PRIMARY HEALTH CARE NEEDS OF AN URBAN AND A RURAL

AFRICAN COMMUNITY

Submitted by:

B S NGUBANE
MBCHB (NATAL)
DTM&H, DPH (WITS)

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SUMMARY

This is a descriptive study of the primary health care needs of
an urban and a rural African community in the district of Lower
Umfolozi.

The selection of the study problem is justified by the general
realisation by all health ministries, in the Third World, that
strategies and policies have to be formulated, in order to make
health care universally available.   Primary health care is the
World Health Organization's strategy for making health care
accessible to every village and family of the Third World, at a
cost these communities can afford and at a distance they can
walk.

For purposes of evaluating the primary health care needs, it has
been necessary to study the communities in terms of population
size, demographic structure, mortality amd morbidity, as well as
birth experience.

Primary health care needs at the level of the individual, family
and community are outlined in this report.   The potential for
extending the present level of provision is recognised, and the
authorities are urged to utilise the existing willingness to
accept primary health care services, that is apparent in the two
communities studies, to involve the communities in primary health
care projects and services.

CHAPTER 1

OUTLINE OF THE STUDY

1.   PRIMARY HEALTH CARE NEEDS OF AN URBAN AND A RURAL AFRICAN
       COMMUNITY

1.1   INTRODUCTION

In his contribution to the FOURTH INTERDISCIPLINARY SYMPOSIUM

OF THE COLLEGE OF MEDICINE OF SOUTH AFRICA, entitled "Medicine

and Health in Developing Southern Africa, in Durban, July 1984,

Dr the Honourable Henry Gluckman, spoke among other things, of

the   terms of reference of the National Health Services

Commission of which he was chairman in 1942 to 1944.   Of these

terms of reference, the first was the most significant, "The

provision of an organised National Health Service in conformity

with the modern conception of 'health' which will ensure

adequate medical, dental, nursing and hospital services for all

sections of the people of the Union of South Africa".

It is clear then that in this country men of vision such as Dr

Gluckman, had forseen what was coming as a revolution in the

health care of the millions of the Third World, even during the

war years.   The pity of it is the long interval from the time

of recommendation to the time of application, largely due to

political ideology in the years that followed National Party ascendency to power in this country. It was only with the advent of the Black National States that the notion of Health Centres became reality in the rural areas. For many years this has been the closest we have come towards preparing for the goal of health for all by the year 2000.

The main thrust of the declaration of Alma Ata, of 12 September 1975, is universally accessible primary health care services at a price the community can afford and with resources they can provide, rendered by the health care workers coming from the people and living with people. This level of primary health care services being backed by technical, logistical and planning of health care institutions personnel in the district hospitals and national ministries of health.

In addition to promoting the health of mothers and children, primary health care is a competent strategy for combating malnutrition, controlling malaria and other communicable diseases, including tuberculosis and leprosy; improving mental health; providing safe water supplies and training health personnel of all categories.

Having achieved the eradication of small pox, promoting mass immunisation against a number of other preventable diseases

becomes a real possibility. Universal child immunisation by
1990 is now the goal of WHO, UNICEF and the World Assembly of
the United Nations.

1.2   STATEMENT OF THE PROBLEM

As with the rest of the Third World communities, rural
communities, especially, and urban communities in the Black
National States, are still far from receiving services that
correspond to their primary health care needs. The priorities
for these communities differ markedly from those of
industrialised First World White South Africa, hence the
problem in this study is that of the primary health care needs
of African communities resident in an urban and a rural area.

1.3   THE OBJECTIVES OF THE STUDY

Implementation of the WHO Primary Health Care model requires
the identification of the main health problems in the community
and the provision of promotive, preventive, curative and
rehabilitative services accordingly.

With this thought in mind, the following were the objectives
formulated:

Firstly to ascertain in respect of African communities resident in urban and rural areas their -

- population size and demographic structure;
- recent morbidity, mortality and birth experience.

Secondly to determine in respect of residents of both of the above communities:

- their social and economic circumstances;
- environmental circumstances.

Thirdly to determine in respect of residents and leaders of the communities studied:

- attitudes to health, disease and health care;
- opinion on priority areas of primary health care intervention.

Fourthly to ascertain in respect of health services:

- existing levels of provision
- current patterns of utilisation
- the opinion of health professionals.

Fifthly to identify priorities for health service intervention. sixthly to make recommendations directed to the improvement of the health status of the communities studied.

1.4   THE OVERVIEW OF THE STUDY

Chapter one gives an outline of the study.

Chapter two outlines the methodology employed in this study. Abramson has been the main reference source.

Chapter three is about the collation and analysis of data. Spencer has been the main reference source.

Chapter four deals with the community leaders' opinions on the priority areas for primary care intervention.

Chapter five examines the levels of provision and current patterns of utilisation of health services by the study communities.

Chapter six is about the priorities for health services intervention and recommendations for the improvement of the health status of the community.

CHAPTER 2

METHOD

2.   DEFINITION OF CRITERIA

"Urban area"

The township known as Ngwelezana in the Lower Umfolozi/Enseleni
Magisterial districts.

"Rural area"

The   area   known   as Matshana in   the   Lower   Umfolozi/Enseleni
magisterial districts.

"Recent"

Within the period 1 January 1985 to 30 June 1985.

"Primary health care"

Health   care   administered outside the wards   and   theatres   of
hospitals.

"Morbidity"

Any illness or injury of sufficient significance to cause it to
be remembered by the respondents

2.1   SELECTION OF SAMPLE AND CONTROL GROUPS

Urban household:

A current plan of the Ngwelezana Township was obtained and a
grid superimposed thereon.   Each intersection of the grid was
numbered and one-hundred intersections were randomly selected
using random number tables.   The households situated at the
selected intersections of the grid were included in the sample
of households.

Rural household:

Photographs of the rural area were obtained from several
vantage points.   One-hundred households were randomly selected
in the manner employed for the urban area.

Patients:

All patients attending the medical practice of the researcher
during the period 1 August 1985 to 31 August 1985 were included
in the study.

Leaders:

Urban area   - All councillors of the Ngwelezana Township were
               included in the study.

Rural area   - The Chief and all Indunas were included in the
               study.

Control groups:

No control group was selected for the purposes of this descriptive study. Comparisons between urban and rural communities have been made, where the data lends itself to meaningful comparison.

2.2   QUESTIONNAIRES

Household survey:

The selected households were visited and residents interviewed. A standard questionnaire was administered and consensus of opinion obtained.

Patient survey:

All patients attending the private medical general practice of the researcher, during the study period, were interviewed and the standard questionnaire utilised in (1) above was administered.

Leaders' Survey:

The opinion of leaders, as defined above, was elicited and a questionnaire designed specifically for this purpose was administered.

Reduction of-bias:

Bias was reduced by:

-       simple random sampling

-       the use of standard questionnaires

-       the adherence to defined criteria.

Collation and analysis of data:

All data was entered onto standard questionnaires and subsequently was transferred onto a collation sheet. Collation and analysis of data was carried out manually.

Publication:

This report will be submitted on 30 September 1986 to the Department of Community Health in partial fulfillment of the requirements for part II of the M.Prax Med (Primary Health Care).

CHAPTER 3

COLLATION AND ANALYSIS OF DATA

3.   INTRODUCTION

Tables have been prepared after collation from the coding sheet. Altogether 335 households were interviewed and a total of 2006 persons were included in this study. For purposes of analysis of data, figures based on the tables are to be used for reference.

3.1   POPULATION SIZE

The combined population of Ngwelezana Township and the Madlebe Tribal area, in which the study population of Matshana reserve is located, was estimated at 14,800 according to the 1985 census.

3.2   DEMOGRAPHIC STRUCTURE

Table   one shows that it is mainly a young population who are in the majority in these two study areas.

Table two shows that up to forty-five percent (45%) of households surveyed have four to seven persons per household.

The Union Slums Act lays down minimum standards for the separation of the sexes for sleeping purposes, as well as the size of area allowed per person for sleeping purposes. Strauss has summarised these conditions as follows:

- Rooms used for sleeping must allow four hundred cubic feet of air space and fourty square feet of floor space per person of ten years or more of age (for persons below ten the respective requirements are two-hundred cubic feet and twenty square feet). Areas such as passages, garages and cellars may not be used for sleeping.

- Rooms used for sleeping must allow persons of opposite sex over ten years of age (except husband and wife) being segregated in separate rooms, separated by brick walls or other adequate roof to ceiling partitions.

The houses in Ngwelezane Township, while properly constructed in terms of this second stipulation, had at least one room that was overcrowded in terms of the fourty square feet stipulation of the Act. In this respect fourty-eight percent (48%) of the households were overcrowded, as a result of a large family size.

The houses in the rural area were almost invariably below standard; only ten houses visited had ceiling. The rest had

interior partitions not reaching up to the roof or the ceiling and as a result providing inadequate partitioning.

Figure one shows the employment status of the combined study population.

Table six shows the educational status of the combined study population. Less than four percent have tertiary education while more than fourty percent have primary education only.

3.3 RECENT MORBIDITY, MORTALITY AND BIRTH EXPERIENCE

Morbidity:

Table seven shows thirty-nine (39) illness categories. Allergy, upper respiratory affections, and diarhoea were the the main causes of morbidity.

Table eight shows morbidity by the area studied. Diarrhoeal disease appeares more frequently in the rural than in urban area. Cough and flu were reported more frequently by the urban population as a problem. This may indicate differences in perception, by the two study populations, of what constitute ill health and morbidity. Headache was reported more frequently by the rural study population as the cause of morbidity than the urban community. High blood pressure was

diagnosed and treated far more frequently among the urban dwellers than in the rural study population. This may reflect the proximity of the clinic and the consequent frequent usage by the Ngwelezana Township residents. Stomachache, which includes dyspepsia and heart burn, were reported more frequently by the Ngwelezane Township residents than by the Matshana people. Nearness of the facility may be a factor here as well.

Table nine shows care used, by morbidity experienced, by the combined study population. The general practitioners were visited more frequently than the Ngwelezane Clinic for cases of diarrhoea, cough, headache, stomachache, consultations leading to operations, bladder problems (urinary tract), measles, tuberculosis and chest problems.

Table ten shows the frequency of morbidity by sex, in the combined study population. Diarrhoea, cough, headaches, high blood pressure and stomachache occured more frequently in the females than males of the study population. Asthma and flu occured almost equally.

Mortality:

The pattern of mortality could not be established during the study period, as no households reported recent deaths, that is, deaths in the last six months.

Birth experience

Table eleven shows that motherhood, by age, is widely distributed from eleven (11) years through to thirty-six (36) years in the combined study population. The mean is twenty-two (22) years of age.

Figure two (2) shows that sixty-seven percent (67%) of the mothers were single parents and had never married.

Figure three (3) shows antenatal care provision; thirty-five percent (35%) of women used the clinic for antenatal care; seven percent (7%) used the general practitioners for antenatal care, while fifty-eight percent (58%) used either the clinic or general practitioners at one time or other.

Figure four (4) shows that eighty percent (80%) of deliveries were in hospital and only twenty percent (20%) at home. There has been a definite shift away from home deliveries and there is no tradition of birth attendants generally identifiable and formally recognised as such by the community.

