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**FACTORS INFLUENCING PRIMARY HEALTH CARE SERVICES UTILISATION BY  
CHILDREN LIVING IN CHILD- HEADED HOUSEHOLDS IN A RURAL  
COMMUNITY OF SWAZILAND**

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By

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## DECLARATION

I declare that **FACTORS INFLUENCING PRIMARY HEALTH CARE UTILISATION BY CHILDREN LIVING IN CHILD- HEADED HOUSEHOLDS IN A RURAL COMMUNITY OF SWAZILAND** is my own work and that all sources I have used or quoted have been indicated and acknowledged by means of complete references and this work has not been submitted before for any other degree at any other institutions.

**SIGNATURE:** .....

(JOYCE SIBANDA

**DATE:** 31 January 2015

## DEDICATION

In loving memories of my husband John Vushe, and daughter Nyashadzashe Primrose Vushe.

May their souls rest in peace.

## ACKNOWLEDGEMENTS

All praise and glory to the Almighty Lord God for granting me strength and good health for this dissertation go through.

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**ABSTRACT**

**Background:** Children living in child-headed households have health needs that require treatment and care. Matsanjani is one of the poorest socio-economic areas of Swaziland with the high number of children orphaned by HIV and AIDS who are often living without adequate family and social supports. These conditions are known for increasing people vulnerability to diseases and hindering access and utilization of health services. However, children living in child-headed households in Matsanjani community do attend the primary health care (PHC) services on regular basis. What influence the utilization of the above services by children living in child-headed households in the Matsanjani community is not clear and well documented.

**Aim of the study:** To explore and describe the views of children living in child-headed households in a rural community of Swaziland regarding factors influencing their utilization of PHC services.

**Design:** A qualitative descriptive design was used to guide the study. Purposive sampling was used to select the most senior child from child-headed households in a rural community. Semi-structured individual face-to-face interviews were used to generate data. Data saturation was reached after twenty interviews. Thematic content analysis was used to analyse data. The researcher used Andersen behavioural model was to identify and organised the emerged themes. Ethical clearance was obtained from the Ethics Committees of the University of South Africa and the Ministry of Health of Swaziland.

**Results:** Fear to develop a deadly disease, perceived seriousness of the condition, desire for compliance to medical treatment, and community support emerged as

enablers of primary health care services utilisation among children living in child-headed households. While lack of money, ignorance, shortage of healthcare personnel, negative behaviour and attitude of health professionals, long waiting hours, unreliable transportation system, and long distance emerged as inhibitors of primary health care services utilisation among children living in child-headed households.

**Conclusion and recommendation:** The results of this study add to our understanding factors that positively and negatively influence the utilisation of primary health care services among children living in child-headed households in rural communities. The findings suggest that the utilisation of primary health care services among children living in child-headed households is influenced by need for care-enabling resources-experience of care triad. Behavioural and social welfare interventions are needed to enhance the utilisation of primary health care services among this vulnerable section of the community in Swaziland. Recommendation for further research is also articulated.

**KEY WORDS:** enabling factors, child-headed households, inhibiting factors, primary health care utilisation, rural and poor community

## LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral therapy
ARVs	Antiretroviral drugs
CABA	Children affected by AIDS
CHH	Child-headed Households
CRC	Convention on the right of the child
CSO	Central Statistics Office
HC	Health Centre
HCW	Health Care Workers
HIV	Human Immunodeficiency Virus
MDGs	Millennium Development Goals
MEPD	Ministry of Economic Planning and Development
MHSW	Ministry of Health and Social Welfare
MSF	Medicins Sans Frontiers
NGO	Non-governmental organisation
NPA	National Plan of Action
NTCP	National Tuberculosis Control Programme
NSF	National Strategic Framework
OCVA	Orphans and Children made vulnerable by AIDS
OVC	Orphaned and Vulnerable Children
PHC	Primary Health Care
PLWHA	People living with HIV AND AIDS
PSI	Population Services International
RHMs	Rural Health Motivators
RRC	Resilience Research Centre
UN	United Nations
UNDP	United Nations Development Program
UNESCO	United Nations Educational Scientific Cultural Organisations
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency of International Development

SADC	Southern African Development Community
SDHS	Swaziland Demographic Health Survey
SPRASP	Swaziland Poverty Reduction Action Strategy Programme
TB	Tuberculosis
VAC	Vulnerability Assessment Committee
WHO	World Health Organisation

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# **CHAPTER 1**

## **ORIENTATION TO THE STUDY**

### **1.1 INTRODUCTION**

The first chapter outlined the background and rationale of the study; the statement of the research problem; the aim and objectives of the study; the significance of the study; the theoretical framework; and the definition of key concepts. An overview of the research method and the structure of the dissertation are provided at the end of the report.

