance was an issue that hinders access to health care especially during rainy seasons because of the topography of the country and low bridges especially in rural areas. Lack of ambulances at community level promotes difficulties in accessing needed healthcare. Without money for the public transport it can be very difficult for women to get to a health facility. Generally women were satisfied with care received at health facilities. Waiting time was viewed to be long by other women (10%). However, they recommended that health staff need to improve on their attitudes, they also recommended that medicines and diagnostic facilities should be made available at all health facilities.

This finding clearly indicates the need for more health facilities in communities so that all citizens are afforded with the care they need. Expansion of maternal health services to improve access needed. One option is to increase outreach services to the "unreachable" areas. Another option is to expand existing facilities by integrating sexual and
reproductive health services in the existing facilities, a move that will encompass policy review and planning and management considerations.

4.1.1 Affordability of health services by women.

One of the key components of primary health care approach to which Swaziland subscribes states that health care has to be affordable to all citizens at costs that are affordable. The situation in Swaziland is that there is a standardized user-fee of E10.00 (US$1.50) that the patient has to pay for all services received including consultation and prescriptions. This user-fee applies to all and is required before treatment by all government health care facilities. As many women are in poor situations, for some clients may seem adequate while for some it may be viewed as a constraint for women to access medical help. An economically disadvantaged woman without the E10.00 may be denied of services that she needs. For the women studied most of them were not in any gainful employment and having to pay for medical services may render the service inaccessible, thus denying a woman who may be in need of medical care is given.

In emergency situations, none of the health care providers reported having denied a woman of treatment that she needed except for one nurse who said that in her clinic patients who do not have the E10.00 do not receive treatment any even in cases of emergency.

WOMEN WITH ACCESS TO SAFE WATER

Findings in this study indicate that women (26.5%) get their water supply from unprotected wells and rivers, piped communal water sources 44.4% and only 28.9% received water from safe sources such water piped into houses. The finding indicates that there is still more work needed to ensure water coverage to all citizens of Swaziland as waterborne diseases are a major problem which contributes to the vicious circle that people are in. This problem is further compounded by the lack of medicine to treat ill people. Lack of safe drinking water, a gender-based division of domestic chores (including the carrying of water), environmental hazards, such as contact with polluted water, agricultural pesticides and indoor air pollution, all have a cumulative negative impact on the health of women.

COMPREHENSIVE PRIMARY HEALTH CARE

The MOH&SW offers a wide range of services of primary health care services. Rural health motivators and Traditional Birth attendants compliment trained health care staff in the provision of some of these services. Information regarding availability of RHMs and TBAs was sought. Although nearly all could not tell the actual numbers of RHMs and TBAs they reported that such community health workers were available in their communities. They further stated that the work that these two cadres are involved in is referring clients to health facilities, provision of treatment to minor ailments, provision of
home based and sometimes TBAs conduct deliveries in the absence of a midwife. The RHMs and TBAs also provide education on general hygiene and personal hygiene and cleanliness.

**Legal representation for women**

The platform for Action and Beijing Declaration adopted by governments at the 1995 Fourth World Conference on Women recognizes that the transmission of HIV/AIDS and other sexually transmitted infections is sometimes a consequence of sexual violence. In such cases women and girls cannot negotiate for safer sex from their assailants thus placing them at high risks of contracting HIV. Sexual, physical, and psychological violence against women and particularly girl children has become a common feature in Swaziland. Men who are known to the women and children and children, such as close relatives who are supposed to offer them protection, perpetrate most violence. Such a situation makes it even more difficult for them to remove themselves from the violent situations. Most women are often forced to have multiple sexual partners in order to survive and stay with violent. In this study women revealed that in their communities violence against women was common. 26.3% reported to have been abused either sexually or physically, 73.7% were never abused. From the interviews it appeared that there were no structures in place that were for the protection of women against violence. However when the views of the women were sought regarding protection of women, community police were cited as one method of curbing the problem. The structure of community police emerged as a neighbourhood watch type group in 1996. This structure has projected itself as an extension of the law, which is supposed to work together with umphakatsi (chief’s residence) as well as the Royal Swaziland Police. Women feel that perpetrators of abuse should be severely punished for their abusive acts.

**OBJECTIVE 3 To recommend components of a health assessment instrument that would be considered locally relevant for Swaziland**

In order to improve the welfare of women and the girl child there is need to:

- Review of customary and general laws for harmonization to eradicate existing conflicts that may occur.
- Inclusion of a Bill of Rights entrenching fundamental human rights and freedoms and explicitly providing for their protection.
- Ratification and incorporation (into national laws) of beneficial international instruments.
- The development of a Social Welfare System in any country is to eliminate social problems and offer an alternative to the traditionally recognized methods of assistance. The Social Welfare system in Swaziland is deficient in its commitment to addressing these problems and currently in need of reform. The following are
recommended actions that are made in order to improve the current state of the Social Welfare in the country:
(a) There is need to advocate and lobby government on the importance of social service provision, particularly with the increase of HIV/AIDS and its effect on the social situation of orphans, the elderly, careers, the disabled etc).
(b) It is recommended that the Draft policy be adapted and adopted if any improvement in the well-being of women is to be achieved.
(c) There needs to be a change in approach of the welfare system in the country, with more emphasis on developmental approach to reduce dependency and wean people of the state provisions.
(d) State subventions should be granted to NGOs that assist in the provision of social services.
(e) There is need to develop social policies that cater for the unique position of women

- It is recommended that the HIV/AIDS policy should take into consideration the plight of orphans, the elderly, disabled persons, women and cultural issues which fuel the pandemic.
- Prosecution should be made to offenders particularly those who knowingly spread HIV to minority groups (women, children, the disabled, poverty stricken etc).
- Statutory guidance on abortion is needed in order to give direction in the grey areas.
- The public should be made aware of abortion services and should be encouraged to use them, as ignorance is the main deterrent to its utilization.
- Sexual rights should be viewed as human rights linked to people’s right to health and national development.

- Reproductive rights and sexual rights should be viewed as human rights linked to people’s right to health and national development.
- Spousal rights to conjugal rights and procreation should be re-looked in view of the HIV/AIDS pandemic and individual’s right to life. This should be the case irrespective of the type of marriage a couple has contracted.
- Statutory guidance on sterilization to give guidance in the currently grey areas due to the generality of common law in necessary.
- Women and men should be allowed equal access to family planning services.
- The government should invest in awareness creation in the reproductive health, as ignorance in this area is the leading killer and undermining the country’s development.
- There is need to strengthen health education on reproductive health particularly to adolescents, women and men of childbearing stage.
- It is recommended that the draft policy on Reproductive Health be adapted and adopted if any improvement in Safe Motherhood Initiative is to be achieved.
- Gender roles, which seem to exist in the society, hindering women from accessing reproductive health services need urgent attention by the Swaziland Government.
- A comprehensive and coherently integrated programme of action should be enforced at national and regional level. The plan would emphasize on obstetric
and neonatal care, infant feeding practices, post-abortion counseling and care, family planning, adolescent and sexual and reproductive health, Sexually Transmitted Infections/HIV/AIDS, infertility, cancer screening and male involvement in sexual and reproductive health.

- A data base system for maternal and peri-natal statistic should be strengthened in order to be used for research purposes.
- Forums to discuss maternal and peri-natal mortality should be encouraged and well coordinated.
- Resource mobilization is necessary in order to improve the coverage and quality of reproductive health services and ensure equity in the allocation of national resources for care of the vulnerable and underserved groups.
- This calls for the reviewing and improvement of the present levels of funding for reproductive health services.
1 INTRODUCTION AND BACKGROUND

The kingdom of Swaziland is located in Southern Africa and covers a surface area of 17,000 square kilometres. Swaziland shares borders with Mozambique in the east and the Republic of South Africa in the south, north and west. The country is divided into four distinct topographical regions, namely: the Highveld, Middleveld, Lowveld and the Lubombo plateau. It is further divided into four administrative regions namely; Hhohho, Manzini, Lubombo and Shiselweni. Each region has an Administrator who is a political appointee and reports to the Deputy Prime Minister. The country is further subdivided into fifty-five (55) administrative centres (Tinkhundla), under which there are about two hundred chieftancies. The Chiefs have control and authority of the country’s land. The legal system comprises a mixture of Roman-Dutch Law and the English Common Law and the unwritten Swazi Law and Custom. With a common language, culture and tradition, Swaziland is one of the few ethnically homogenous countries in Africa.

Swaziland is ruled by a Monarchy, with executive and legislative powers vested in the King (Ingwenyama). The administrative system is dual in nature with traditional and modern values, practices and institutions co-existing and determining social, economic and political behaviours. The traditional government is based on Swazi tradition and custom, is headed by the King and Queen (Indlovukazi), and consists of chiefs, councils and other appointees grouped into administrative centres, the “Tinkhundla”. The King is advised by a standing committee- the Swazi National Council, a body comprising members of the royal family, chiefs and other citizens appointed by the King. Co-administrative existing with the traditional Tinkhundla system of government is the modern administrative structure headed by the Prime Minister made of the Cabinet and the Parliament whose members are elected by the public on a non-political party basis. The modern administrative structure consists of various sectorial Ministries headed by Ministers and run by Principal Secretaries.

According to the Central Statistics Office (CSO) the population of Swaziland is estimated at 980722 in 1997 (Provisional Census Data) increasing from the census figures of 374,697 in 1966, 449,534 in 1976 and 681,059 in 1986. These figures translate into an intercensal growth rate of 2.7 percent compared to a figure of 3.2 percent during the 1976-86 intercensal period. This implies a population doubling time of about 25 years. The country’s population is relatively young with about 45 percent of the population under 15 years of age, 60 percent aged under 21 years and only about 3 percent being 65 and older. About seventy (70%) percent of the population lives in rural areas. In Swaziland Youth is defined as a person aged 15-29 years, and make up about 28 percent of the population, while women of reproductive age represent 25 percent of the population. The median age of the population is about 16 years. The total fertility rate of 6.9 lifetime birth per woman recorded in 1976 dropped to 6.4 in 1986 and 5.6 percent in 1991, 5.8 percent in 1997 (CSO, 1997). The antenatal care coverage in Swaziland is fairly high. Nearly 98 percent of pregnant women attend antenatal clinics (ANC) at least once, two-thirds of the expetant mothers attend ANC at least five or more times. Despite the high attendance rate the quality of antenatal care is reported to be unsatisfactory.
The majority of mothers (more than two thirds) book late in the second and third semesters and only 56 percent of all projecte maternity cases actually deliver at health facilities. Nearly 44% of mothers deliver at home and are in most cases assisted by Traditional Birth Attendants (TBAs). Maternal deaths are frequent in Swaziland. In 1995 overall Maternal Mortality rate was 229/100000 live births. The majority of maternal deaths are attributed to preventable or treatable conditions such as haemorrhage (24%), hypertensive diseases of pregnancy (19%), sepsis (14) and other causes (24%) which include lack of clinical skills in handling obstetric and abortion emergencies. Shortage of doctors and adequately skilled midwives is another factor. The referral system is weak. TBAs pose additional problems by administering some form of heral oxytocins to expedite labour, offer minimal care to abnormal and complicated deliveries such as breach and multiple pregnancies which ideally should be referred (MOHSW, 1995).