Immunisation and feeding:

The babies, though immunised, were not having evidence for such immunisation in seventy-seven percent (77%) of cases, of vaccine given. The stage of the immunisation process could not

be specified.   BCG was specified in twenty-three percent (23%) of cases only.

Figure five (5) shows that breastfeeding occured together with other feeds in ninety-five percent (95%) of cases.   Only two percent (2%) used bottle feeding alone.   Enquiry about childhood related illness brought so much non specific information as to make these responses unusable for analysis, as seen in Table sixteen (a).

Family planning:

Table twelve (12)   shows the frequency of utilisation of family planning services.

3.4   FIRST CHOICE OF CARE

Table thirteen   shows firts choice of care by type of health service provision, for the combined study population.   The clinic was used as first choice in seventy percent (70%) of cases, while general practitioners were used in eighteen percent (18%) of cases of first choice.   The out-patient department of Ngwelezane Hospital was hardly utilised as first choice, this may well be due to insistance on referrals only being seen first at the out-patient department.

Table fourteen   shows that females and males utilised the clinic and general practitioners in preference to other types of care.   There does not seem to be any differences based on gender in the choice of care.

Table fifteen (15)   shows choice of health service by area of residence.   There seems to be a greater tendency to use the clinic as first choice of care than the general practitioners, by the rural people.   This could be due to the fee for service demanded by the general practitioners.

Table sixteen (16)   shows that the clinic was considered as most effective for the following specific illnesses:

Fits   —   71% of respondents

Diarhoea   —   79% of respondents

Cough   —   80% of respondents

Broken bones -   7% of respondents

The same figures show the general practitioner as being more effective than the hospital Out-Patient Department in dealing with the above specific illnesses.   The rating of the effectiveness of the herbalist and faith healer, in care of fits, is higher than for the other specified diseases.

With regard to care for broken bones the effectiveness of the medical doctors ranks highest above other forms of care, as shown in Table 23 (d).

3.5   ADVISE ON HEALTH MATTERS

Table twenty (20)   shows   the health advice for the combined study population.   Sixty-five percent (65%) of the respondents cited the mass media as their source of medical advice, as against the eighteen percent (18%) receiving their health advice from Western-trained medical personnel.   Only three percent (3%) of the respondents acknowledged practitioners of traditional medicine and faith healers, as sources of health advice.

3.6   MEMBERSHIP OF SOCIAL GROUP

Figure six (6)   shows that eighty-five percent (85%) of respondents in the two communities have membership in church groups. Savings, gardenings and rural groups share the remaining five percent (5%) of membership.

3.7   ECONOMIC CIRCUMSTANCES

Table twenty-one (21) shows the number of persons in a

households contributing to household income. The majority have three persons contributing. Though the individual earnings may be low, the combined income is able to cover the household needs.

Table twenty-two (22) shows ownership per household. Ninety-five percent (95%) own some property or possession of value such as the house, radio or television set. Forty-two percent (42%) own their own house plus a radio. In general, the vast majority of the households, some relatively poor and some relativeley well-off, were neat and tidy. There seems a striking desire to acquire urban Western standards of living, as evidenced by the ubiquitous radio receiver, the occassional television sets and modern household furnishings, for example, table, chairs and settees in both urban as well as rural households. This could be seen as Western transformation of African communities.

Table twenty-three shows the types of food produced by households. Slightly less than half of households surveyed produced food of one type or another. Urbanisation was the main reason for the decline in food production by households. The majority of those who did not produce any household food were the Ngwelezane Township residents.

Table twenty-four (24) shows food eaten daily in the households. More than half of households had staple only in their daily meals, which was invariably a mealimeal product. These were consequently at the risk of deficiency diseases, especially where under-fives were involved.

However a number of the households had meat and vegetables daily.

Figure seven (7) shows the type of housing, for the combined study population. Housing is mainly brick and iron. The housing is adequate for the majority of the population, in terms of insulation and ventilation.

Table twenty-five shows over which items most of the household finances are spent. An inordinately high amount appeares to be spent on health care. It was difficult to determine if there was any bias towards the health profession as the interviews were conducted by the doctor's family members.

Figure eight (8) shows the method of excreta disposal for the combined study population. There is hardly anyone using the open veld.

Figure nine   (9)   shows that garbage disposal is hygenic in that it is either collected or deposited in a pit.

3.9   WATER SOURCE

Figure   ten   (10)   shows that forty-nine percent (49%) of households have piped water and twenty-four percent (24%) depend on boreholes for their domestic water supplies.   The problem is the rest who may still be using a contaminated domestic water source and hence remain a risk even for those with clean water.

Figure eleven (11)   shows that sixty-two percent (62%) of households store their domestic water in open containers and this water is therefore potentially contaminated.

Figure   twelve (12)   shows that the energy source and the cooking apparatus is predominantly gas or paraffin. Gas as a source of energy has a potential of leaking and causing fires.   There have been many cases of poisoning, some fatal, due to careless storage of parrafin in the home.

3.10   CONSENSUS IN HOUSEHOLDS ON THE IMPORTANT CAUSES OF DISEASE

Table twenty-six (26) is about household consensus on the important causes of disease. Consensus accepts the germ thory but adds witchcraft as equally important in the causation of diseases.

Table twenty-seven is about the household consensus on the important determinants of good health. Adequate nutrition, cleanliness and avoidance of substance abuse, mainly alcohol and tobacco, are accepted as the most important determinants of good health by the majority of households in the combined study population. For some, frequent purgation is also a preriquisite for keeping healthy.

Table twenty-eight shows health and environmental matters to be community priorities for the combined study population. For some, communication, prevalence of violence and socio-economic problems, such as unemployment, are major community problems needing urgent attention.

CHAPTER 4

COMMUNITY LEADERS' OPINIONS ON PRIORITY AREAS FOR PRIMARY
CARE INTERVENTION

4.   INTRODUCTION

Ngwelezane Township is divided into six wards, each ward
electing a councillor onto the board administering the
township, in terms of housing allocation, peace and order,
environmental hygiene and community needs.

The rural area studied falls under the Madlebe Tribal
Authority area of local government.   The Chief and his
Indunas are responsible for siting homesteads, allocating
fields for ploughing and providing grazing land.   There is
no provision for health administration or environmental
control   in the Western sense,   although complaints
regarding these will be reported to the indunas.

The opinions of the leaders in these two study areas are
summarised below:

4.1   MOST IMPORTANT PROBLEMS FACED BY THE COMMUNITY

Urban Areas

- Lack of community hall and lack of recreational facilities were hampering development of the Ngwelezane Township community.

Urban areas

- The acute housing shortage was leading to overcrowding in the township and was responsible for the growth of a massive squatter camp (slum area) at the nothern edge of the township.

- inappropriate refuse disposal at the edge of a large river, running through the township, was causing water pollution and serious health hazards in the squatter camp population, who drew their domestic water from this river.

- unhygienic grave digging was causing a foul smell in the nearby township cemetry.

Rural area:

-       lack of adequate clean water supplies;

-       drought, hunger and unemployment were being felt
        more harshly by the community as no relief was
        being provided.

-       inadequate health facilities in the rural area
        forced people to walk far more than eight
        kilometres to Ngwelezane clinic in the township.

-       three boreholes had broken down and though reported
        to the relevant officer of government department,
        no repairs had been effected over a whole year.

SPECIFIC HEALTH PROBLEMS WHICH HAVE BEEN REPORTED TO THE
LEADERS OF THE STUDY COMMUNITIES

Urban areas

-       fears of cross infection of township residents'
        children following serious outbreak of diarhoeal
        disease in the squatter camp;

- contamination of township children by rural children in the primary school, with ringworms and scabies; and

- the growing encroachment of the slum onto the township.

Rural areas

- no major health problems had been reported;

- hunger and lack of shelter for some elderly people without the extended family, were a problem with two leaders. This attributes to the urban drift of the young active population; and

- resistance to latrine building and lack of enforcement.

3. THE MEASURE TAKEN TO MEET THESE PROBLEMS

- securing of new residential sites as extension to the Ngwelezane Township by about 1 000 sites, would help ease the acuteness of the housing backlog;

- regular consultations with the health insepectors' department about environmental hygiene had been initiated and frequent inspections were now started; and

- a new site for waste (garbage) disposal had been identified and the Empangeni Town Council authorities were giving expert advice.

Rural areas

- no definite procedures had been formulated;

- the Chief was always preaching to and urging the people to build pit latrines. There was no legal means of enforcing such construction and use of pit latrines, however; and

- only the government can help in provision of a clinic in the rural area.

4   POLICY ON PRIMARY HEALTH CARE

None of the leaders in both study communities had formulated a policy on primary health care.

5.   LIAISON WITH HEALTH PERSONNEL

Urban areas

-    Regular contact and regular meetings with health
     inspectors were now part of the town Councils'
     agenda.

Rural areas

-    Attempts were being made at spring protection, but
     fencing had not been done and protection was not
     effective to date.

6.   ENFORCEABLE MEASURES TO CONTROL DANGEROUS DISEASES IN THE
      COMMUNITY

There were no provisions for such enforcements. Only
gentle persuasion was used in both study communities.

7.   MEASURES SPECIFICALLY RELATING TO CONTROL OF:

-    pollution and contamination of water sources;

-    excreta disposal; and

-    littering in the streets and homes.

Both communities were unable to effect this except by attempts to persuade the people in each case.

8.   SELF-HELP SCHEMES BEING PROMOTED

Urban area

-       each ward had extra land for optional vegetable gardens; and

-       the Ngwelezana Hospital authorities have consented to have the Ngwelezana Clinic Committees established and the residents were going to run the clinic committees.

Rural areas

-       vegetable gardening had been given a considerable boost by involving Red Cross in the gardening effort. The garden group had a viable committee, with savings in excess of R6,000, at the end of 1985. A hundred households were involved in the Nqutshini gardens. Red Cross had helped them raise money to buy a bakkie to transport their produce to the Empangeni town markets.

-     chlorination of water had been started in the tanks erected by students (Witwatersrand Engineering students) who helped the women with manually operated pumps.

CHAPTER 5

LEVELS OF PROVISION AND CURRENT PATTERNS OF UTILISATION OF

HEALTH SERVICES

5.   INTRODUCTION

In any survey of the utilisation of health services, variables at the level of the individual as well as system variables have to be included, as demonstrated in the Belgian study on Utilisation of Primary Health care Services.

Perceived morbidity, predisposing factors and enabling factors are important variables at the level of the individual.

There is a strong relationship between perceived presence and perceived seriousness of morbidity on the one hand and utilisation on the other hand.

The health perspective, which includes medical knowledge, values and attitudes, seems to have a differentail influence on utilisation behaviour, depending on age and social background of the respondent.

Ngubane (1975) has pointed out, and drawn a clear and wholly rational distinction between diseases of the body, which the White doctor may be able to remedy, and social, or mental diseases, which izangoma or diviners are more likely to understand and able to relieve.

Accessibility and socialization were found to be factors having a clear influence on the use of the general practitioner services in the Belgian study. The importance of the presence and the organisation of the supply had a strong influence on the pattern of utilisation behaviour.

The study population of Ngwelezana Township and the Matshana reserve have medical services provided by the following institutions:

- Ngwelezane Hospital Out Patients' Department
- Ngwelezane Clinic situated in the township
- 15 to 20 General Practitioners in the Empangeni town
- Empangeni Family Planning Clinic in town.

For the purposes of this study it is only the patterns of utilisation at the Ngwelezane Clinic that we are concerned with as this clinic serves solely the two study

populations as well as part of another Tribal Authority across the Umhlathuze River.

The period of observation was from 1st October 1985 through to 31st December 1985. The patterns of utilisation at this clinic are shown in Figure forty-one (41).

The reason for utilisation were as follows:

—	Minor ailments	36%
—	Antenatal care	20%
—	Immunisation	10%
—	Family Planning	10%
—	Child health	8%
—	Chronic illness - hypertension	
	asthma	
	diabetes	7%
—	Tuberculosis	9%

There is a clear dominance of the curative character of the service over the promotive-preventive aspects.

The high frequency of attendances for minor ailments provides a valuable opportunity for health education, case

tracing and promotive-preventive care, as the patients are not gravely sick nor needing urgent referral to hospital.

The population served is approximately 29,740 by this single health facility and the Ngwelezane Hospital is largely utilised for referral.

The clinic functions daily except on Sundays. All deliveries are referred to Ngwelezane Hospital maternity section.

Among the health professionals there was general consensus that the facility was being heavily utilised. Most of the available time was given to curative activities on a daily basis and to promotive-preventive exercise once a week for immunisation day and for antenatal care, and family planning activities, respectively.

Time for health education of mothers at the child health clinic was inadequate so was the space for demonstrating oral rehydration for diarhoeal dehydration.

There was inadequate staffing of the clinic in the senior health professional categories of sister, medical officer and social worker.

The school nursing service was run from Ngwelezane Clinic for the schools in the two study communities. The major problem in this area were widespread bilharzias, scabies and undernutrition.

Red Cross was co-operating in alleviating the nutrition problem by provision of high protein soups for children.

On the whole, primary care work was proceeding well though further manpower inputs and increase in working space would greatly increase the reach of the service in these communities studied.

CHAPTER 6

PRIORITIES FOR HEALTH SERVICE INTERVENTION, AND
RECOMMENDATIONS FOR THE IMPROVEMENT OF THE
HEALTH STATUS OF COMMUNITY STUDIED

From the foregoing data analysis it is possible to define the communities in terms of the objectives of this descriptive survey.

Population and demographic structure reflects the Third World character of our African communities - more than fifty percent (50%) being below forty (40) years of age.

Planning has to consider the needs of such a population in terms of preventive-promotive and curative strategies. Maternal and child health services are a priority need for early detection of abnormalities and preventable complications; postnatal care and well-baby clinics serve a much needed preventive and promotive function.

Morbidity and mortality can be influenced positively by accelerated child immunisation in view of available health advice via radio. We can then contribute positively to

the WHO - UNICEF goal of Universal Child Immunisation by the Year 1990.

Equally important are youth services in the form of health education against sexually transmitted diseases and advice aimed at preventing and limiting promiscuity in the face of evermounting young single parenthood.

With the predominantly young population actively involved in industries as workers, primary health care services have to be established at the work place. This will be part of the ongoing efforts to prevent occupational diseases.

Water borne diseases, dysentry in particular, still contribute significantly to morbidity in the community. All efforts should be made to teach people techniques of purifying their domestic water on a small scale. Solution to this complex problem depends on government's laying the necessary infrastructure for adequate clean domestic water supplies.

It would seem that people have been sufficiently conscientized regarding environmental hygiene and personal hygiene in view of the sizeable number having pit

latrines. It is necessary to reinforce these health values in health educational programmes.

In summary, health services intervention would be mainly to reinforce the existing levels of provision at the promotive-preventive and curative levels. The aim would be to reach every household and to know at all times the level of protection, in terms of immunisation against preventable diseases, of every child, be it pre-school or school going age. This would entail strengthening, existing health services through central planning and development of a regional support structure, for instance increased community participation.

Implementation of primary health care centres around the "Health Team" concept in which are included a medical doctor, a nursing sister, an agricultural officer, social worker and the community itself would bring us very close to the ideal level of primary health care provision. Unfortunately we do not have such a team in the communities studied.

It would be salutary for health authorities to recall the Pholela Health Care programme of the 1940's. In that programme health was to be decentralised effectively,

every community having adequate cover within reach of their limited budgets.

The training of community health care workers has not to date been taken up sufficiently to cover all rural communities.

Experience in other Third World countries have shown the community health workers as invaluable health team members in bringing primary health care to rural communities. It is hoped that this little survey can contribute to the realization, by all concerned, of the urgency of primary health care provision especially in the rural areas.

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                               Blindness in National Programmes. WHO,
                               Geneva.

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                               Oxford University Press, New York.

Ngubane, H   (1978)   Body   and   Mind   in   Zulu   Medicine.
                               Academica Press, London.

Spencer, I N F   (1980)   Community Health.   Shuter and Shooter
                               Pitermaritzburg. South Africa.

Stark, R   (1985)   Lay Workers in Primary Health Care.
                               Social Science and Medicine, Volume 20,
                               Number 3, Perganon Press, Oxford.

200 ─

49.2%

150 ─

34.6%

FREQUENCY

100 ─

50 ─

8.4%   7.5%

0 ─   0.3%

0-14 Yrs 15-24 Yrs 25-34 Yrs   35-44 Yrs 44+ Yrs

AGE GROUP

TABLE 2

60 ─

50 ─

40 ─

FREQUENCY

30 ─

20 ─

10 ─

0 ─

1   2   3   4   5   6   7   8   9   10   11   12   13

NUMBER OF PERSONS PER HOUSEHOLD

TABLE 3

NUMBER OF MALES IN A HOUSEHOLD

TABLE 4

NUMBER OF FEMALES IN A HOUSEHOLD

TABLE 5

OCCUPATIONAL STATUS OF THE COMBINED POPULATIONS
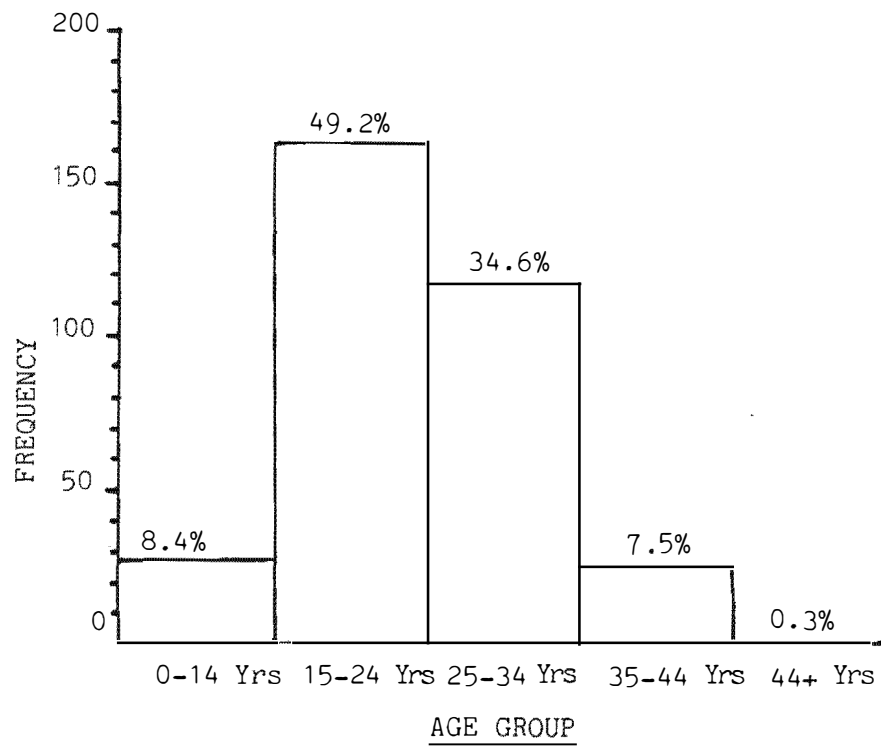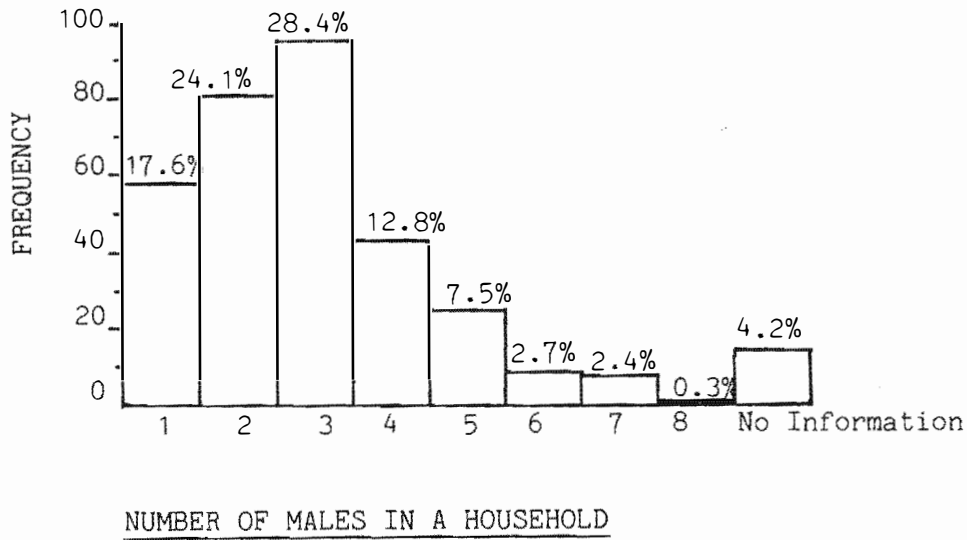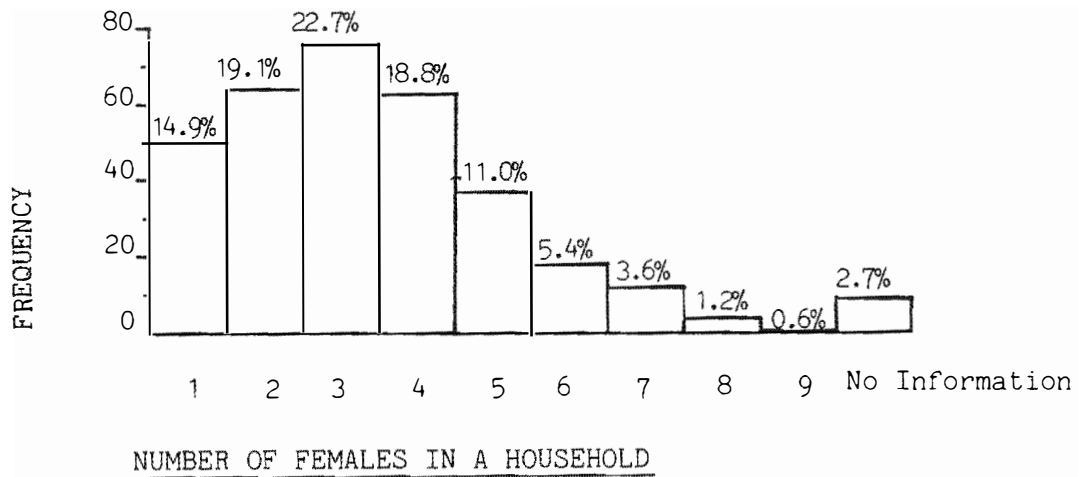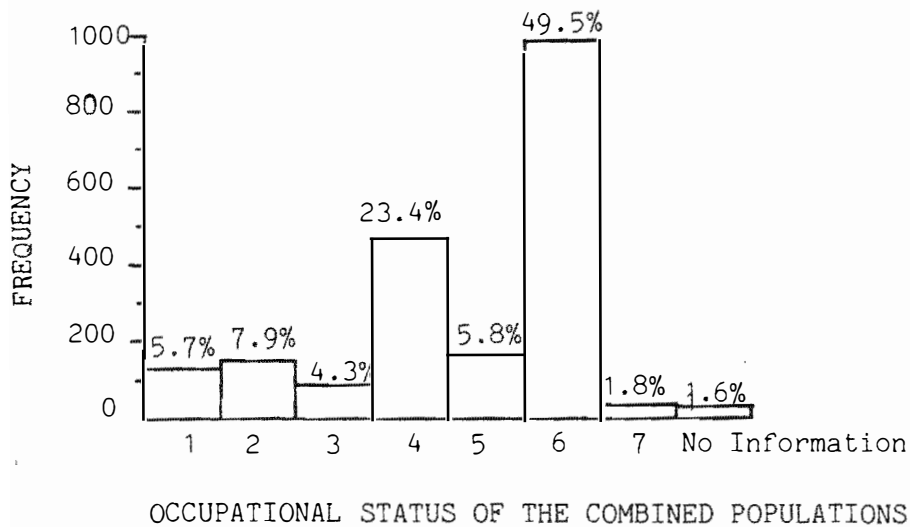
KEY:

1. Professional
2. Non-manual
3. Manual skilled/
   semi-skilled
4. Manual unskilled
5. Housewife
6. Children/students
7. Pensioners
8. No Information

FIGURE 1

19.5%   24.0%

Employed
Unemployed
The rest
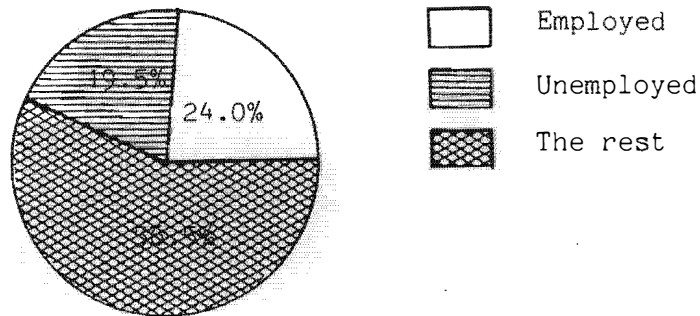
UNEMPLOYMENT STATUS OF THE COMBINED STUDY POPULATION

TABLE 6

KEY:
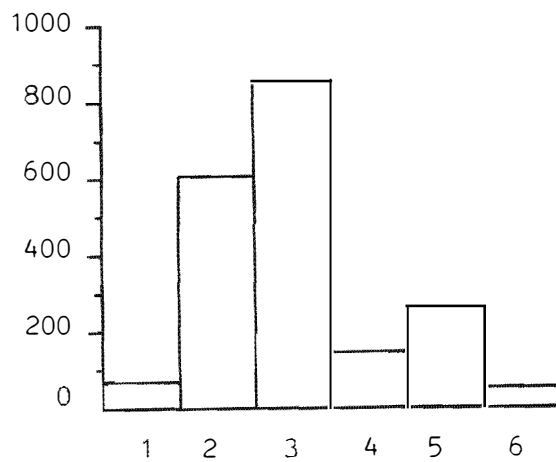
1. Tetiary education
2. Secondary education
3. Primary education
4. Illiteracy
5. Preschool children
6. No information

EDUCATIONAL STATUS OF THE COMBINED STUDY POPULATION

TABLE 7

MORBIDITY IN COMBINED URBAN AND RURAL COMMUNITIES OF NGWELEZANE
AND MATSHANA AREA

DIAGNOSIS	FREQUENCY	PERCENTAGE
1. Asthma	27	10.7
2. Diarrhoea	27	10.7
3. Cough	25	10.0
4. Flu	21	8.0
5. Headache	18	7.0
6. H.B.P.	17	6.7
7. Stomachache	12	6.8
8. Kidney problems	10	4.0
9. Backache	9	3.6
10. Toothache	9	3.6
11. Bilharzia	7	2.8
12. Knee problem	6	2.4
13. Eye problem	4	1.6
14. Fits	4	1.6
15. Operations	4	1.6
16. Rash	4	1.6
17. Pox (Chicken pox)	4	1.6
18. Tonsillitis	4	1.6

DIAGNOSIS	FREQUENCY	PERCENTAGE
19. Bladder problems	3	1.2
20. Ear trouble	3	1.2
21. Measles	3	1.2
22. Tuberculosis	3	1.2
23. Ulcers	3	1.2
24. Arthritis	2	0.8
25. Chest problems	2	0.8
26. Cholera	2	0.8
27. Feet problems	2	0.8
28. Stroke	2	0.8
29. Tetanus	2	0.8
30. Vomiting	2	0.8
31. Worms	2	0.8
32. Wounds	2	0.8
33. Alcoholic	1	0.4
34. Appendicitis	1	0.4
35. Burns	1	0.4
36. Diabetic	1	0.4
37. Malaria	1	0.4
38. Ovaries	1	0.4
39. Raped	1	0.4
TOTAL	252	100%

TABLE 8

TABLE OF MORBIDITY BY AREA

DIAGNOSIS	URBAN	RURAL
1. Asthma	13	14
2. Diarrhoea	10	17
3. Cough	16	9
4. Flu	12	9
5. Headache	5	13
6. H.B.P.	11	6
7. Stomachache	8	4
8. Kidney problems	5	5
9. Backache	3	6
10. Toothache	7	2
11. Bilharzia	4	3
12. Knee Problems	2	4
13. Eye problems	4	0
14. Fits	1	3
15. Operation	1	3
16. Rash	4	0
17. Chicken pox	3	1
18. Tonsillitis	3	1

DIAGNOSIS	FREQUENCY	PERCENTAGE
19. Bladder problems	2	1
20. Ear trouble	1	2
21. Measles	0	3
22. Tuberculosis	0	3
23. Ulcers	2	1
24. Arthritis	0	2
25. Chest problems	1	1
26. Cholera	0	2
27. Feet problems	1	1
28. Stroke	0	2
29. Tetanus	0	2
30. Vomiting	0	2
31. Worms	2	0
32. Wounds	2	0
33. Alcoholic	1	0
34. Appendicitis	0	1
35. Burns	0	1
36. Diabetes	1	0
37. Malaria	1	0
38. Ovaries	1	0
39. Raped	0	1
TOTAL	252	100%

TABLE 9

MORBIDITY BY CARE IN THE COMBINED STUDY POPULATION

DIAGNOSIS		CLINIC	GENERAL PRACTI- TIONER	HOSPITAL	HERBA- LIST	DIVI- NER	FAITH HEALER	TOTAL
1.	Asthma	10	17	0	0	0	0	27
2.	Diarrhoea	14	12	0	1	0	0	27
3.	Cough	11	13	1	0	0	0	25
4.	Flu	14	7	0	0	0	0	21
5.	Headache	8	10	0	0	0	0	18
6.	H.B.P.	6	10	1	0	0	0	17
7.	Stomach	5	6	0	0	1	0	12
8.	Kidney	6	4	0	0	0	0	10
9.	Backache	4	5	0	0	0	0	9
10.	Toothache	3	6	0	0	0	0	9
11.	Bilharzia	4	3	0	0	0	0	7
12.	Knee problem	3	3	0	0	0	0	6
13.	Eye problem	2	2	0	0	0	0	4
14.	Fits	2	2	0	0	0	0	4
15.	Operation	0	4	0	0	0	0	4
16.	Rash	2	2	0	0	0	0	4
17.	Chicken pox	3	1	0	0	0	0	4
18.	Tonsillitis	2	2	0	0	0	0	4
19.	Bladder	1	3	0	0	0	0	4
20.	Measles	3	0	0	0	0	0	3

DIAGNOSIS	CLINIC	GENERAL PRACTI- TIONER	HOSPITAL	HERBA- LIST	DIVI- NER	FAITH HEALER	TOTAL
21. Tuberculosis	0	3	0	0	0	0	3
22. Ulcers	1	2	0	0	0	0	3
23. Arthritis	1	1	0	0	0	0	2
24. Chest problem	1	0	0	0	0	1	2
25. Cholera	0	2	0	0	0	0	3
26. Feet problem	1	0	0	1	0	0	2
27. Stroke	1	1	0	0	0	0	2
28. Tetanus	1	1	0	0	0	0	2
29. Vomiting	1	1	0	0	0	0	2
30. Worms	1	1	0	0	0	0	2
31. Wounds	2	0	0	0	0	0	2
32. Alcoholic	1	0	0	0	0	0	1
33. Appenditis	0	1	0	0	0	0	1
34. Burns	0	1	0	0	0	0	1
35. Diabetic	0	1	0	0	0	0	1
36. Malaria	1	0	0	0	0	0	1
37. Ovaries	0	1	0	0	0	0	1
38. Raped	0	1	0	0	0	0	1
TOTAL	117	129	2	2	1	1	252

TABLE 10

TABLE OF MORBIDITY BY SEX

DIAGNOSIS		MALE	FEMALE
1.	Asthma	14	13
2.	Diarrhoea	10	17
3.	Cough	11	14
4.	Flu	11	10
5.	Headache	2	16
6.	H.B.P.	4	13
7.	Stomachache	3	9
8.	Kidney problems	5	5
9.	Backache	4	5
10.	Toothache	5	4
11.	Bilharzia	6	1
12.	Knee problems	1	5
13.	Eye problems	1	3
14.	Fits	2	2
15.	Operation	1	3
16.	Rash	2	2
17.	Chicken pox	3	1
18.	Tonsillitis	0	4
19.	Bladder problems	3	0
20.	Ear trouble	3	0

DIAGNOSIS		MALE	FEMALE
21.	Measles	2	1
22.	Tuberculosis	3	0
23.	Ulcers	2	1
24.	Arthritis	1	1
25.	Chest problems	1	1
26.	Cholera	2	0
27.	Feet problems	1	1
28.	Stroke	0	2
29.	Tetanus	1	1
30.	Vomiting	0	2
31.	Worms	1	1
32.	Wounds	2	0
33.	Alcoholic	1	0
34.	Appendicitis	1	0
35.	Burns	1.	0
36.	Diabetic	1	0
37.	Malaria	0	1
38.	Ovaries	0	1
39.	Raped	0	1