Extrapolating the data from the latest census, conducted in 1997, the population is estimated at approximately 1,100,000 in 2004. The 1997 census showed that about 46% of the population is aged 15 – 49 years and the male - female distribution is 45% - 55%. The population of the Manzini region is slightly higher than the other three regions (30.2%). Manzini town is the largest town and the industrial centre of the country. The 1997 census also showed that a total of 66% of de facto household heads were female and 5.4% were aged below 20 years. Also according to the 1997 census, the majority (77%) of the Swazi population was living in rural areas with only 23% of the population living in urban or peri-urban areas.

As in many African countries, most people in Swaziland live on subsistence farming. About two thirds (69%) of the Swazi population live below the poverty line defined as E128.60 (about US$22.00) per month (Budget speech by the Minister of Finance, 2005); in spite of a high per capita income of US$1,350 (UN, 2003). Life expectancy in Swaziland has been reported to be declining from 65 years in 1991 to 38 years in 2002. It is projected that if current trends in HIV infection persist, life expectancy in Swaziland will fall below 30 years by the year 2010.

1.1 The Swaziland health care system

Health care at community level is ensured by the services provided by rural health motivators (RHM’s) whose duties include giving health talks, condom distribution, referrals, and advising communities on issues such as environmental sanitation, breastfeeding and general prevention of diseases. In addition to the formal health care services, traditional medicine is practiced through traditional healers/herbalists, etc.

The country has both private and public health facilities distributed around the country. The country’s health care delivery system is divided into three main levels namely the clinic, which is the first level of contact and a primary health care unit, the health centres (HC) and the public health units (PHU), which is the second level of contact, and the hospital, which is the last level. About 80% of the total population resides within 8 km radius of a health facility. Antenatal care is offered at clinics as part of the services
offered at the out-patient department and at health centres, PHUs and hospitals as part of the services offered at the maternal and child health department. More than 90% of pregnant women are reported to make contact with the ANC services at least once during pregnancy (Swaziland Community Health Survey, 2002). The health care programmes in Swaziland are coordinated at the central level by the Ministry of Health and Social Welfare (MoHSW) and at regional level by the regional health management teams.

1.2 HIV/AIDS/STI situation in Swaziland

Swaziland has been extremely affected by the HIV/AIDS pandemic. The prevalence rate among antenatal clients, as measured by the sentinel surveillance, has rapidly risen from 3.9% in 1992 to 38.6% in 2002, placing it among the worst affected countries in the world. The rapid rise has been consistent among the four regions, and is noted in urban as well as in rural areas. The worst affected age category among women appears to be the 20-29 year old, although the prevalence rate among teenage girls (15-19 years) was also extremely high (32.5%). Sero-prevalence data among men is scarce. A survey conducted among a high-risk population, namely sugar estate workers, in 2002 showed a similar high-prevalence rate of 37.5%. No population-based HIV sero-prevalence survey has ever been conducted in Swaziland. The Demographic and Health Survey (DHS) planned to be conducted in 2005, will include a biological component allowing a more accurate estimation of the population prevalence rates.

As the epidemic matures, the impact is becoming visible through an increasing number of patients suffering from AIDS opportunistic infections, an increase in mortality rates and a rapidly growing population of orphans and vulnerable children. It is estimated that the number of orphans, which was about 32,000 in 2001, will increase to over 120,000 (approximately 15% of the population), by 2010 (Stanecki 2001, Swaziland HIV/AIDS Modelling Mission Report). Already the problem of orphans is overwhelming the capacity of the extended family to cope and as such child headed households are on the increase, school drop outs, hunger and deepening poverty is evident in the population.

The Crude Death Rate (CDR) has increased, as a result of AIDS mortality, from 9.9 to 22.7 deaths per 1,000 populations and is projected to reach 30.2 deaths per 1,000 populations by 2010. If no action is taken annual AIDS deaths are projected to increase to around 22,000 by 2015, exceeding non AIDS-related deaths by nearly 20,000. The projected population size in 2015 is estimated at 1.58 million, about 41% lower than it would have been in the absence of AIDS. (World Bank 2001, Selected Development Impacts of HIV/AIDS).

In the education sector it is projected that there will be an increase in children not enrolled in primary school from 3.5% in 1999 to 30% by 2015. The quality of education may also decline due to increased HIV/AIDS related deaths among teachers. The ratio of teachers to students has shifted from 1:35 in 1997 to 1:52 in 2000 (MOE 1999, Impact Assessment of HIV/AIDS on the Education Sector). In the Health sector, the demand for hospital beds has increased with HIV/AIDS-related conditions taking up more than 50
percent of the beds. As a result there is generalised congestion in hospital wards, increasing the burden both at the hospital and at home. Regrettably the environment at home is ill prepared for this task and the family, affected by a reduction in income because of the loss of their productive members, are struggling to provide basic care.

One of the key features of the HIV/AIDS epidemic is that it affects the most productive part of the population (15 to 49 years). This has significant implications for the labour force, hence contributing to economic decline. The epidemic affects both the quality and quantity of labour supply in the economy. Highly trained and educated individuals are few and their replacement result in great national costs. Evidence from different studies indicates that the main cost to society is not the direct costs of medical care and prevention but rather costs resulting from the loss of economical production and the more complex and less easily estimated costs of social disruption and instability.

The prevalence of STIs, other than HIV, also continues to be high in Swaziland. Although the sero-prevalence of syphilis among antenatal clients (as measured by the sentinel surveillance using the RPR test) has gradually decreased from 11.6% in 1994 to 4.2% in 2002, it remains very high. In 2003 a first round of biological sentinel surveillance of STI among ANC clients at two selected clinics was conducted, showing prevalence rates of 7.8% for gonorrhoea, 18.2% for chlamydia infection, 7.8% for syphilis and 21.9% for trichomonas infection and thereby confirming high prevalence rates of STIs.

HIV infection by region

The increase in the level of HIV infection is consistent among the four regions and among urban and rural areas. Manzini region continues to be the region with a slightly higher level of infection than the other regions. Shiselweni region, that used to be the region with a slightly lower level of infection, has caught up with the Hhohho and Lubombo region and these three regions have now a similar level of infection.

Trends in HIV prevalence

Trends in overall HIV prevalence among antenatal clients

Table 1 and figure 1 present the trends in the overall prevalence since the beginning of the ANC sentinel surveillance in 1992. A steady and persistent increase is observed that continues in 2004. Figure 7 presents the increase in HIV prevalence between sentinel surveillance rounds. We note that the sharp increase (12.2%) between 1992 and 1994 gradually declined to 2.6% between 1998 and 2000 and has since then slightly increased again to around 4% between two rounds.
Figure 4: The prevalence of HIV among antenatal clients from 1992 to 2004

Figure 5 and Table 1: Trends in the level of HIV infection among antenatal clients, by region 1992-2004.

Source. 9th Sentinel sero-surveillance report 2004
HIV infection by age

Women aged 20 to 29 years continue being the age group worst affected. The increase in HIV infection is mostly due to the continued increase among women older than 25 years. A sign of hope is found in the stabilisation of the level of infection among young women 15 to 24 years old. In teenage girls (15 to 19 years) there was even a slight decline. This could indicate the start of a decline in the number of new infections and be a result of the interventions that therefore need to be intensified.

Figure 6: Trends in the level of HIV infection among antenatal clients 15 to 24 years old 1992-2004

![Graph showing trends in HIV infection among antenatal clients 15 to 24 years old 1992-2004]

Source. 9th Sentinel sero-surveillance report 2004

HIV infection by other characteristics

The level of infection is high among all women, irrespective of whether they are married or not, and the level is higher among women with a lower level of education. Women who tested positive for syphilis and women who reported STI complaints in the past 6 months had a substantially higher level of HIV infection.
The level of syphilis infection

The level of syphilis infection, as measured with the RPR test, continues high. In total, 8.1% of the women tested positive. There is even an increase compared to 2002, breaking the downward trend that was noted before. The number of women reporting genital complaints that could indicate a STI (genital ulcers and/or an offensive genital discharge) was also high. One in five women (20.4%) reported such a complaint.

Figure 7: Trend in the level of syphilis infection (RPR) among antenatal clients in Swaziland 1994-2004

Source. 9th Sentinel sero-surveillance report 2004
Figure 8: HIV prevalence rate by location of the site

![Bar chart showing HIV prevalence rates by location. Urban location has a higher prevalence rate compared to rural location.]

Source. 9th Sentinel sero-surveillance report 2004

HIV Prevalence by age

Table 11 and figure 4 present the age specific prevalence rates. The highest prevalence was found in the 25-29 years age group (56.3%), followed by the 20-24 years old (46.3%) and the 30-34 years old (41.0%). The prevalence in the 15-19 years age group was 29.3% and in the 35-39 years age group 30.9%. The prevalence rate in women 40 years and above was 38.0%, but caution has to be taken because of the small sample size in this age group.

Figure 9: HIV prevalence rate by age group
Figure 5 shows the HIV distribution by single year of age. Although caution has to be taken because of the small sample sizes in each single year of age, the figure clearly illustrates how HIV prevalence gradually rises to peak around 26 years and then declines to stabilise in the older age groups.

**Figure 10: HIV prevalence rate by single year of age group**
The prevalence rate in the 15-24 years age group is a national and international core indicator for measuring trends in the impact of HIV prevention interventions because it reflects recently acquired infections. It is presented by region in table 12. The overall prevalence in this group was 39.4%. The regional distribution follows a similar pattern as the distribution of the prevalence in all ages combined. Manzini region showed the highest prevalence (42.8%), followed by Shiselweni (38.8%), Lubombo (38.1%) and Hhohho region (37.3%). In addition, the prevalence rate in the 15-19 years age group, which reflects even more recent infections, is presented by region in the same table. Caution has to be taken in comparing between regions because of the small sample sizes.
CHAPTER TWO: LITERATURE REVIEW

This section of the report presents an abbreviated literature and review of policy documents that were reviewed for the study.

Access to health services is crucial for all women because they have ongoing reproductive health needs, suffer from more chronic conditions and are more likely to be poor- which means they are less likely to have private insurance and more likely to suffer from poor health than men. Because of their biologic make-up women are the most affected by the deadly HIV and AIDS.

In Swaziland Women's legal status represents a considerable constraint to their independence, equality, and development. All Swazis are subjected to two legal systems- Roman Dutch law and customary law. This situation has more profound implications for women. Under customary law women are regarded as minors passing from the control of their father or eldest family male to that of their husband. Customary marriages account for 80% of all marriages. Under customary law the only property which a Swazi woman can own is cattle acquired upon marriage, or her earnings and other property acquired through her work. Women are obliged to consult men even when their own property is involved. Under customary law a Swazi woman is obliged to obtain her husband’s or senior male member’s consent before doing things, including seeking health care for herself or her children. This situation hinders women’s access to health care (UNDP,1994). Too often in Swaziland women die from pregnancy and related complications of pregnancy. The majority of maternal deaths are attributed to preventable or treatable conditions such as haemorrhage (24%), hypertensive diseases of pregnancy (19%), sepsis (14%). Lack of clinical skills in handling obstetric and abortion emergencies (24%) and shortage of doctors and adequately trained midwives all lead to maternal mortality in Swaziland (WHO,2001).