TOTAL = 252

TABLE 11

AGE	%	AGE	%
11	2.5	14	2.5
16	2.5	17	5.0
19	10.0	20	7.5
		21	2.5
		22	10.0
		23	7.5

AGE	%
24	5.(
25	7.5
26	5.(
27	2.5
28	2.5
29	2.5
30	7.5
32	5.(
33	2.5
35	2.5
36	5.(
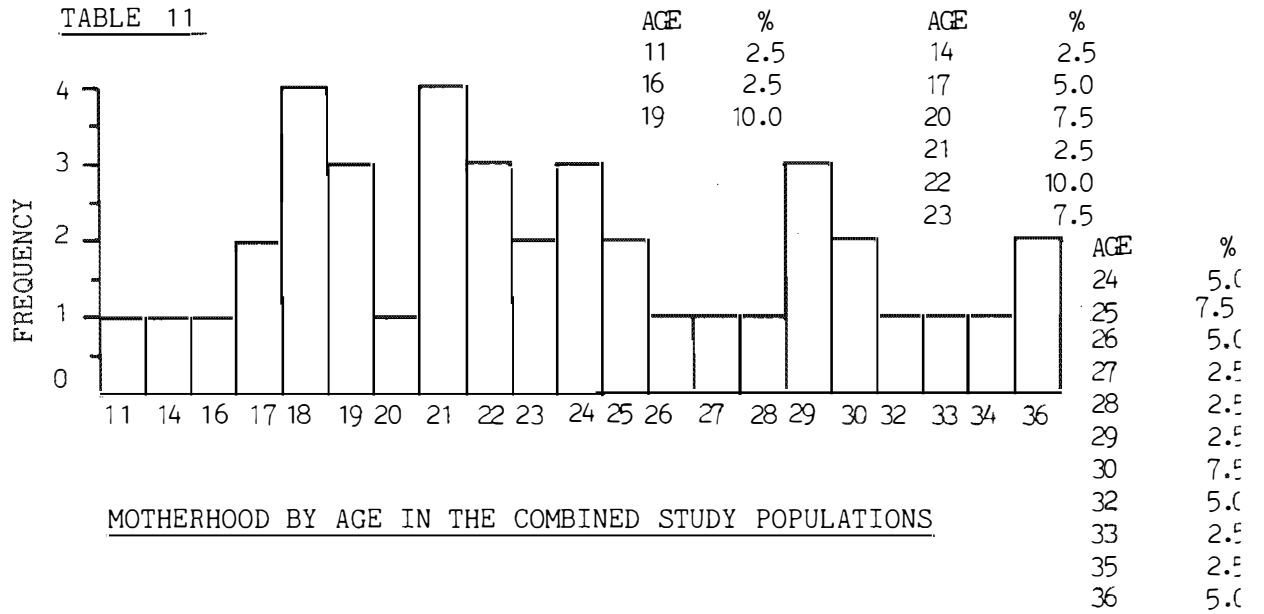
MOTHERHOOD BY AGE IN THE COMBINED STUDY POPULATIONS

FIGURE 2

67.5%

- Never married
- Married
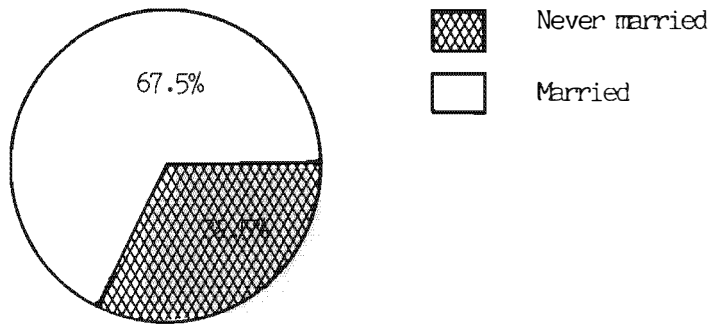
MARITAL STATUS OF MOTHERS IN THE COMBINED STUDY POPULATION

FIGURE 3

7.5%   35.0%

57.5%

- Clinic
- General practitioner
- General practitioner + clinic
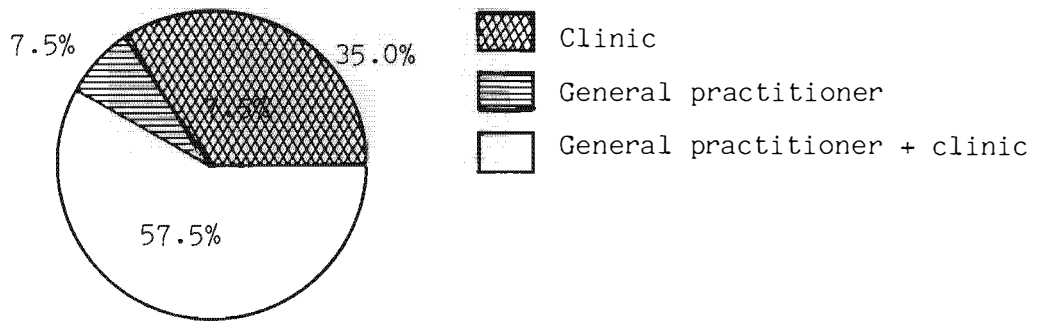
ANTENATAL CARE BY SERVICE ATTENDED

FIGURE 4

80.0%

▨ Other

☐ Hospital
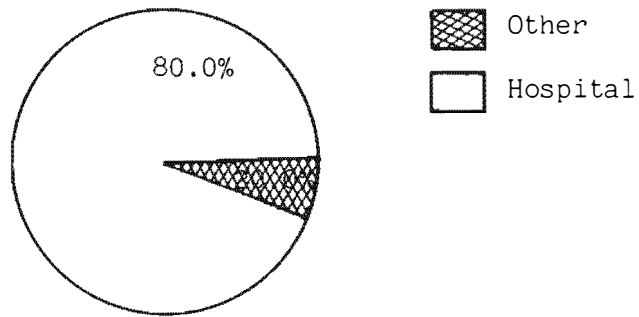
PLACE OF CONFINEMENT BY PREGNANT MOTHERS

FIGURE 5

95.0%

▨ Bottle

☐ Breast
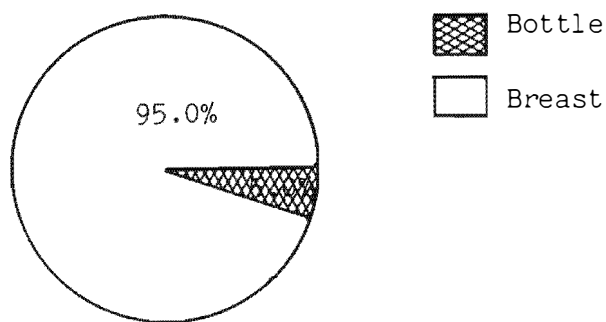
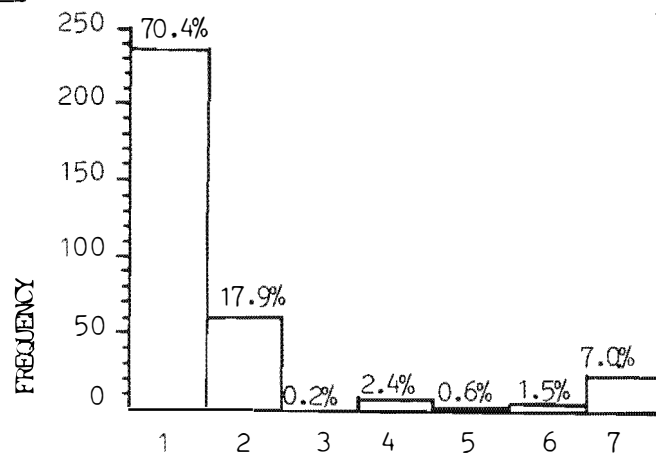INFANT FEEDING BY TYPE OF FEED USED BY HOUSEHOLDS

TABLE 12
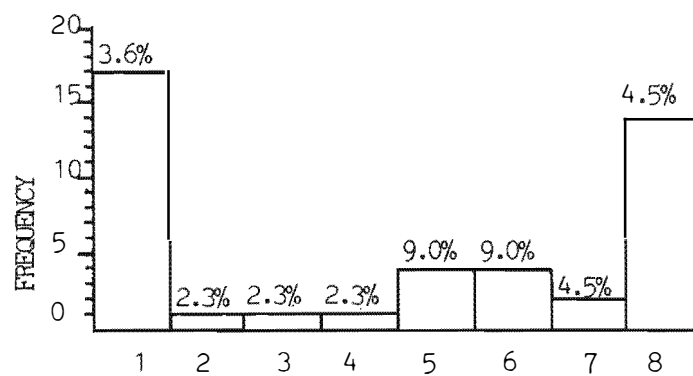
KEY:

1. Pills only
2. Depo Provera
3. Depo Provera and pills
4. I.U.D.
5. Advice only
6. Advice and pills
7. Advice and depo
8. Has tried all; advice, pills, depo provera

TABLE 13

250 ─┤ 70.4%

200 ─

150 ─

100 ─

FREQUENCY

50 ─ 17.9%

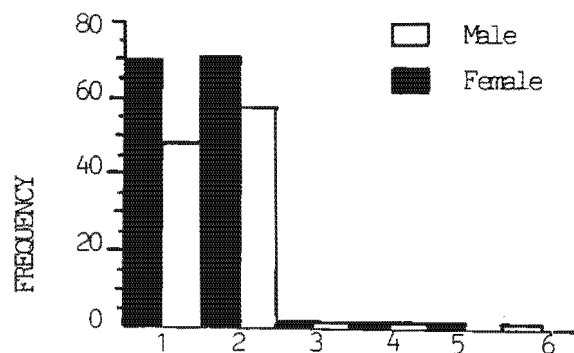0 ─ 0.2% 2.4% 0.6% 1.5% 7.0%

1   2   3   4   5   6   7

KEY:

1. Clinic
2. General Practitioner
3. Hospital
4. Inyanga (Herbalist)
5. Isangoma (Diviner)
6. Umthandazi (Faith Healer)
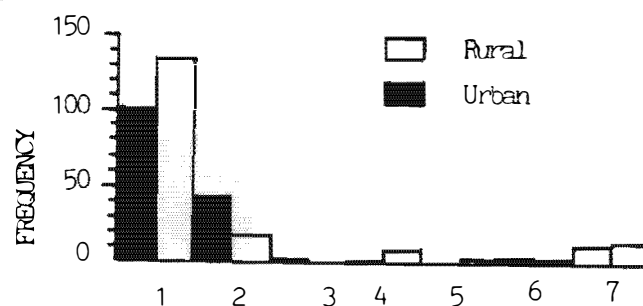7. No Information

TYPE OF CARE

TABLE 14

80 ─

60 ─

FREQUENCY

40 ─

20 ─

0 ─

1   2   3   4   5   6

□ Male
■ Female

KEY:

1. Clinic   46.3
2. General Practitioner   51.2
3. Hospital   0.8
4. Inyanga (Herbalist)   0.8
5. Isangoma (Diviner)   014
6. Unthandazi (Faith
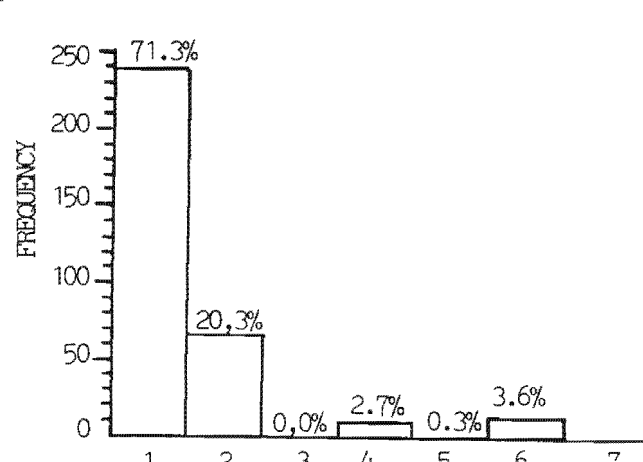   Healer)   0.4

FREQUENCY OF CARE BY SEX

TABLE 15

150 ─

100 ─

FREQUENCY

50 ─

0 ─

1   2   3   4   5   6   7

□ Rural
■ Urban

KEY:

1. Clinic   70.
2. General Practitioner   17.
3. Hospital   0.
4. Inyanga (Herbalist)   2.
5. Isangoma (Diviner)   0.
6. Umthandazi (Faith
                Healer)   1.
7. No information   6.
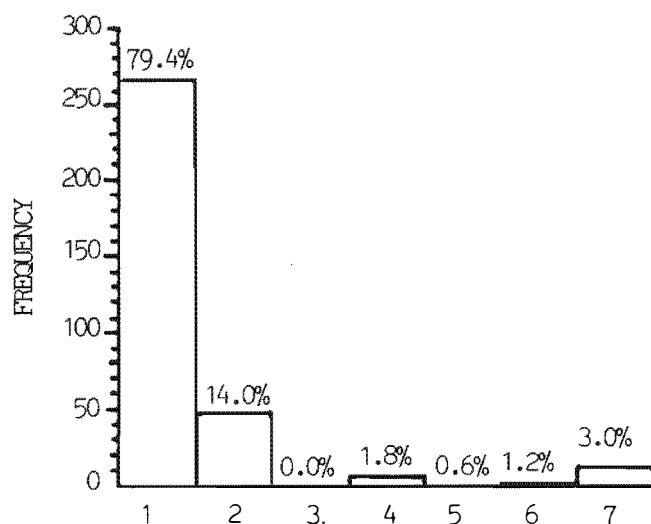
CHOICE OF HEALTH SERVICE BY AREA OF RESIDENCE

TABLE 16

250 ─┤ 71.3%

200 ─

150 ─

FREQUENCY

100 ─

50 ─ 20,3%

0 ─ 0,0% 2.7% 0.3% 3.6%

1   2   3   4   5   6   7

KEY:

1. Clinic
2. General Practitioner
3. Hospital
4. Inyanga (Herbalist)
5. Isangoma (Diviner)
6. Umthandazi (Faith Healer)
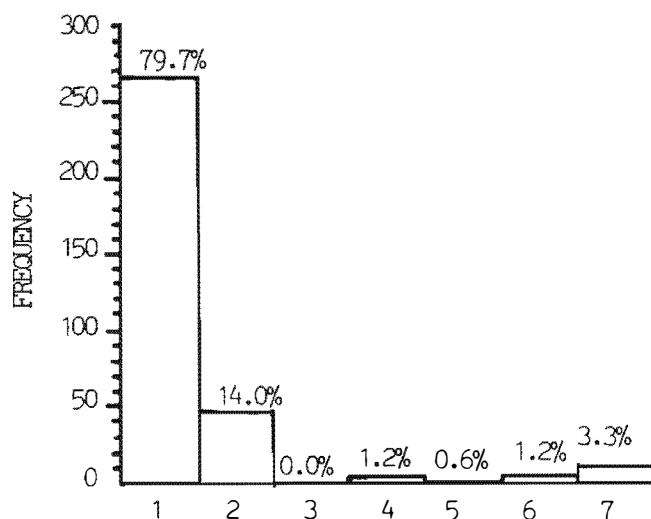7. No information

TABLE 17

KEY:
1. Clinic
2. General Practitioner
3. Hospital
4. Inyanga (Herbalist)
5. Isangoma (Diviner)
6. Umthandazi (Faith Hea)
7. No Information

MOST EFFECTIVE CARE FOR DIARHOEA BY CHOICE OF TYPE OF HEALTH SERVICE
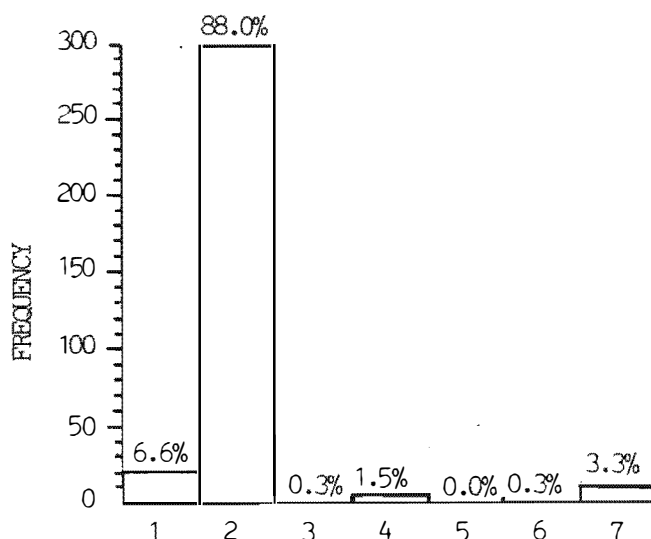
TABLE 18

KEY:
1. Clinic
2. General Practitioner
3. Hospital
4. Inyanga (Herbalist)
5. Isangoma (Diviner)
6. Umthandazi (Faith Heal)
7. No Information)

MOST EFFECTIVE CARE FOR COUGH BY CHOICE OF TYPE OF HEALTH SERVICE
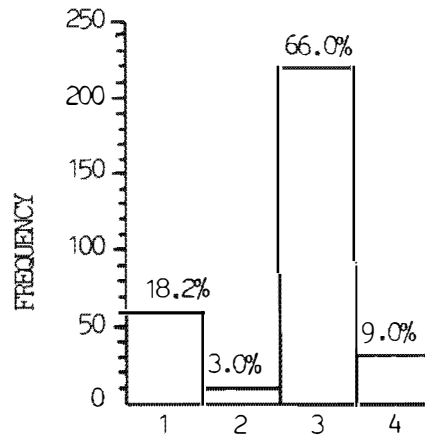
TABLE 19

KEY:
1. Clinic
2. General Practitioner
3. Hospital
4. Inyanga (Herbalist)
5. Isangoma (Diviner)
6. Umthandazi (Faith Heal)
7. No information

MOST EFFECTIVE CARE FOR BROKEN BONES BY CHOICE OF TYPE OF SERVICE

TABLE 20

ADVICE ON HEALTH MATTERS BY SOURCE OF THE HEALTH ADVICE

KEY:

1. Western medical perso⌐
    - doctors, nurses
2. Traditional medical p⌐
    - herbalists, divine⌐
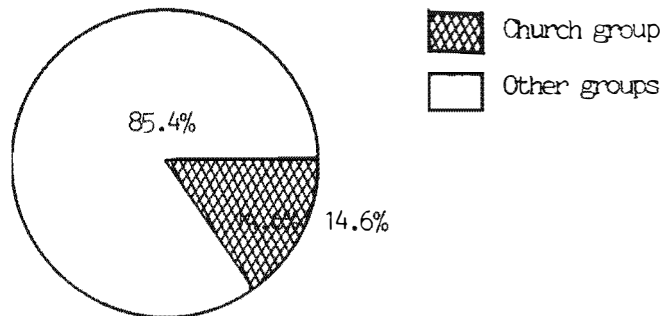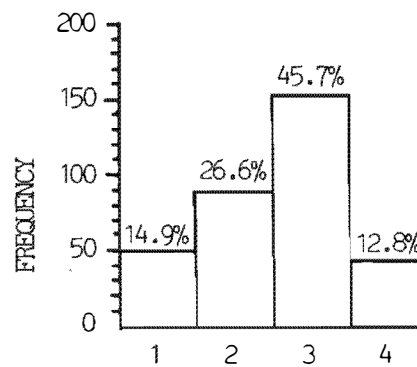3. Mass media
    - newspapers, radio &
4. No information

FIGURE 6

MEMBERSHIP OF SOCIAL GROUPS

TABLE 21

NUMBER OF PERSONS CONTRIBUTING TO HOUSEHOLD INCOME

TABLE 22

OWNERSHIP BY MEMBERS OF THE COMBINED STUDY POPULATIONS:

ITEM	FREQUENCY	PERCENTAGE
Car	1	0.3
Radio	1	0.3
Radio & TV	1	0.3
House	28	8.3
House & a car	1	0.3
House & TV	3	0.9
House, TV & car	2	0.6
House & Radio	144	43.0
House, radio & car	33	9.9
House, radio & TV	49	14.6
House, radio, TV & car	56	16.7
No information	16	4.8
TOTAL	335	100%

TABLE 23

FOOD PRODUCED BY HOUSEHOLDS IN THE COMBINED STUDY POPULATIONS:

TYPE		FREQUENCY	PERCENTAGE
1.	Fruit	22	6.6
2.	Leaf	17	5.1
3.	Leaf/fruit	4	1.2
4.	Beans	10	3.0
5.	Beans/fruit	10	3.0
6.	Beans/leaf	3	0.9
7.	Beans/leaf/fruit	5	1.5
8.	Cereal	3	0.9
9.	Cereal/beans	6	1.8
10.	Cereal/beans/leaf	1	0.3
11.	Cereal/beans/leaf/fruit	3	0.9
12.	Milk	26	7.8
13.	Milk/fruit	1	0.3
14.	Milk/leaf	2	0.6
15.	Milk/leaf/fruit	1	0.3
16.	Milk/beans	3	0.9
17.	Milk/beans	8	2.4
18.	Milk/beans/leaf	1	0.3
19.	Milk/beans/leaf/fruit	4	1.2

TYPE		FREQUENCY	PERCENTAGE
20.	Milk/cereal	3	0.9
21.	Milk/cereal/leaf	1	0.3
22.	Milk/cereal/beans	3	0.9
23.	Milk/cereal/beans/fruit	3	0.9
24.	Milk/cereal/beans/leaf	5	1.5
25.	Milk/cereal/beans/ leaf/fruit	6	1.8
26.	No information	183	54.6
TOTAL		335	100%

TABLE 24

FOOD EATEN DAILY IN THE HOUSEHOLDS OF THE COMBINED STUDY POPULATIONS:

TYPE		FREQUENCY	PERCENTAGE
1.	Staples alone	149	44.5
2.	Staples/vegetables	24	7.2
3.	Staples/vegetables/ beans	68	20.3
4.	Staples/vegetables/ beans/meat	94	29.0
TOTAL		335	100%