Several studies have reported that a mother's health affects the health of her children. Women who are in poor health or poorly nourished are more likely to give birth to unhealthy babies, and often cannot provide adequate care, diminishing the chances their children will survive and thrive. The reduction in women's productivity also places an economic burden on their families, communities and societies. The death of a mother is devastating for her family. Studies in Bangladesh show that when a mother dies after giving birth

Gender inequities, sexual coercion, and violence by intimate partners undermine women's sexual and reproductive autonomy and jeopardize their health and well-being. Women who lack sexual autonomy often are powerless to refuse unwanted sex or to use conception and thus are at greater risk of unwanted pregnancies, STI's, and HIV. The reproductive health field is attempting respond to the need to address the conditions of people's sexual lives by sensitizing and training health workers, developing referral, and developing negotiating skills in both women and men. At the community level, efforts to bring about more equitable gender relations are ever more common. Pregnancies to very young mothers also carry increased risk for both mother and baby. Children born to
mothers under age 18 have a greater chance of dying before age five, compared with births to mothers aged 20 to 34. Teenage girls who are not physically mature are at greater risk of obstructed labor and complications during delivery. They are less likely to obtain prenatal care and to have the means to safeguard the health of their infants. Adolescent girls are also more likely to undergo unsafe abortions than older women. Even where abortion is legal, access may be difficult for unmarried girls. In many countries the number of abortions to adolescents is growing and unsafe abortion is a leading cause of death among teenage girls. AIDS kills people at the height of their reproductive and productive years, with devastating consequences for families, communities, and national economies.

At the International Conference on Population and Development (ICPD) in 1994, 179 nations agreed on a plan to advance human well being and slow population growth by improving access to health care, education and employment opportunities, especially for women. The conference emphasized the importance of providing good quality reproductive health services, including family planning, to all who need them, with particular attention to the social, economic and health status of women.

In sub-Saharan Africa, where HIV infection rates are the highest in the world, condom use is lowest, at 1 percent among married couples. With growing numbers of infections among women due to the increase in heterosexual transmission of HIV, women account for 55 percent of all infected people in sub-Saharan Africa. Comprehensive reproductive health services, especially care in pregnancy and childbirth and for sexually transmitted infections, are key to preventing disability and death and improving women's health. Better access to emergency care during childbirth and safe abortion services would also contribute significantly to lower maternal death rates. Family planning diminishes risks associated with frequent childbearing and helps reduce reliance on abortion.

In the face of the AIDS pandemic and the spread of other STIs, efforts to educate the public and promote condom use are critical. The threat of HIV/AIDS has also heightened the need for programs that help women and men-and especially young people-strengthen their communications and negotiating skills. An important obstacle to couple negotiation of contraceptive use and protection from STDs including HIV is that most women have unequal access to resources and decision-making. Yet women are more vulnerable to the consequences of unplanned pregnancies and often HIV/STI's. For these reasons, countering the prevailing gender stereotypes that increase risky behaviors and decrease couple communication is a key strategy for promoting good reproductive health. Ultimately, good sexual and reproductive health benefits everyone.

The risks associated with sexual activity and childbearing vary tremendously from country to country, reflecting differences in public health policies, income levels, and social and cultural practices affecting sexual relationships and access to healthcare. In developed countries, one woman in 2,100 dies during pregnancy or childbirth over the
course of her lifetime. The situation is quite different in the developing world where a woman's risk of death from maternal causes is 1 in 60, fully 35 times that of her developed country counterpart. More than a quarter of pregnant women in developing countries still receive no prenatal care and nearly half give birth with no help from skilled health personnel.

Improving the social and economic status of women, which greatly affect and are affected by poor reproductive health, is a vital concern. Increasing a woman's educational level and control over financial resources can improve her status within the household, thereby increasing not only her role in decision-making, knowledge about health and services available to her, and access to food and other resources that contribute to good health.
METHODOLOGY

This section of the report presents the methodology that was followed in conducting the study.

Target population

The target population for this study was all women of child bearing age (15-49 years) living in Swaziland with the exception of those who were in special institutions such as prisons, mental health institutions, schools and universities.

Sampling method

A multistage sampling approach was used in this study as follows:
Two of the four regions of Swaziland were selected using HIV prevalence in both urban and rural geographic settings. Enumeration areas were selected using the 1997 Census Enumeration sites. From the EAs households were selected using the circular systematic sampling method. Within households systematic random sampling was carried out to identify eligible women. Where there was only one eligible woman in a household, that person would be interviewed.

Sample size determination

Sample size was determined using the HIV/AIDS prevalence rates in the two selected study regions. These are Hhohho and Lubombo. These regions represent both urban and rural geographic settings of Swaziland. Lubombo region is typically rural. Sample size determination was calculated based on the national rural and urban HIV prevalence as indicated in the 8th Sentinel Survey (2002). The prevalence for the rural areas was reported to be 32.7% and 35% for urban settings. The formula adopted for the calculation of the sample assumed a normal distribution. The desired 95% confidence interval for this difference of 2.3% was set to be between 5% to 25% giving a standard error of 5%. The sample size in each group was calculated using formula $N = \frac{P_1(100-P_1) + P_2(100-P_2)}{e^2}$

$32.7(100-32.7) + 35(100-35)/5^2$

$(32.7 \times 67.3) + (35 \times 65)/25$

$22007.1 + 2275)/25$

$4475.7/25 = 179$ women

179 women in each region giving a total of 358 community women. The actual number of women interviewed was 500 women.
Study sites

Two regions were identified for inclusion in the study. Within these regions selected enumerations areas were identified. These sites included communities and health facilities.
In each region enumerations areas were selected such that there was representation of urban as well as rural geographic settings. Only one referral hospital was studied and four health facilities in each region were included for study.

Table 2: Study Sites

<table>
<thead>
<tr>
<th>Hhohho</th>
<th>Lubombo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mbabane government hospital (urban)</td>
<td>Siteki SEB (urban)</td>
</tr>
<tr>
<td>Lobamba (rural)</td>
<td>Siteki Public Health Centre (urban)</td>
</tr>
<tr>
<td>Motshane (rural)</td>
<td>Dvokolwako Health Centre (rural)</td>
</tr>
<tr>
<td>Sigangeni (rural)</td>
<td>Siphofaneni (rural)</td>
</tr>
<tr>
<td>Horo (rural)</td>
<td>Lomahasha (rural)</td>
</tr>
<tr>
<td>Msunduza (urban)</td>
<td>Matsanjeni (rural)</td>
</tr>
<tr>
<td>Fonteyn (urban)</td>
<td></td>
</tr>
<tr>
<td>Timphisisni (rural)</td>
<td></td>
</tr>
</tbody>
</table>

Table 3: Study sample  N=510

<table>
<thead>
<tr>
<th>Sample</th>
<th>Hhohho</th>
<th>Lubombo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community women</td>
<td>240</td>
<td>190</td>
</tr>
<tr>
<td>Family planning women</td>
<td>40</td>
<td>10</td>
</tr>
<tr>
<td>Maternity women</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>Nurses</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>310</td>
<td>200</td>
</tr>
</tbody>
</table>

Data collection instruments

Data collection instruments were developed to capture the quality of care offered to women and the responsiveness of health care facilities to women’s health needs. Factors such as physical barriers, health care provider attitudes, economic and social factors were included in the questionnaire. Exit interviews were conducted with women who had visited health care facilities to capture their satisfaction with care received. Focus group discussions were conducted with women and the youth in communities. These focus group discussions were intended to get deep insight in relation to what women feel about the care they receive. Three sets of instruments were used. One was for women at community level the other was used with health care providers at health facilities and the other was used to collect information from women postpartally and the other was used for exit interviews with family planning.
PRETESTING

Tools used for data collection were pretested at Ludzeludze Inkhundla which was not included in the study sample. The purpose of the pre-test was to ensure the tool was getting the information for which it was intended. Results of the pre-test showed that it was easy to administer and easy for the participating women to understand.

Data processing and analysis

Colour coding was done to distinguish data from each of the two regions that were studied. Data from Hhohho was coded in green whilst data from Lubombo was entered into white forms. The coding was done in order to ensure that quality was maintained throughout the data collection, data entering and data.

After each interview data was checked for accuracy and completeness. All questionnaires were kept in a safe cabinet at the office of the Consultant, Department of Community Health Nursing to ensure that only the researcher could have access to the information gathered. This was to ensure that privacy and anonymity of participants was maintained. Data was analyzed using a computer software package, SPSS for descriptive statistics. Data from focus group discussions was analyzed using content analysis. All questionnaires were numbered serially.

Limitations of the study.

The exclusion of women aged below 15 years and those above 49 is a limiting generalisability of findings to all women in Swaziland. Exclusion of women in prisons and other institutions further compounds the problem of generalization of findings. Additional limitations arise from the fact that the time allocated to the study was very limited. This was coupled by inadequate funding for the study. Consideration of time and funding forms the basis for quality studies.
CHAPTER FOUR: FINDINGS

This report is presented in sections. Section one presents the demographic profile of the women section two represents findings emanating from this study and section three presents an analysis of the policy documents that were reviewed.

The study was conducted by interviewing five hundred (500) women recruited from both urban and rural geographic settings in the Hhohho and Lubombo regions. The ages of the women ranged between fifteen and forty nine (15-49) years. The youth which is defined as not older than 29 years of age formed the majority (54%) of women in this study.

Table 4: Age distribution

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>24</td>
<td>4.8</td>
</tr>
<tr>
<td>20-24</td>
<td>95</td>
<td>20.6</td>
</tr>
<tr>
<td>25-29</td>
<td>143</td>
<td>28.6</td>
</tr>
<tr>
<td>30-34</td>
<td>79</td>
<td>15.9</td>
</tr>
<tr>
<td>35-39</td>
<td>75</td>
<td>14.3</td>
</tr>
<tr>
<td>40-44</td>
<td>63</td>
<td>12.7</td>
</tr>
<tr>
<td>45-49</td>
<td>16</td>
<td>3.2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>500</td>
<td>100</td>
</tr>
</tbody>
</table>

Education.

Nearly one third of the Swazi Population is illiterate. Although the national proportions for male and female are almost identical (36% for men and 37% for females). Older women are significantly less literate than younger counterparts. Findings of this study show that women (15.7%) aged above 40 years had attained some level of education while those (84%) who had attained some level of education were aged below 40 years. This finding is unacceptable as many studies have indicated that education is considered to be a key to economic and social progress because it changes peoples’ attitudes and provides skills which facilitate economic growth. Attainment of adequate level of education enables a person to make positive contribution to society. The education level observed in this study show that 10% percent of the women had never been to school. This finding was observed in both urban and rural settings included in this study. The percentage of secondary and college education was higher in urban sites than it was in rural settings. Lubombo region presents a picture of lower levels of education as compared to Hhohho region. This could be explained by the fact that Lubombo is considered more rural than Hhohho. This finding seems consistent with the Ministry of Health & Social Welfare (2000) report that 50% of respondents in the Lubombo region
were reported not to be doing well in terms of educational attainment. This finding is consistent with reports from other studies that Minority women face lower levels of education, higher levels of unemployment and poverty. Levels of education reported in this study show that education for women is to some extent low. as shown in figure

**Figure. showing distribution of educational status of women**

Marital status

Two hundred and ninety four (58.8%) of the women were married, 170 (34%) single, 16(3%) separated and 20(4%) were widowed.