FIGURE 7

29.0%

71.0%

Mud Thatch

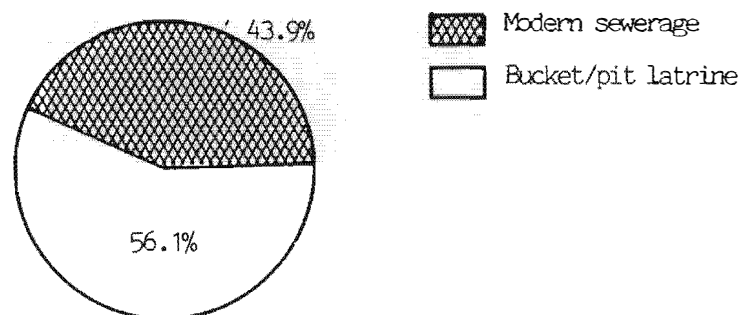Brick Iron

TYPE OF HOUSING

TABLE 25
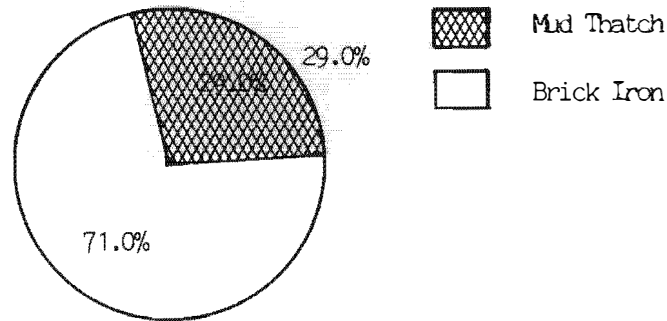
EXPENDITURE: FIRST PRIORITY IN HOUSEHOLDS
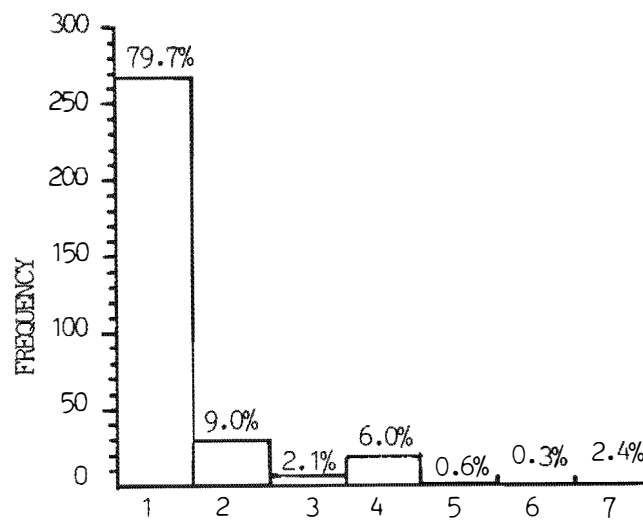
KEY:
1. Health care
2. Food/Fuel
3. Clothing and shelt
4. Education
5. Transport
6. Don't know
7. No information

FIGURE 8

43.9%
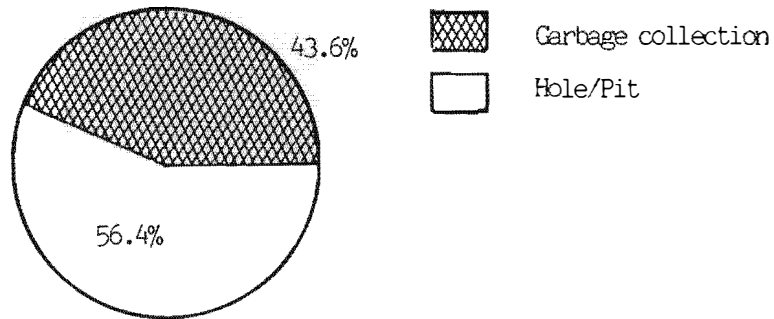
56.1%

Modern sewerage

Bucket/pit latrine

EXCRETA DISPOSAL FOR HOUSEHOLDS

FIGURE 9

Garbage collection
Hole/Pit

43.6%

56.4%

GARBAGE DISPOSAL FOR HOUSEHOLDS

FIGURE 10

Piped water
Bore holes
No information

48.1%

27.7%
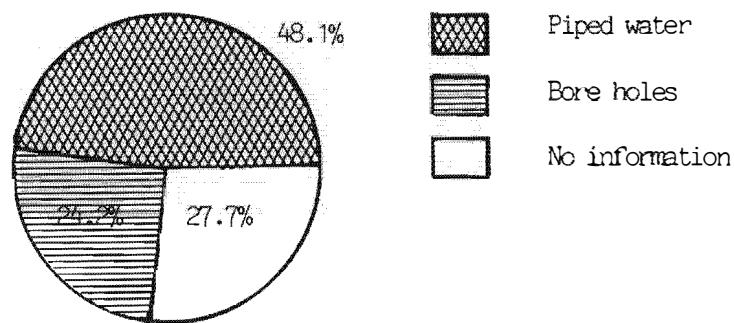
WATER SOURCE FOR HOUSEHOLDS

FIGURE 11

Indoor tap
Open vessens

37.6%

62.4%
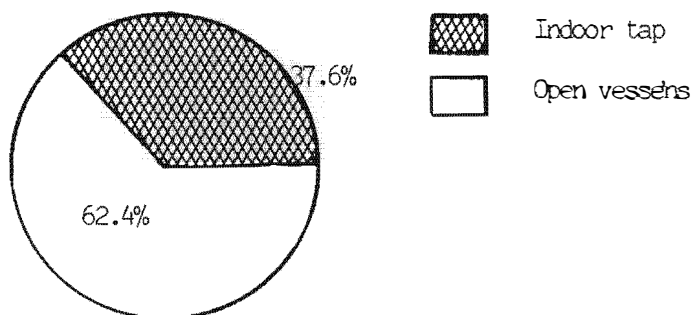
WATER STORAGE IN HOUSEHOLDS

FIGURE 12

Electric stove
Gas paraffin stove

49.0%

51.0%
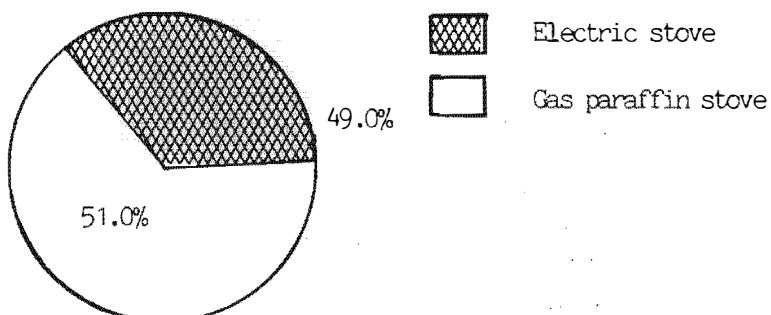
TABLE   26

IMPORTANT CAUSES OF DISEASES: CONSENSUS IN HOUSEHOLDS IN THE
COMBINED STUDY POPULATIONS:

CAUSE		FREQUENCY	PERCENTAGE
1.	Faith related	3	0.9
2.	Don't know	1	0.3
3.	Malnutrition	8	2.4
4.	Malnutroition/faith related	1	0.3
5.	Witchcraft	15	4.5
6.	Witchcraft/faith related	1	0.9
7.	Germ theory	208	62.1
8.	Germ theory/faith related	8	2.4
9.	Germ theory/ malnutrition	9	2.7
10.	Germ theory/ witchcraft	69	20.6
11.	No information	9	2.7
TOTAL		335	100%

TABLE 27

HOW TO KEEP HEALTHY: CONSENSUS IN HOUSEHOLDS IN THE COMBINED STUDY
POPULATIONS:

DETERMINANTS OF GOOD HEALTH		FREQUENCY	PERCENTAGE
1.	Ancestor worship	5	1.5
2.	Frequent purgation/ancestor worship	1	0.3
3.	Cleanliness	11	3.3
4.	Cleanliness/ancestor worship	2	0.6
5.	Cleanliness/frequent purgation	1	0.3
6.	Cleanliness/no alcohol/no smoking	18	5.4
7.	Cleanliness/no alcohol/no smoking/ frequent purgation	1	0.3
8.	Nutrition	13	3.9
9.	Nutrition/ancestor worship	8	2,4
10.	Nutrition/frequent purgation	1	0.3
11.	Nutrition/no alcohol/no smoking	2	0.6
12	Nutrition/no alcohol/no smoking/ frequent purgation	1	0.3
13.	Nutrition/cleanliness	48	14.3
14.	Nutrition/cleanliness/frequent purgation	4	1.2
15.	Nutrition/cleanliness/frequent purgation/ancestor worship	13	3.9
16.	Nutrition/cleanliness/no alcohol/ no smoking	169	50.5

DETERMINANTS OF GOOD HEALTH	FREQUENCY	PERCENTAGE
17. Nutrition/cleanliness/ no alcohol/no smoking/ ancestor worship	2	0.6
18. Nutrition/cleanliness/ no alcohol/no smoking/ frequent purgation	26	7.8
19. Nutrition/cleanliness/ no alcohol/no smoking/ frequent purgation/ancestor worship	1	0.3
20. No information	8	2.4
TOTAL	335	100%

TABLE 28

COMMUNITY PRIORITIES: CONSENSUS IN HOUSEHOLDS IN THE COMBINED
STUDY POPULATIONS:

	PRIORITIES	FREQUENCY	PERCENTAGE
1.	Socio-economic	1	0.3
2.	Communication/transport	1	0.3
3.	Communication/transport/socio-economic	1	0.3
4.	Environment	3	0.9
5.	Environment/socio-economic	1	0.3
6.	Environment/communication/transport	2	0.6
7.	Environment/communication/transport/violence	1	0.3
8.	Health	19	5.7
9.	Health/socio-economic	3	0.9
10.	Health/violence/socio-economic	2	0.6
11.	Health/communication	6	1.8
12.	Health/communication/socio-economic	2	0.6
13.	Health/environment	14	4.2
14.	Health/environemnt/socio-economic	1	0.3
15.	Health/environment/violence	1	0.3
16.	Health/environment/violence/socio-economic	3	0.9
17.	Health/environment/communication	179	53.4

PRIORITIES		FREQUENCY	PERCENTAGE
18.	Health environment/communication/ socio-economic	1	0.3
19.	Health/environment/ communication/violence	2	0.6
20.	Health/environment/ communication/violence/ socio-economic	71	21.2
21.	No information	21	6.3
TOTAL		335	100%

TABLE 29

PATTERNS OF UTILISATION OF HEALTH SERVICES AT NGWELEZANE CLINIC
1 OCTOBER 1985 TO 31 DECEMBER 1985

CATEGORY OF CARE		OCT.	NOV.	DEC.	TOTAL	PERCENT
1.	T.B. cases treated	293	311	297	901	6.0
2.	Antenatal clinic	1188	1001	828	3017	20.0
3.	Postnatal examination	-	-	-	-	-
4.	Child health	418	437	335	1190	8,0
5.	B.C.G. Vaccination	72	68	63	203	1.4
6.	Poliomyelitis	189	199	144	532	3.6
7.	Diphtheria Pertussiss	233	222	188	643	4.3
8.	Measles	60	45	21	126	0.8
9.	Minor ailments	2015	1708	1694	5417	36.3
10.	Chronic illness	30	28	47	105	0.7
11.	Veneral diseases	238	235	267	740	5.0
12.	Family planning	568	475	409	1452	9,7
TOTAL		5517	4891	4533	14941	100%

<u>ANNEXURE "A"</u>

<u>NUMBER</u>:   ____

<u>AREA</u>:   NGWELEZANE SITE NO.:   ____

            RURAL CLUSTER NO.:   ____

<u>RESPONDENT</u>

NAME   :   ....

AGE   :   ....

MARITAL STATUS   :   ....

OCCUPATIONS   :   ....

EMPLOYMENT   :   ....

EDUCATION   :   ....

ADDRESS   :   ....

                                      ....

                                      ....

                                      ....