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>294</td>
<td>58.8</td>
</tr>
<tr>
<td>Single</td>
<td>170</td>
<td>34</td>
</tr>
<tr>
<td>Separated</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>Widowed</td>
<td>20</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>500</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Residence

One hundred and forty four (28.8%) women resided in urban settings while 356 (71.2%) were in rural settings. This finding seems to confirm reports from CSO report that about 70% of the population of Swaziland lives in rural areas.

<table>
<thead>
<tr>
<th>Residence</th>
<th>Hhohho</th>
<th>Lubombo</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>99</td>
<td>45</td>
<td>144</td>
</tr>
<tr>
<td>Rural</td>
<td>201</td>
<td>155</td>
<td>356</td>
</tr>
<tr>
<td>Total</td>
<td>300</td>
<td>200</td>
<td>500</td>
</tr>
</tbody>
</table>

Fertility

Fertility is one of the most important demographic phenomena, which determines population change. High levels of fertility rates coupled with other factors such as migration into a country, low levels of deaths can result in high population growth which has a bearing on socio-economic development of the country. Fertility rate of women in this study was 4 with higher births in the rural than in urban areas. The highest number of children born per woman was higher in the rural that in the urban and among the youth (15-29years). According to the 1997 Population and Housing Census analysis report, the decline in fertility was first observed from 1886 where a decrease of about 2 lifetime births was observed in 1997. In this study number of births per woman ranged from 0 to 9, and the average number of children per woman was found to be 4. This observation could be explained by the fact that contraceptive usage is reported to be 33% which shows that family planning services are recognized and utilized by most women in Swaziland (Community Health Survey, 2002)

SECTION TWO

This portion of the report presents finding obtained through interviews with women. Key findings on constraints and challenges to women’s access to and basic services are discussed

Economic factors

In many developing countries including Swaziland women if employed are discriminated. The jobs they hold are in most cases inferior to those held by men. In this study only 8.5% were in gainful employment whilst 70.9 % were earning their living by selling fruits and vegetables including other odd jobs such goods such as clothes, blankets, dishes etc. Brewing of bear and hair dressing. Twenty (20.6%) were unemployed housewives. Lack of employment could explain the difficulties that women encounter. They remain dependent on men because of their poor economic status which could render women vulnerable to HIV/AIDS and other sexually transmitted infections as
they cannot negotiate for safer sex. They often fall prey to engaging in unprotected sex in order to gain money as it is reported in many studies.

**Socio-cultural factors**

There are risky cultural practices that men engage in or consent to and these put both partners at risk of HIV/AIDS infection. The cultural practices such as polygamy, wife inheritance, multiple sex partners and confinement are influencing men’s sexual behavior. However there are cultural practices such as the rights of passage and umcwasho that are positive to behavior change, but they need strengthening for them to be more effective. Married women in Swaziland remain legal minors despite the Age of Minority Act which recognizes majority at 21 years. Under the Marriage Act No.47/1964 women married in civil marriages “in community of property remain legal minors because of the marital power of their husbands, which entitles men and their families to control women and their properties. Marital power recognizes men as the head of the family and the wife’s position as a perpetual minor. It is acknowledged worldwide that the family as an institution plays a pivotal role in preserving and transmitting cultural values from generation to generation. The Swazi society is patriarchal in nature and therefore male interests tend to dominate over those of females. Swazi culture also tends to promote group rights over individual rights. Group rights are mainly defined in family, kinship and clan arrangements defined in patriarchal terms. A combination of patriarchy with preference for protection of group rights over those of individuals creates an environment conducive to marginalization of women and violation of their rights. The low status of women in Swaziland is further entrenched by a number of cultural practices such as polygamy, widow inheritance, the customary right of preferring male successors etc. In polygamy there tends to be competing for scarce resources.

In most cases, the women find themselves overburdened with responsibility of providing for all the family needs. The family plays a major role in determining what rituals and practices are performed. Women are subjected to the above practices do not ordinarily have authority to veto a family decision and their options are not considered. These practices marginalize and erode the human rights of women and militate against their full participation in national development. As a result of the cultural practices stated above human rights are not adequately protected. There is also imbalance in decision making capacity and sharing of responsibilities because roles are culturally allocated differently for men, women, boys and girls within the family. Swazi laws and customs relating to women are obsolete, and tend to negate any attempts to improve women’s rights.

Women in Swaziland never attain the age of majority and are answerable to a male figure in the family- father, husband, or brother in law. A husband’s consent is needed before family planning is prescribed. Many women who want to practise family planning are inhibited by their spouse’s lack of support. Minority women face lower levels of education, higher levels of unemployment and poverty, and the lack of private or public health insurance coverage. Women in polygamous relationships tend to compete for their husband’s attention by bearing many children; many still feel bound to produce a male child to carry on the family name. FLAS IEC research findings report that teenagers start
having sexual relations as young as 15. Family planning provision is hampered by the fact that in rural areas services are often available only one day a week. While most of the population receive their health related information from the radio, at least 10% of the population do not have access to this source of information. The inaccessibility of some areas due to poor roads and shallow bridges, especially during the rainy season is another obstacle (WHO, 2001).

Within marriages cultural beliefs often do not allow women to refuse a sexual proposal from their husband and women’s economic dependence on men can play a major role in sexual relations both within and outside marriage. In a survey of school aged girls in the Manzini region and Lubombo regions of Swaziland almost 30% believed that women engage in sexual relations with men for economic reasons and 13.9% believed that a girl could not refuse a sexual proposal made by a man. Improving the social and economic status of women which greatly affect and are affected by poor reproductive health is a vital concern. Increasing a woman’s education and control over her financial resources can improve her status within the household, thereby increasing not only her role in decision making, knowledge about health and services available to her and access to food and other resources that contribute to good health.

Decision making

Of the 500 women interviewed only 14% reported that they were responsible for decision making in their households. For the remaining 84% decisions within households were made by husbands (45%), joint decision was reported by 25% of the women, Fathers (5%) father-in-law 5%) mothers-in-law (2%) and grandmothers (2%) are also influential in making decisions within households. These findings demonstrate that women are denied the freedom to make decisions because according to Swazi culture family members play a dominant role in decision making. Women as individuals cannot make decisions even those decisions that affect their own lives.

Table shows distribution of decision making powers within households

<table>
<thead>
<tr>
<th>Person responsible for decision making</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>70</td>
<td>14</td>
</tr>
<tr>
<td>Joint (Husband and self)</td>
<td>126</td>
<td>25</td>
</tr>
<tr>
<td>Husband</td>
<td>225</td>
<td>45</td>
</tr>
<tr>
<td>Father</td>
<td>25</td>
<td>5</td>
</tr>
<tr>
<td>Father-in-law</td>
<td>25</td>
<td>5</td>
</tr>
<tr>
<td>Mother-in-law</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Mother</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Grandmother</td>
<td>9</td>
<td>1.8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>500</td>
<td>100</td>
</tr>
</tbody>
</table>
Despite the fact that men are the main decision makers, they often do not accompany women when they have to get medical attention at health facilities. Few men accompany women when they need to be transported to a health facility. There were very few women (3.4%) who reported that husbands accompany them to a health facility.

**Means of transport to health facility**

To assess the quality of care of health facility information was gathered through identifying time spent to reach a facility, distance taken and mode of transportation used to get to a nearest health facility. Fourteen percent (14%) reported that the clinics were quite close to their residence, as they took less than one hour travel. 52% reported that it took them about an hour, and according to them the distance was acceptable. However for the remaining 34% of the women the location of the health facility was reported to be difficult to reach as it took them two hours and more to reach. This finding means that access to a health facility could be constraining to some women. This situation could also mean that women do not receive medical attention that they need as they may be reluctant to go to a health facility because of the time it takes. Complications of pregnancy such as bleeding, and/or even rupture of the uterus could occur as a result of delayed medical attention. Death may be inevitable for women requiring emergency obstetric care that is not obtainable because of the time taken to reach a health facility. The figure below shows the time taken by respondents to reach a health facility.

**Figure 14: time taken to reach a health facility**
The mode of transport to a health facility was mainly through use of public transport (buses and kombis) as 75% reported that they relied heavily on public transport to reach a health facility. Other means of transport cited were walking (5%), use of private cars (5%) ambulance (5%). The findings show that there is need for ambulances to support women who need to be transported to health facilities. The same sentiments were raised in the focus group discussions where women suggested that government should consider purchase of community ambulances would reduce dependence on public transport. Women in focus group discussions said “it would be better for government to buy ambulances for the communities we live in because it takes a very long time for the ambulance to arrive when requested to come for an ill person”. They further stated that sometimes they cannot afford paying for public transport. This was also echoed in focus group discussions as women were saying “the public buses and Kombis are expensive as we are not working, we rely on selling fruits and vegetables, and there is not much money, we need ambulances”. It is evident that for an economically disadvantaged woman the use of public transport could hinder accessing health care. Women in this study were basically of low socioeconomic status, and therefore access to health care for them is an issue that renders health care in accessible for some women.

As reported in the MOH&SW study 2001, the time taken to reach a health facility is very difficult for some areas in Swaziland especially where the roads are reported to be of poor quality. In this study 11.1 percent of the women living in rural areas reported that the roads were good. The remaining 88.9% reported that the roads were not all not good especially in rainy season reaching a health facility is very difficult reported that the roads were good in rural areas. The topography of the Kingdom is such that small distances can be quite difficult to cover and hence travel time to facilities is more robust in measuring access to facilities than distance to facility.

Access to Health

The government of Swaziland has primary responsibilities of ensuring access of Swazi population to quality health care services. Health is considered a critical ingredient for economic growth, development and poverty reduction. Health care delivery in Swaziland is largely based on the tenets of Primary Health Care (PHC), adopted by the government in 1983 as a basis for development of the national health sector. The government established a health network infrastructure consisting of primary, secondary and tertiary health care facilities, which provide curative, preventative and rehabilitative services. In line with PHC tenets the government also decentralized the health system to improve access to care for all Swazis: the Regional Management Committees were established to manage health centre and clinics in each of the four regions.

In this survey 60.3% of the respondents reported that health care facilities were within accessible distance. 39.7% of the women indicated that the health facilities in their communities were very far. This finding clearly indicates the need for more health facilities in communities so that all citizens are afforded with the care they need. As
suggested by WHO (2001), expansion of maternal health services to improve access needed. One option is to increase outreach services to the "unreachable" areas. Another option is to expand existing facilities by integrating sexual and reproductive health services in the existing facilities, a move that will encompass policy review and planning and management considerations.

**Affordability of health services by women.**

One of the key components of primary health care approach to which Swaziland subscribes states that health care has to be affordable to all citizens at costs that are affordable. The situation in Swaziland is that there is a standardized user-fee of E10.00 (US$1.50) that the patient has to pay for all services received including consultation and prescriptions. This user-fee applies to all and is required before treatment by all government health care facilities. As many women are in poor situations for some clients this user fee was reported to be adequate but for others while for some it is viewed as a constraint to access medical help. An economically disadvantaged woman without the E10.00 may be denied of services that needs. For the women studied most of them were not in any gainful employment and having to pay for medical services may render the service inaccessible, thus denying a woman who may be in need of medical care. For every service there is a fee attached to it. At health facilities nurses reported that clients are indeed required to pay before receiving any treatment even in emergency situations. However, in emergency situations, none of the health care providers reported having denied a woman of treatment that she needed except for one nurse who said that in her clinic patients who do not have the E10.00 do not receive treatment even in cases of emergency.

**Availability of other services**

<table>
<thead>
<tr>
<th>Services</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood supply 24 hours</td>
<td>3</td>
<td>30 70</td>
</tr>
<tr>
<td>Availability of toilets and sufficiency</td>
<td>7</td>
<td>70 30</td>
</tr>
<tr>
<td>Incinerators</td>
<td>1</td>
<td>10 90</td>
</tr>
<tr>
<td>Counselling services for HIV/AIDS</td>
<td>8</td>
<td>80 20</td>
</tr>
<tr>
<td>Emergency stork</td>
<td>6</td>
<td>60 40</td>
</tr>
<tr>
<td>Pap smear</td>
<td>3</td>
<td>30 70</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>30 70</td>
</tr>
</tbody>
</table>

**Ambulance facility.**

Of the ten health facilities that were in the study, only 3(30%) reported that they had an ambulance facility meant to transfer patients to referral facilities. For those health facilities (80%) that reported having no ambulance facilities, patients were advised to use
public transport to get to the nearest referral health setting. When the ambulance was called from the health facility from a referral hospital the time it took to reach the clinic was reported to be about 2 hours by 40% of the reporting clinic and more than 2 hours by the remaining 85%. Means of communicating were mainly through telephone use by most (80%) respondents. These findings could mean that patients who do not have money are denied of services that they need. This could lend some women to die unattended to especially if the woman could be bleeding from complications of pregnancy.

**HEALTH CARE FACILITY**

In order to ascertain availability and accessibility of health care services for women nurses at health care facilities were interviewed. Nine were female and only one was a male nurse, a finding demonstrating that nursing is predominantly a woman’s profession. They were all registered nurses in general nursing and midwifery. Six of them had received a post diploma certificate in Community Health Nursing. Information related to type of services was obtained from these nurses and the women at community and women who were interviewed during exit interviews. The health facilities that were visited reported that they offered integrated services on a daily basis. This was in accordance with the recommendation by WHO that services should be made available. Further to this recommendation, WHO also recommended that in order to make services accessible they should be integrated. Within an integrated service a woman coming in with a sick baby should be allowed to get her physical examination if she is also not well. The table below shows the type of services and frequency of service offerings.

<table>
<thead>
<tr>
<th>Type of service offered</th>
<th>Number of facilities</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning</td>
<td>10</td>
<td>Daily</td>
</tr>
<tr>
<td>Antenatal care</td>
<td>10</td>
<td>Daily</td>
</tr>
<tr>
<td>Maternity care</td>
<td>4</td>
<td>Daily</td>
</tr>
<tr>
<td>Neonatal care</td>
<td>4</td>
<td>Daily</td>
</tr>
<tr>
<td>STIs</td>
<td>10</td>
<td>Daily</td>
</tr>
<tr>
<td>VCT</td>
<td>2</td>
<td>Daily</td>
</tr>
<tr>
<td>ART</td>
<td>4</td>
<td>Daily</td>
</tr>
<tr>
<td>PMTCT</td>
<td>4</td>
<td>Daily</td>
</tr>
<tr>
<td>Curative</td>
<td>10</td>
<td>Daily</td>
</tr>
</tbody>
</table>

Some of the health facilities (6 out of ten) were unable to provide maternity care because those centres were not equipped to conduct such services. This was observed particularly in clinics that were based in rural settings. This observation was also true for other
services such as ART, PMTCT, VCT and Neonatal care. From this finding it can be concluded that health facilities still need to be equipped properly for services to be made accessible. Ensuring adequate supply of service will be making health care accessible to women and children who are in most cases frequent users of health care facilities. The distance from a referring health facility to other health facilities was sought in order to ascertain the time it would take a woman to reach a facility which could be offering needed services. A distance was viewed as near if it was less than 10 kilometres walking and furthest if it was more than ten kilometres.

Eight (8) of the health facilities were reported to be far from the health facility and four (4) were reported to be near. The nearest health facility was within the 10 kilometres of walking distance. Although this could seem to be within what is recommended, for a sick or pregnant woman this could mean that the woman cannot be able to access health care that she or her baby may need.

ACCESS TO SAFE WATER

Since the mid 1980s Swaziland has made significant strides in improving access to potable water supplies and sanitation facilities, especially in rural areas. Rural coverage rates rose from 30% of the rural population to 45%. Sanitation coverage shows similar patterns, from 355 of the total population in 1982 to 1992. Nevertheless, inadequate sanitation and hygiene and poor access to potable water supplies continue to affect large segments of the population, especially in rural areas. More than 54% of the rural population still relies on unprotected water sources and nearly 30% still rely on the bush for excreta disposal. Disposal of solid waste is an additional problem for the rural populations since very few households have access to sewerage facilities. With so many Swazi families dependent on unsafe water supplies and lacking safe means for disposal of faeces, diarrhoeal diseases and other water-borne diseases such as schistosomiasis continue to account for widespread morbidity and mortality. Poor hygiene practices in the home also contribute to ongoing risk of infection (UNICEF, 1992, Summary Situation Analysis Children and Women in Swaziland).

Similar findings are observed in this study as 26.5% of women report that their water supply was obtained from unprotected wells and rivers, piped communal water sources 44.4% and only 28.9% received water from safe sources such water piped into houses. The finding indicates that there is still more work needed to ensure water coverage to all citizens of Swaziland as waterborne diseases are a major problem which contributes to the vicious circle that people are in. This problem is further compounded by the lack of medicine to treat ill people. Several studies have reported that many people weaken because of waterborne disease and, as a result, are more susceptible to other infections. Their physical capacity decreases and they cannot work and provide their families with money and food. A lack of sufficient nutritional food weakens people, especially children, even further. They become even more susceptible to diseases. Children run behind at school, because they cannot be educated when they are ill. Waterborne diseases frustrate the economic development of many people. The appearance of HIV in developing countries makes more people susceptible to infectious diseases. To improve
the economical progress of developing countries, water contamination and spread of infectious diseases must be handled. This may be achieved through (drinking) water treatment, sewage, waste and sewage water treatment and education on personal and food hygiene. Lack of safe drinking water, a gender-based division of domestic chores including the carrying of water), environmental hazards, such as contact with polluted water, agricultural pesticides and indoor air pollution, all have a cumulative negative impact on the health of women.

RANGE AND QUALITY OF SERVICES AVAILABLE TO WOMEN AT COMMUNITY LEVEL.

While Swaziland as whole can be described as a lower middle income country Development Report (1994) state that about 400,000 people live below poverty line and they are in rural areas. The current national economic slowdown is proving to be exceptionally deep and broad. Depressed employment opportunities, poor agricultural production, plus rising staple food prices and the effects of HIV/AIDS have undermined livelihoods. Poverty is endemic on Swazi National Land where 70% of the population contribute to the agricultural sector’s modest 10% share of the GDP. In 2002 Swaziland was incorporate as a beneficiary under a WFP regional Emergency Operational Plan which is currently in operation. The WFP and a National consortium of NGOs formed a partnership to distribute food aid to the most affected (UNCEF, 1994). About 54% women in this study reported that they are aware of the food distribution to needy people in their communities. 44.6% were not aware of such a service. This finding seems to suggest that about half of the women in communities do not have access to food that is meant to alleviate starvation among the needy. For poverty alleviation it is important that there is adequate access of the poor to social services in the communities.

Other services such as those aimed at reducing sexual and gender based violence, women (71%) reported that in their communities there were no SGBV services. However, there is rural and urban variation in the manner in which services are provided at community level. For those women in rural communities only 11% reported that they got their information from mobile services

Community based care

Community based care is provided from 162 health clinics and 187 outreach sites, all run by nurses. These include five first referral level health centre and eight public health units offering both preventative and curative services. There are four regional referral hospitals, and two non-profit hospitals receiving subsides from MOHSW. There is a relatively large private sector in Swaziland. As well as the two mission hospitals there are 73 other mission facilities including health centre, clinics and outreach services. Industry supports 53 private clinics and 4 NGOs provide health care.
Antiretroviral (ARV) Therapy

The rapid spread of the HIV virus has translated into widespread AIDS illness and deaths. Uncurbed this is devastating families, eroding sectoral capacities, compounding vulnerabilities with increasing child-headed households and OVCs. With the high prevalence of HIV in Swaziland, ARV therapy is an essential intervention to reduce the number of AIDS related deaths and arrest the vicious cycle.

Swaziland has made considerable progress towards provision of antiretroviral treatment as guided by the Health Sector Response plan to HIV and AIDS (2003-2005). It has scaled up considerably: 3000 people are currently on ARVs (2004) with projections estimating 6000 extra by the end of 2004 to meet the 3*5 target. Prior to 3*5 only 600 patients were receiving treatment. To date, five hospitals are providing ART and it is estimated that approximately 4000 patients were on ARV treatment by end of August 2004. ARV treatment is provided at no cost to patients since January 2004.

Community based care is provided from 162 health clinics and 187 outreach sites, all run by nurses. These include five first referral level health centre and eight public health units offering both preventative and curative services. There are four regional referral hospitals, and two non-profit hospitals receiving subsides from MOHSW. There is a relatively large private sector in Swaziland. As well as the two mission hospitals there are 73 other mission facilities including health centre, clinics and outreach services. Industry supports 53 private clinics and 4 NGOs provide health care.

Availability of trained community health workers or volunteers

A situational analysis of the health workforce in Swaziland conducted by the Ministry of Health & Social Welfare in collaboration with the World Health Organization (2004) reported a total of 1681 midwives, 137 Community Health Nurses, 84 medical doctors and 6 Obstetricians and Gynaecologists, 275 nurse assistants, and a number of allied health professionals whose work is supplemented by approximately 4000 Rural Health Motivators (RHMs). The major challenge to workforce planning in Swaziland is lack of data that integrates information about the number of persons, deployment and educational level. The doctor/patient ratio is 1:5953 and a nurse/patient ratio is 1:356. There are imbalances in the distribution of staff between private and public providers and between rural and urban areas, with urban areas having a disproportionate share of staff: the private sector has about half of all the nurses in Swaziland, and has twice the number of doctors than the public sector. This has worsened capacity problems in the public sector, which struggles to fill vacant posts. There are high rates of workforce attrition and a small pool of qualified staff from which to recruit replacement.