1. HOUSEHOLD DEMOGRAPHY

OBJECTIVE 1 (i)

	SEX	AGE	MARITAL STATUS	EDUCATION	EMPLOYMENT	OCCUPATION
1.	□	□□	□	□□	□	□
2.	□	□□	□	□□	□	□
3.	□	□□	□	□□	□	□
4.	□	□□	□	□□	□	□
5.	□	□□	□	□□	□	□
6.	□	□□	□	□□	□	□
7.	□	□□	□	□□	□	□
8.	□	□□	□	□□	□	□
9.	□	□□	□	□□	□	□
10.	□	□□	□	□□	□	□

ADDITIONAL NOTES

....

....

OBJECTIVE 1 (ii)

2.   MORBIDITY AND MORTALITY:

ILLNESS OR DEATH IN MEMBERS OF THIS HOUSEHOLD IN THE PAST 6 MONTHS

TYPE OF CARE USED

	SEX	AGE		CLINIC	G.P.	OLD	INYANGA	UMTHANDAZI	ISANGOMA
1.	☐	☐ ☐		☐	☐	☐	☐	☐	☐
2.	☐	☐ ☐		☐	☐	☐	☐	☐	☐
3.	☐	☐ ☐		☐	☐	☐	☐	☐	☐
4.	☐	☐ ☐		☐	☐	☐	☐	☐	☐
5.	☐	☐ ☐		☐	☐	☐	☐	☐	☐

OUTCOME:

	RECOVERY	DEATH	DIAGNOSIS
1.	☐	☐	....
2.	☐	☐	....
3.	☐	☐	....
4.	☐	☐	....
5.	☐	☐	....

4. Under normal circumstances who do you go to first for health
    care?

    Clinic   ☐

    GP/Hospital   ☐

    Inyanga   ☐

    Umthandazi (Faith Healer)   ☐

    Isangoma   ☐

    Other   ☐

    D/K   ☐

5. Which in your opinion is the most effective type of care for
    each of these illnesses?

    Fits   Clinic   ☐

                GP/Hospital OPD   ☐

                Inyanga   ☐

                Umthandazi   ☐

                Isangoma   ☐

                Other   ☐

                D/K   ☐

Diarhoea	Clinic	☐
	GP/Hospital OPD	☐
	Inyanga	☐
	Umthandazi	☐
	Isangoma	☐
	Other	☐
	D/K	☐
Cough	Clinic	☐
	GP/Hospital OPD	☐
	Inyanga	☐
	Umthandazi	☐
	Isangoma	☐
	Other	☐
	D/K	☐

Broken bones   Clinic   ☐

                    G/P Hospital OPD   ☐

                    Inyanga   ☐

                    Umthandazi   ☐

                    Isangoma   ☐

                    Other   ☐

                    D/K   ☐

6.   From which of the following do you receive advice on health matters?

                            Radio   ☐

                            Newspapers   ☐

                            Personnel at clinic/GP   ☐

                            Relatives/Community   ☐

                            Inyanga/Umthandazi   ☐

                            Other   ☐

                            D/K   ☐

7. <u>Family planning related activity</u>

Have you ever received any of the following:

Post natal examination and family planning advice: YES ☐

NO ☐

Pap smear examination   YES ☐

NO ☐

Intra uterine device insertion   YES ☐

NO ☐

Depo provera injection   YES ☐

NO ☐

Contraceptive pills

YES ☐

NO ☐

8. <u>BIRTHS TO MEMBERS OF THE HOUSEHOLD IN THE PAST SIX MONTHS</u>

	AGE OF MOTHER	MARITAL STATUS	ANC	BIRTH PLACE	TYPE OF DELIVERY
1.	☐ ☐	☐	☐	☐	☐
2.	☐ ☐	☐	☐	☐	☐
3.	☐ ☐	☐	☐	☐	☐
4.	☐ ☐	☐	☐	☐	☐
5.	☐ ☐	☐	☐	☐	☐

<u>ADDITIONAL NOTES:</u>

....

....

9. <u>IMMUNISATION AND NUTRITION AS WELL AS RELATED MORBIDITY AND MORTALITY</u>

	AGE	BCG	POLIO I	DWT I	POLIO II	DWT II	BOOSTER	BREAST	BOTTLE
1.	0-4 months	☐	☐	☐	☐	☐	☐	☐	☐
2.	5 months	☐	☐	☐	☐	☐	☐	☐	☐
3.	7 months	☐	☐	☐	☐	☐	☐	☐	☐
4.	9 months	☐	☐	☐	☐	☐	☐	☐	☐
5.	1 year	☐	☐	☐	☐	☐	☐	☐	☐
6.	2 years	☐	☐	☐	☐	☐	☐	☐	☐

	AGE	PORRIDGE AND MILK	OTHER FOODS	ILLNESSES	DEATHS
1.	0-4 months	☐	☐	☐	☐
2.	5 months	☐	☐	☐	☐
3.	7 months	☐	☐	☐	☐
4.	9 months	☐	☐	☐	☐
5.	1 year	☐	☐	☐	☐
6.	2 years	☐	☐	☐	☐

<u>ADDITIONAL NOTES</u>

....

....

10. SOCIAL CIRCUMSTANCES

Community group to which household belongs:

Church ☐

Savings ☐

Gardening group ☐

Burial group ☐

Other ☐

D/K ☐

Number of people contributing to household income:

Five ☐

Four ☐

Three ☐

Two ☐

One ☐

None ☐

D/K ☐

Ownership:

House ☐

Radio ☐

Television ☐

Car ☐

Other ☐

D/K ☐

Food produced by household:

Milk   ☐

Cereal   ☐

Beans   ☐

Leaf   ☐

Fruit   ☐

Other (specify)   ☐

D/K   ☐

Food eaten in the household:

	DAILY	WEEKLY	MONTHLY
Staples alone	☐	☐	☐
Staples with vegetables	☐	☐	☐
Staples with beans	☐	☐	☐
Staples with meat	☐	☐	☐
Other (specify)	☐	☐	☐
D/K	☐	☐	☐

Expenditure priorities:

	FIRST	SECOND	THIRD
Health care	☐	☐	☐
Food	☐	☐	☐
Clothing and shelter	☐	☐	☐
Education	☐	☐	☐
Transport	☐	☐	☐
Other (specify)	☐	☐	☐

11. ENVIRONMENTAL CIRCUMSTANCES

    Housing

	Mud Thatch Roof	Brick Iron Roof
Type	☐	☐
Number of rooms	☐	☐

    ADDITIONAL NOTES

    ....

    ....

    ....

    ....

12. SANITATION:

    Excreta disposal:

    Modern sewerage   ☐

    Pit latrine   ☐

    Veld   ☐

    Other   ☐

    D/K   ☐

Waste disposal

Garbage collection ☐

Hole ☐

Open space ☐

Other ☐

D/K ☐

13. WATER SOURCE

Piped water (chlorinated) ☐

Bore holes ☐

Protected spring ☐

River ☐

Unprotected spring ☐

Other ☐

D/K ☐

14. WATER STORAGE IN THE HOUSE

Indoor water pipe ☐

Open vessel ☐

Other ☐

D/K ☐

15. <u>COOKING APPARATUS</u>

Electricity-plate or stove   ☐

Gas stove   ☐

Paraffin stove   ☐

Coal/wood stove   ☐

Open fire   ☐

Other   ☐

D/K   ☐

16. <u>CONSENSUS OF OPINION IN HOUSEHOLD ON THE FOLLOWING:</u>

Important causes of disease:

Germ theory   ☐

Witchcraft   ☐

Undernutrition or malnutrition   ☐

Faith related   ☐

Other (specify)   ☐

D/K   ☐

    ☐

How to keep healthy:

Nutrition   ☐

Cleanliness   ☐

No alcohol no smoking   ☐

Frequent purgation   ☐

Traditional practices e.g.
ancestor worship   ☐

Other   ☐

D/K   ☐

Health services:

Accessible (5 km) on foot   ☐

Inaccessible (10 km) on foot   ☐

Effective   ☐

Need improvement   ☐

19. <u>CONSENSUS ON COMMUNITY PRIORITIES</u>

Most important needs of the community:

Health related   ☐

Environmental   ☐

Communication and transport   ☐

Violence and thuggery   ☐

Socio-economic   ☐

Other (specify)   ☐

D/K   ☐

How community can meet its needs:

Self help   ☐

Goverment intervention   ☐

Charity   ☐

Other   ☐

D/K   ☐

To whom are community needs reported:

Induna   ☐

Chief   ☐

Magistrate   ☐

Health Officer   ☐

Agricultural Officer   ☐

Other   ☐

D/K   ☐

20. DIARRHOEAL MORBIDITY, MORTALITY AND TREATMENT IN UNDER FIVES

20.1 Are there any children under 5 years old living in this

household now?   YES ☐

                                                  NO ☐

If yes, how many children?   ☐

20.2   Did an episode of diarrhoea start in any of these children

in the past two weeks?

                                                  YES ☐

                                                  NO ☐

If yes, how many children?

If the answer to question 2 is NO, go to question 4. If

answer to question 2 is YES ask question 3.

For each child who had diarrhoea answer the following

question:

20.3 As treatment, did the child receive:

	CASE 1	CASE 2	CASE 3
Home remedies e.g. coca-cola tea starchwater other	☐	☐	☐
Specially prepared salt and sugar solution	☐	☐	☐
Oral rehydration solution	☐	☐	☐
Intravenous therapy	☐	☐	☐

20.5 Have any children less than 5 years old died in this household in the past year?

YES ☐

NO ☐

If yes, how many deaths? ☐

20.6 Have any babies been born to women in the household in the past?

YES ☐

NO ☐

If yes, how many babies? ☐

Make sure these births are included in either 1 or 4 above.

If answer to question 4 is yes, ask questions 6, 7 and 8.

20.7 For each death that occured during the week before death did the child have _

	DEATH 1	DEATH 2	DEATH 3
Diarrhoea	☐	☐	☐
Dysentry	☐	☐	☐
Fever	☐	☐	☐
Cough	☐	☐	☐
Tetanus	☐	☐	☐
Rash	☐	☐	☐

Family's opinion of cause of death (specify)

....

....

....

....

....

Additional information as to cause of death:

....

....

....

....

....

ANNEXURE "B"

OBJECTIVE 3

LEADER'S QUESTIONNAIRE

LEADERSHIP CAPACITY

NAME : ....

AGE : ....

MARITAL STATUS : ....

OCCUPATION : ....

EMPLOYMENT : ....

EDUCATION : ....

ADDRESS : ....

....

....

....

1. What are the most important problems faced by this community?

....

....

....

....

....

....

2. What specific health problems have been brought to your

attention by the community?

....

....

....

....

3. What measures are being taken or will be taken to meet the

problems?

....

....

....

4. What is your policy on primary health care?

....

....

....

....

5. Do you liaise or have any contact with health personnel in

the area? - Health Inspectors

_ Clinic Sisters

- Hospital Superintendent

....

....

....

6.   What measures do you enforce to control dangerous diseases in the community?

....

....

....

7.   Are there any measures to control the following:

(a)   Pollution and contamination of water source:

....

....

....

(b)   Excreta disposal:

....

....

....

(c)   Littering in the streets and homes:

....

....

....

8.   What self help schemes are being promoted in the community?

....

....

....

....