Resulting absolute shortages of health personnel in Swaziland at all levels of the public health system have stalled and compromised the quality of service delivery. Without improved capacity development in the health sector, to enable effective and sustained service delivery, concerns have been raised about the ability of the health sector to dispense ARV drugs. Given the population and geographical size of the country, and also
the fact that the age groups affected are people at the peak of their economic and reproductive careers, these figures translate into a decline of the population over the next decade, as a result of the combined effect of lower fertility and higher mortality rates. In addition to reducing life expectancy by almost 25 years (from 59.7 years in 2001 to a projected 38.3 in 2015), the HIV and AIDS pandemic has a direct bearing on human resource development. It kills prime-age adults, many of whom are skilled workers in key sectors of agriculture, transportation, education, health, correctional and armed forces.

ACCESS TO LEGAL REPRESENTATION IN MATTERS RELATED TO SEXUAL AND GENDER BASED VIOLENCE

The platform for Action and Beijing Declaration adopted by governments at the 1995 Fourth World Conference on Women recognizes that the transmission of HIV/AIDS and other sexually transmitted infections is sometimes a consequence of sexual violence. In such cases women and girls can not negotiate for safer sex from their assailants thus placing them at high risks of contracting HIV. Physical and psychological violence against women and particularly girl children has become a common feature in Swaziland. Men who are known to the women and children and children, such as close relatives who are supposed to offer them protection, perpetrate most violence. Such a situation makes it even more difficult for them to remove themselves from the violent situations. Most women are often forced to have multiple sexual partners in order to survive and stay with violent husbands (UNDP, 2002). In this study women revealed that in their communities violence against women was common. 26.3% reported to have been abused either sexually or physical abuse, 73.7% were never abused. From the interviews it appeared that there were no structures in place that were for the protection of women against violence. However when the views of the women were sought regarding protection of women community police were cited as one method of curbing the problem. The structure of community police emerged as a neighbourhood watch type group in 1996 (WLSA, 2000). It is important to point out that although this seems to be effective in discouraging perpetrators other views of curbing violence should be explored. This structure has projected itself as an extension of the law, which is supposed to work together with umphakatsi (Chief’s residence) as well as the Royal Swaziland Police in Swaziland (WLSA, 2001).

HIV/AIDS Counselling/IEC

Comprehensive reproductive health services, especially care during pregnancy and childbirth and for sexually transmitted infections are key to preventing disability and death and improving women’s health. Better access to emergency care during childbirth and safe abortion services would also contribute significantly to lower maternal death rates. Family planning diminishes risks associated with frequent childbearing and reduces reliance on abortion. The threat of HIV/AIDS has also heightened the need for programmes that help women and men and especially young people strengthen their communication skills and negotiating skills. An important obstacle to couple negotiation of contraceptives use and protection from STIs including HIV is that women have unequal access to resources and decision making. Yet women are more vulnerable to the
consequences of unplanned pregnancies and often STIs. For these reasons, countering the prevailing gender stereotypes that increase risky behaviours and decrease couple communication is a key strategy for promoting good reproductive health. The availability of HIV/AIDS counselling and IEC services was communicated to only (42.1%) of the women who had been discharged from the maternity ward. More than 50% had not been informed of HIV/AIDS and IEC services. This finding implies that women lack information regarding HIV and yet based on their biologic make-up and other factors women are the most vulnerable to HIV and other STI infections. In order to ensure that all women are informed it is important that health care providers should seize the opportunity to inform patients while still within their care as it may be difficult to reach the women once they are discharged. 73.7% were talked to about testing for detection of HIV infection. Other services such as STIs diagnosis and treatment were known to only (36.8%) of the women. Knowledge of such services is important so that women can utilize them as there is a high STI infection rate among women as evidenced by the STIs reported in the 2002 Sentinel Surveillance. Child immunization and growth monitoring services were known by (15.8%). Women need to be informed about available services especially those that deal with children in order to ensure that their children’s health is monitored to ensure healthy development and growth.

Family planning services constitute one of the major elements of women’s health. Immediately following delivery information regarding Family Planning should be communicated to women especially when they are still in the wards for them to make informed decisions concerning their future reproductive health decisions. Family planning services should provide for fertility services. As part of a comprehensive programme fertility services should be provided. Women (15.8%) in this study had sought consultation for fertility before.
CHAPTER FIVE

ORGANIZATIONS PROVIDING HEALTH AND BASIC SOCIAL SERVICES TO WOMEN.

This section of the report presents selected organizations that provide basic and social services to women in Swaziland.

The country has a number of non governmental organizations operating under different mandates, with some having been established to assist women to fight hunger and poverty and to help them exercise their rights through the law. There are two main NGOs that deal with women’s’ issues. These are Pare briefly described below

5.1 Women and the Law in Southern Africa (WLSA)

WLSA has six programs with action research being the core program; the others being Information Generation, Legal Advice and services Lobbying and Advocacy; Networking; Training and Education.

WLSA conducts activist research in the even countries. By activist research we mean research which is intended to inform and influence action being taken to improve women’s legal position and which incorporates action into the research by educating women about their legal rights, providing legal advice, questioning and challenging the law as well as instigating campaigns for changes in the law in the course of research.

The research program is carried out in phases during which all the seven countries choose a research topic. Research is planned collectively by the researchers in the seven countries, and the results are compared at the regional level.

5.2 Family Life Association of Swaziland (FLAS)

Family Life Association of Swaziland is a non governmental organization that is leading in the provision of family planning information and reproductive health care services in Swaziland. FLAS is a professional organization staffed with dedicated and technically skilled staff and a highly motivated participatory volunteer body. FLAS believes in and advocates for the right to informed free choice for all in the reproductive age groups striving to ensure that the people of Swaziland have access to information and affordable reproductive health services. FLSA has found that many men in rural areas have the attitude that modern contraception is foreign intrusion that does not integrate well with traditional practices. They also believe that it kills. FLAS increases the knowledge of men on Family planning and assures them that contraception is safe. FLAS has trained
private sector nurses, industry based distributors have been trained to disseminate education on family planning STDs/AIDS and supply non prescriptive contraceptives in their communities.

5.3 Swaziland Action Group Against Abuse (SWAGAA)

Their mission is to halt the widespread sexual abuse of women and young children - some under 2 years of age - by the male population, who believe they will be cured of illness by such actions. SWAGAA employs full, part time and voluntary staff to address their aims: Counsellors, medical workers, legal advisers, forensic nurses, administrators, help-line operatives, and lecturers. Swaziland Action Group Against Abuse, a non-profit making non-governmental organization started in Swaziland more than ten years ago.

5.2 ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH PROGRAMME AND STD/HIV/AIDS.

Adolescents and youth constitute a significant proportion of the population of Swaziland. Adolescents and youth contribute to high fertility rate as is shown by the high proportion of teenage pregnancy. This is evidenced by the high incidence of teenage antenatal attendance and high ration of institutional deliveries among teenagers (27%). Of an estimated 56% of women giving birth at health institutions about a quarter are adolescents aged 15-19 years. Early childbearing is an impediment to improvement in the educational, economic and social status of women. For female adolescents early marriage and early motherhood can severely curtail educational and employment opportunities and can lead to a long term adverse impact on their quality of life and that of their children. Poor educational attainment and, lack of economic opportunities and sexual exploitation are important factors that contribute to the high levels of adolescent childbearing. Therefore programmes addressing reproductive health needs and rights of adolescents should involve them in all stages of design and implementation.

Currently there is lack of a precise policy within the existing reproductive health programme, lack of user-friendly institutions, unfavourable service provider-attitudes and some existing socio-cultural constraints. For example the influence of culture and religion which has resulted in various norms and practices regarding the use of modern contraceptives, age at marriage, polygamy and preferential treatment of the boy child. A comprehensive reproductive health programme can enhance reproductive health of adolescents by providing information to help them attain a level of understanding required to make responsible decisions.

The result of all these factors has been inadequate knowledge of sexuality, early initiation of sexual activity, early childbirth, unsafe abortion, STD/HIV/AIDS and subsequent risk of infertility and cancer. This has affected their educational and socio-economic status and their self esteem and empowerment.

5:3 FAMILY PLANNING PROGRAMME IN SWAZILAND
In spite of the progress made in Swaziland towards fertility reduction, there remains a substantial unmet need for family planning services. The quality of family planning programme is often directly related to the level and continuity of contraceptive use and to the growth and in demand for a wide range of services. Concern over the quality of care offered within the national programme thus becomes important in efforts to satisfy the unmet need for family planning. In particular, making services accessible is an immediate concern. Similarly, the involvement of men and their support for family planning is very crucial because of the central role men play in the community. Family planning services are offered by the MOH& SW, NGO and the private sector, through static mobile and CBD programmes.

There is no policy, which explicitly states specific rights relating to reproductive health including family planning; it is assumed in the operation of the health sector that every citizen is assumed to have a right to adequate and accessible health care including family planning and to this end the Government provides subsidized family planning services at the public health facilities. In the absence of statutory provision on this subject, Swaziland is left with common law to look up to in terms of legal regulation in this area.

At common law, a wife who takes contraception without her husband’s permission or knowledge is not in breach of their matrimonial contract nor is she committing an offence (WLSA 2004). Under Swazi law and custom different rules and regulations obtain. Procreation is so much at the heart of the marriage that is not even left to the married couple alone to decide. Decisions pertaining to procreation and sterilization are taken at family level with the husband and his family having a significant role to play.

On the basis of the above, under Swazi law and custom decisions on sterilization and contraception are left to neither the individual woman nor the couple. These are decisions involving the wider family. The welfare of the family, in particular, continuance of its lineage compromises that of the individual. However, that does not mean that Swazi law and custom did not or does not recognize the value of contraception and sterilization. Swazi custom recognizes contraception as it had its own ways of family planning like prolonged breastfeeding, abstinence for certain periods after childbirth abstinence during mourning periods, and the use of herbs that were known to reduce fertility in women.

Therefore, whilst customary law views procreation as important and encourages each woman to have as many children as she can, it also recognizes the value of family planning. Whilst a health practitioner who gives contraceptives to a woman married by customary rites does not breach any legal regulation if s/he does so without the husband’s consent, a woman married by customary rites is by virtue of the extensive marital power of her husband and his family required to seek husbands’ consent.

**GAPS**

- Male involvement in family planning initiatives has been persistently marginalized; consequently men sometimes oppose the initiatives.
• Family planning services and service providers are not gender sensitive to the needs of men, further aggravating the issue.
• Permanent sterilization is not easily accessible to women yet men access vasectomy without their wives’ consent.
• Limited resources for the delivery of effective family planning methods, for example in rural clinics and/or mobile clinics, lack of privacy may limit the choices of certain family planning methods.
• The absence of a policy guideline on family planning issues makes it difficult to implement family planning initiatives.
• Cultural practices (as stated earlier) which encourages large family sizes and limits the use of effective family planning methods.

**Operational constraints**

• The absence of an explicit reproductive health policy which would have included, among other things, policies on gender, IEC, and advocacy family planning adolescent sexual and reproductive health, post abortion management, data collection, analysis and dissemination, community involvement and participation, population policy operational structures, etc is partly the reason for uncoordinated planning and difficulties encountered in effecting rational resource allocation.
• Lack of comprehensive and coherently integrated programme of action at national and regional level is a shortcoming.
• There are inadequate resources (human, financial and equipments) to support safe motherhood efforts in both private and public services. The migration of qualified/experienced personnel is making the situation worse, leaving some of the health facilities manned by inexperienced nurses and nursing assistants who are inadequately prepared to manage reproductive health challenges. Similarly, obstetricians are inadequate to provide quality care; the few that are in service post are not fully utilized to extend services beyond the health facilities they serve.
• Poor demonstration of clinical skills by health care professionals in the management of obstetrical problems as reported by the Rapid Evaluation Methodology (REM) study which was conducted by the Ministry of Health and Social Welfare in 1994. This professional inadequacy according to the REM was identified in the management of obstetrical emergencies, intrapartum care as well as resuscitation of the newborn.
• The patient referral system (ambulances, blood bank, community and within health care settings) lacks coordination to effectively respond to emergency obstetric situations.
• A system for recording maternal and infant deaths is lacking, similarly an inquiry into maternal/fetal deaths is not effectively practiced. Consequently, conditions or practices resulting to maternal deaths are poorly documented and not well articulated.
• Late booking to ANC is a norm practiced by 60% of clients; this situation poses problems in the identification and management of pregnancy risk conditions.
- Counselling for risk conditions/situations including STIs/HIV/AIDS is inadequate at service provision levels.
- Gender disparity in decision-making regarding the use of family planning services and limited physical access to family planning services are constraints. Additionally, male involvement in sexual and reproductive initiatives appears to be limited.
- Outreach sites lack privacy to permit meaningful family planning counselling and physical examination when the need arises. A key implication in this regard is the limited choice of family planning methods for visiting clients.

The health information system lacks pertinent information that can be utilized for research purposes.

**POST ABORTION CARE (PAC)**

In Swaziland, abortion is a crime at law both to the expectant woman on whom it is performed and to the person performing it. Abortion is regulated by Roman Dutch Common law who define it as unlawfully and intentionally killing and causing expulsion from the uterus of a human foetus. The only circumstances under which abortion is permitted under the Roman and Dutch Common law is where it is “necessary” (incest, abnormal foetus, depression including suicidal threats, and the woman’s personal circumstances) to save the life of the pregnant woman (WLSA 2004). The interpretation given to necessity therefore, is that if the doctor on reasonable grounds is of the opinion that the probable consequences of the continuance of the pregnancy will put the woman’s physical and or psychological state at risk. However Abortion is available in both private and public health facilities. Abortion is also offered when there is a medical indication for its procurement; in order to protect the rights of an unborn baby. Though abortion is available to any woman when it is “necessary”; however the lengthy procedures required by the Ministry of Health & Social Welfare may render it impossible for some women to access abortion legally within the medically sanctioned period.

In cases of sexual violence, for example, in instances of rape where abortion may be legally invoked, this entitlement is sometimes lost because some of the women and girls do not report the rape immediately. By the time action is taken the pregnancy has advanced to a point that termination can only be considered if it is immediately available. There is lack of uniformity in offering abortion treatment; private services are more responsive and prompt in the delivery of the abortion service than public services. Access to private facilities is mainly determined by availability of financial resources to consume the service and pay for the procedure.

A much neglected category of women who suffer due to the lack of abortion services are adolescents and women with gross physical or mental disability; these women are vulnerable to sexual abuse and thus become pregnant in a bid to protect their children or limit the effects of sexual abuse on their “imbecile” girl children, several parents opt to have them sterilized. Abortion service is not easily available to them even when the consenting parents or guardian willing for the necessary procedure to be performed.
SWAZILAND NATIONAL AIDS PROGRAMME

Swaziland is rated as one of the countries with high HIV prevalence rate (38.6% among pregnant women). Factors contributing to high HIV infection in the country include: multiple partners, breakdown in traditional norms, poverty, and high prevalence of Sexually Transmitted Infections and limited involvement of women in decision-making on sexual issues.

Policy development relating to HIV/AIDS in Swaziland begun in the year 2000, and has resulted in a National HIV/AIDS policy. However, with rates of infection continuing to increase and the effects of current losses due to AIDS (and related causes) a policy which clearly articulated contributing factors to HIV infection is mandatory if change is to be seen.

Gaps in the policy

- Inefficient application of the HIV/AIDS policy due to scarcity of resources (rising insurance costs and coverage, the disproportionate supply of medical services, and existing medical structure and procedures).
- The perspective of women’s multiple roles which includes caring for sick family members (without the necessary protective clothes) yet neglecting they own health; consequently they acquire the infection.
- Cultural factors (polygamy, rape, powerlessness, poverty) which increase the vulnerability of women to HIV/AIDS; yet these factors are not specifically addressed in the policy.
- The progressive increase in the HIV/AIDS pandemic has seen more children orphaned because their parents have died from HIV related illnesses. Most of these children are then cared by grand parents, relatives, or remain on their own. The social support for these children is not addressed in the policy. Additionally, the Social Welfare Department has no system in place to effectively identify and monitor (on daily basis) the state of these children. As a result, some of these children are withdrawn from school (due to financial problems), abused by community members/relatives (who are supposed to provide support), or they lose property/belongings from lack of protection from the state.

SOCIAL WELFARE SERVICE

Swaziland has a long history in social service provision, established during the colonial period. The government has maintained the provision of this service with a section known as the Social Welfare Department within the ministry of Health following a Legal Gazette No 147 of March 26 1996. The Department is mandated to address all welfare issues in the country and is decentralized to the four regions of Swaziland with offices in each of administrative towns of the regions. The diverse functions of the department are
The Social Welfare Department provides the following services:

- **Child welfare**: The Social Welfare Department is the custodian of all Child Protection legislation in the country and for this reason one of its core activities is to ensure and promote the welfare of children notable amongst these are the Adoption of Children Act of 1952, the Child Care Service Order of 1977 and the Maintenance Act of 1970. These Acts provide the basis of activities for the Department in terms of Child Welfare Promotion.

- **Public Assistance**: This is a social assistance programme which provides benefits to needy or destitute members of Swazi society. The beneficiaries of the assistance are the destitute, the terminally ill, widows, the disabled and the elderly. There is no legislation governing this programme but according to Kasenene (1998), the practice that has developed is that those in need are required to apply for this assistance at their local government office and a social worker will act upon the application by making a home visit to assess the level of destitution of the applicant. If the application is successful monetary assistance is provided at E40 (US$3.81) to E65 (US$6.19) per month paid out of beneficiaries on a quarterly basis.

- **Support to Persons with Disabilities**: two type of assistance is offered to disabled members of the society; (1) the public assistance programme and (2) Vocational training mainly to provide skills for the earning of a living in order to maintain themselves. Sadly, there is no legislation regulating the implementation of this programme, as a consequence the activities are based on practice.

- **Disaster Management**: the Department is also mandated with the disaster assistance programme under the Swaziland Administration Order of 1950. The Regional Social Workers receive reports of disasters through the local authorities and process them in most cases by referring them to Non-Governmental Organisations that provide disaster relief such as the Red Cross Society.

- **Family Counselling**: According to Kasenene (1998:7) another function of the Social Welfare Department is to provide counselling services to families regulated by the Marriage Act of 1964 and Maintenance Act of 1970. The aim here is to bring marital harmony in families especially those living in the urban areas, where traditional services for counselling have been alienated. However, not many families utilize this service, due to lack of awareness of the existence of these services.

**Gaps**

- There is no Social Welfare Policy in the country; a draft policy was developed by a consultant in 1998, to this date it remains in a draft form. There is also no plan or strategy in place for the eradication of social problems and for the provision of social services to disadvantaged groups. This situation is further compounded by the fact that there are programmes in place which are not regulated by any law or
policy but by practice. Women are therefore disadvantaged because they are the majority users of the social services.

- There is lack of impact assessments on the Social Welfare Services, which could be used to in the transformation of Social Welfare Services in the country. The Social Welfare Department in Swaziland emerges from a history and tradition of delivery. Most of these are based on the colonial legacy which was inherited and may no longer be valid in the contemporary Swaziland. This disadvantage the department as it becomes static in its operations without the flexibility to respond adequately to women’s contemporary social problems. One such problem is violence against women which is a serious problem in the country and is highlighted by the Swaziland National Platform for Action. The resolution of this problem requires an innovative and holistic approach, which the present structure of the social welfare department is not adequately equipped to deal with.

- Women, who because of their social valuation and subordinate status in society suffer most from poverty, whether brought by disaster or disability, require the use of the social service the most; find they unassisted by the present Swazi social welfare system. The present system operates a welfare based approach which further entangles the women in the poverty trap. For instance, the provision of E40 a month, which is below the E47.70 rate, ascribed poverty level. This approach does not work to free the women from poverty but continues to exacerbate their problems.

- Moreover, the tradition of the officers being located in the administrative towns make these services inaccessible to the disadvantaged groups including women. Women are discouraged from accessing these services due to difficulty to afford the transport costs into the towns and thus do not benefit from this assistance.

- There has been an increase of abused children in the country; sadly they are poorly protected by the law. The Convention of the Rights of the Child has not been translated to national legislation to protect children from abuse.

- In 1997 the elderly were found to constitute 3% of the total population. According to the National Population Framework for Swaziland (Draft) (2000), many elderly people live in poverty and under very difficult circumstances. With the increase in HIV/AIDS pandemic, the majority of orphans are cared for by elderly women. The policy does not specifically address the plight of the elderly.

- There are numerous factors that curtail the Department in effectively and efficiently delivering on the much-needed services, they are:

  (a) Understaffing; the Department is clearly understaffed to deliver on its broad mandate. For example, the Lubombo region has one social worker working on all services being provided by the Department, covering a population of 194,323 people; this is humanly impossible.
(b) Lack of resources; in addition to staff shortage, there are limited/lack of essential resources to accomplish these services. Home visits are mandatory to effectively deliver the services, but the Department has no vehicles, a circumstance that inhibits them from functioning accordingly.

(f) Lack of appropriate legislation and policy to assist staff in the Department to deal adequately with their cases. This also creates problems in the way the same Department deals with similar cases- as there are no clear standards of operation, there is bound to be inconsistency in the handling of cases which results in confusion to the consumers of the service.

THE LEGAL FRAMEWORK

Swaziland operates a dual legal system comprising Swazi law and custom, and general law (received common law supplemented by statute). The former comprises practices and traditions of the Swazi people as developed over time while the latter was imported in terms of section 2(1) of the General Law and Administration Act 4 of 1907 which states, The Roman-Dutch common law, save in so far as the has been heretofore or may from time to time hereafter be modified by statute, shall be law in Swaziland (WLSA 2004).

These two systems of law operate simultaneously, each having legitimacy to deal with legal matters according to its own rules and interpretations. Each system is on par with the other and there is no clear hierarchy in terms of which is to take precedence in instances where the two diverge on the determination of the same issue, as they often do. This situation causes much consternation in the legal arena where the decision taken on a matter may differ simply because of the forum and law used in its adjudication.

This is primarily the case in matters concerning family law in which both systems have a well developed jurisprudence. With respect to women, matters relating to the family are precisely the area in which women find themselves subordinated by patriarchy manifesting itself in the guise of societal adherence to custom and tradition. Thus, in many cases the two systems of law are in concert in their regard of the woman as a subordinate to her male counterpart. However, where protections do exist in one system, they may be vitiated by the matter being determined according to the very law that is to the disadvantage of the woman on that particular issue.

Access to Courts

The rules and regulations of each of the legal systems as defined above are applied in the operation of the different court systems provided for this purpose. The matter to be determined in the courts are dependent on jurisdiction, which is applied for both matters which the courts may hear these matters. In terms of the jurisdiction, this is applied for both matters which the courts can redress as well as the persons over which the courts may hear these matters. In terms of the jurisdiction to matters, Swazi National Courts are limited to ‘petty’ offences and crimes such as ‘minor’ assaults and they are limited in the sentences which they can impose. The persons that can be brought before the courts are limited to Swazi nationals only. Conversely, the general law courts have jurisdiction over
all persons residing within the borders of the country and their jurisdiction in matters and sentences increases depending on the courts place within the hierarchy. The inherent jurisdiction of the High Court, for example is unlimited as a consequence of its ability to determine any matter brought before it.

The letter of the law does not determine access to the courts by gender and any person, female or male may be institute or be party to legal process. However, WLSA (2004) observed that this is limited to some extent for women married under certain marital regimes which truncate a woman’s legal capacity to do so independently without her husband’s assistance. In this way a married woman’s ability to access courts is severely compromised as decisions in this regard rest solely with her husband who may not be willing to take steps in this regard.

Also, practically it is usually difficult for women to take advantage of their entitlement to appeal to legal redress when experiencing problems where such action would be appropriate. This is caused by several factors including the lack of financial resources of women which are inhibiting as most often than not, legal process requires relatively large amounts of money which women cannot afford. In this regard, the absence of a legal aid structure, beyond pro deo legal representation makes the inability of the indigent to access courts more glaring.

The operation of the courts themselves is colored by attitudes of predominantly male officials who sometimes lack sensitivity in dealing with cases involving women, as a result, a woman litigant or offender finds herself in a position of disadvantage by her mere presence in the courtroom, a public space within the presence of men, and this may affect the quality of justice she receives.

International law: Swaziland’s position

Swaziland, as a member of the International community is partly to some of the International Legal Instruments, Conventions, Treaties and Protocols adopted by various organizations of states at international, continental, and regional levels. In this regard Swaziland participates at, amongst others, the United Nations (UN), the Organization of African Unity (OAU), and the Southern African Development Community (SADC) respectively. However, in actual benefit to citizens, the authorities have not exhibited the political will or commitment into reality (WLSA 2004).

In terms of Swazi law, a three-tiered process is necessary for protective international legislation to be binding on the state at the national level at which citizens can derive benefit from it. These are signature (which signifies agreement in principle with the instrument but has no legal binding consequences), ratification (which is binding inter state parties but not between states and its nationals), incorporation (whereby the instrument is translated into national law and has the effect of conferring rights upon the nationals of the state to claim the protections provided for by the instrument).
Activity in this area has been characterized by uncertainty as to whose responsibility it is to sign and ratify International Instruments and to date there is no clear policy in this regard. Consequently there obtains a situation where any Minister, or relevant authority, including the King may sign such instrument. This interaction with international legal instruments occurs in a matter so uncoordinated at central executive level that in some instances there is ignorance about just which Instruments have or have not been ratified.

Gaps
- There is no policy relating to the signing, ratification and incorporation of the International laws
- Instruments that have been ratified by Swaziland have not been incorporated into domestic law.
- The dual legal system which is used in Swaziland may cause confusion in the legal arena where some decisions taken on matters may differ because of the forum and law used in its adjudication. Women are the worst affected by the lack of uncertainty in the law, and where two laws are in concert they only reinforce the subordination of women.
- There is no legal aid structure to help people who might need financial assistance for an appeal court. Women are worse affected by this situation, thus cases of violence against women may not receive the justice they deserve.
- A woman’s access to legal aid may be severely limited by her social position (minority status) whereas a man can easily access legal aid without a written consent from her wife.

ACCESS TO LAND

In Swaziland, as elsewhere in the world, land is one of the most valuable resources; as such women too whether rural, urban, or peri-urban continue to strive to access this scarce resource for their day to day livelihood. Land is basically divided into two tenure systems, namely the Swazi National Land and the Title Deed Land.

The Swazi National Land: is held in trust for the Nation by the King as Ingwenyama of Swaziland. It is allocated through the Chiefs by a customary system referred to as ‘kukhonta’- paying homage to a Chief. The assumption is that every Swazi has access to this land through family lineage that is a father for unmarried women and girls, a husband or through a son for grown up unmarried women. However, practice has shown that there is an increasing number of people particularly women who are experiencing problems with accessing Swazi National Land.

This is particularly the case with women whose marriages have failed as a result they have been expelled from matrimonial homes.

Although it is argued that such a practice is “unSwazi” if she has not been found committing an act of adultery or witchcraft and dully returned to her natal home, the fact is that it is on the increase. There is also an increasing number of single women who have no access to Swazi National Land. Some have sons who turn against them when they become of age by taking over the home, to the exclusion of the mother who had it
accessed in the son’s infancy through his name. A further problem associated with accessing land through a son is that of giving access to the homestead to the child’s father and his family. Here, the homestead is called by the son’s name which is the same as the fathers. In that way the woman becomes estranged in her home which she established single-handedly. Other women simply do not have sons to use for the purpose of acquiring land; this simple means that they will never acquire Swazi National Land, or they may seek refuge from their brothers or any male relative.

Though it is argued that a man needs to have a wife to be able to access Swazi National Land the position is not the same in controlling the land allocated to them. This is the case to a point that a man can expel the same woman who made it possible for him to access the land.

**Title Deed Land**

Access and control over deed land is mainly determined by economic status in Swaziland. However, for women, by and large a woman’s right to direct access and control over title deed land is determined by her marital status coupled with the type of marriage regime according to which she is married. Thus women who are married according to Swazi Law and Custom and those married by civil rites out of community of property can register land in their own name.

However, women married by civil rites in community of property are precluded from registering title to land in their own names. Even where they pay for the land it is still registered in the name of the husband. The Deeds Registry Act No.37 of 1968 precludes women married by civil rites in community of property from registering land in their own names, provided that:

“Immovable property, bonds or other real rights shall not be transferred or ceded to, ,or registered in the name of, a woman married in community of property, save where such property, bonds or real rights are by law or by condition of bequest or donation excluded from the community” (WLSA 2004).

The denial by the law to women of their rights to access and control a resource of such importance such as land is detrimental not only to women but to society as a whole in that it inhibits women’s potential to develop themselves and in turn contribute to the development of the country.

**Gaps**

- Women married by civil rites in community of property are not accorded land rights.
- Women are generally treated as minors in land issues.
- The land policy which addresses gender disparities is still in draft form.
- The Convention on Elimination of all forms of Discrimination against Women has not been domesticated.
Chapter 6

This section of the report presents recommendations for action to increase women’s access to health and related basic social services in Swaziland.

The law should be amended to allow all Swazis to have equal access and control of land regardless of their sex and marital status and the property regime stipulated that marriage.

- The draft land policy which addresses gender disparities and others in access to land both under Swazi National and Title Deed land should be adopted and entrenched by being recognized by the Constitution currently under the draft.
- Domestication of the Convention on Elimination of All Forms of Discrimination against Women (the Women’s Convention). In particular Article 15(2) which calls upon State parties to:
  “Accord to women, in civil matters, a legal capacity identical to that of men and the same opportunities to exercise that capacity. In particular they shall give women equal rights to conclude contract and to administer property”.

- Review of customary and general laws for harmonization to eradicate existing conflicts that may occur.
- Inclusion of a Bill of Rights entrenching fundamental human rights and freedoms and explicitly providing for their protection.
- Ratification and incorporation (into national laws) of beneficial international instruments.
- The development of a Social Welfare System in any country is to eliminate social problems and offer an alternative to the traditionally recognized methods of assistance. From the discussion we can conclude that the Social Welfare system in Swaziland is deficient in its commitment to addressing these problems and currently in need of reform. The following are recommended actions that are made in order to improve the current state of the Social Welfare in the country:
  (g) There is need to advocate and lobby government on the importance of social service provision, particularly with the increase of HIV/AIDS and its effect on the social situation of orphans, the elderly, careers, the disabled etc).
  (h) It is recommended that the Draft policy be adapted and adopted if any improvement in the well-being of women is to be achieved.
  (i) There needs to be a change in approach of the welfare system in the country, with more emphasis on developmental approach to reduce dependency and wean people of the state provisions.
  (j) State subventions should be granted to NGOs that assist in the provision of social services.
  (k) There is need to develop social policies that cater for the unique position of women
• It is recommended that the HIV/AIDS policy should take into consideration the plight of orphans, the elderly, disabled persons, women and cultural issues which fuel the pandemic.
• Prosecution should be made to offenders particularly those who knowingly spread HIV to minority groups (women, children, the disabled, poverty stricken etc).
• Statutory guidance on abortion is needed in order to give direction in the grey areas.
• The public should be made aware of abortion services and should be encouraged to use them, as ignorance is the main deterrent to its utilization.
• Sexual rights should be viewed as human rights linked to people’s right to health and national development.

• Reproductive rights and sexual rights should be viewed as human rights linked to people’s right to health and national development.
• Spousal rights to conjugal rights and procreation should be re-looked in view of the HIV/AIDS pandemic and individual’s right to life. This should be the case irrespective of the type of marriage a couple has contracted.
• Statutory guidance on sterilization to give guidance in the currently grey areas due to the generality of common law in necessary.
• Women and men should be allowed equal access to family planning services.
• The government should invest in awareness creation in the reproductive health, as ignorance in this area is the leading killer and undermining the country’s development.
• There is need to strengthen health education on reproductive health particularly to adolescents, women and men of childbearing stage.
• It is recommended that the draft policy on Reproductive Health be adapted and adopted if any improvement in Safe Motherhood Initiative is to be achieved.
• Gender roles, which seem to exist in the society, hindering women from accessing reproductive health services need urgent attention by the Swaziland Government.
• A comprehensive and coherently integrated programme of action should be enforced at national and regional level. The plan would emphasize on obstetric and neonatal care, infant feeding practices, post-abortion counselling and care, family planning, adolescent and sexual and reproductive health, Sexually Transmitted Infections/HIV/AIDS, infertility, cancer screening and male involvement in sexual and reproductive health.
• A data base system for maternal and peri-natal statistic should be strengthened in order to be used for research purposes.
• Forums to discuss maternal and peri-natal mortality should be encouraged and well coordinated.
• Resource mobilization is necessary in order to improve the coverage and quality of reproductive health services and ensure equity in the allocation of national resources for care of the vulnerable and underserved groups.
• This calls for the reviewing and improvement of the present levels of funding for reproductive health services.
Chapter 7. References


Women and Law in Southern Africa Research and Educational Trust (WLSA)


Kingdom of Swaziland. Budget speech 2005 presented by Majozi V. Sithole, the Minister of Finance, to the Parliament of the Kingdom of Swaziland. March 2005.