### **1.2. BACKGROUND AND RATIONAL OF THE STUDY**

The family is often regarded as the cornerstone of the society, the primary provider of support, protection and socialization. Its members are connected by kinship, marriage, birth or choice (Kayongo & Onyango 2006). Over time family structures and functions changed leading to the emergence of various forms of family. The HIV and AIDS epidemic has made a paradigm shift in the family structure in most African countries including Swaziland. One of these changes includes the emergence of a social group called child-headed households (Busch, Glass & McELmurray 2008).

Children living in child-headed households have not only lost their parents but also the family support which may compromise their childhood rights including the right to access healthcare services. Child-headed households, like any other households have health needs that require medical attention. It is well known that a household ability to access healthcare services is influenced by several factors including level of

education, income, health seeking behavior amongst others (Richter & Desmond 2008). The relationships between the above factors and access to healthcare services are well-documented in the literature (UNICEF & Save the Children 2013).

Swaziland is divided into four administrative regions namely Manzini, Hhohho, Shiselweni and Lubombo. Matsanjeni is a remote rural area situated in the northern part of the Shiselweni Region. This study was interested with child-headed households in the Matsanjeni area. The area has the highest number of child-headed households due to the high prevalence of HIV and AIDS (SPRASP 2011). The area is served by one Health Centre which provides a range of primary health care (PHC) services. In addition, the area is known for severe drought and extreme poverty making children living in child-headed households more vulnerable than other children living in child-headed households in well-resourced part of the country. Matsanjeni is largely affected by three interrelated devastating scourges namely HIV AND AIDS, poverty and food insecurity (UNICEF 2013). For child-headed households living with the above condition, utilisation of healthcare services is just one of the many challenges that they encounter on a daily basis.

Child-headed household in Swaziland is largely attributed to HIV epidemic. Swaziland National Strategic Framework for HIV and AIDS (2009) estimated the number of orphaned and vulnerable children (OVC) to be 130 000 and projected to reach 200 000 by 2010 and to 250 000 in 2015. The Swaziland Demographic Health Survey indicated that 0.63 % of all Swazi households are headed by children aged less than 18 years. Some of the orphans are left at very young ages to look after their young

siblings. Children orphaned by HIV and AIDS are usually left without resources due to the chronic nature of HIV-related illnesses (SDHS 2006/2007). Under such circumstances, the eldest child is often expected to maintain the younger siblings while struggling with the impact of HIV epidemic and may also be HIV-positive themselves (UNICEF 2008).

The above situation may burden their experiences in all aspects of life including access to health care services. However, children's access to healthcare in Swaziland is guaranteed by the country's Constitution and the human right charter of 2005. The constitution stipulates that children have the right to primary health care services. Ideally, children are under the care and support of an adult who will exercise these rights on their behalf. However, children living in child-headed households may not have this support. This lack of adult support and many other factors affect their experiences in accessing and utilizing the available resources including primary health care services.

### **1.3 STATEMENT OF THE RESEARCH PROBLEM**

It is clear that children living in child-headed households have health needs that require treatment and care (UNICEF 2008). It is also clear that most children living in child-headed households in the rural community of Matsanjeni are orphaned by HIV and AIDS and live without adequate family and social supports (SDHS 2006-7). These circumstances are known for increasing people's vulnerability to diseases as well as hindering their access and utilization of health services (Andersen 1995).

Finally, anecdotal report and the researcher' own experience working with this community indicated that children living in child-headed households do attend the PHC services on regular basis but what influence these children's utilization of the above services is not clear and well documented in Swaziland. I believe that understanding factors influencing their utilization of PHC services will assist health professionals to formulate interventions aimed at strengthening the utilization of PHC services among vulnerable children living in similar community in Swaziland.

#### **1.4 AIM AND OBJECTIVES OF THE STUDY**

The aim of this study was to explore and describe the views of children living in child-headed households in a rural community of Swaziland regarding factors influencing their utilization of PHC services.

The objectives of the study were twofold:

- To explore and describe factors that positively influence (enablers) PHC services utilisation by children living in child-headed households in a rural community of Swaziland.
- To explore and describe factors that negatively (inhibiting) PHC services utilisation by children living in child-headed households in a rural community of Swaziland.

#### **1.5 SIGNIFICANCE OF THE STUDY**

The results of the study contribute to enhancing our understating regarding factors influencing the utilization of health services by children in child-headed households in rural community. The information generated from the study could be used by health professionals, policy-makers, and community-based organization as baseline

information to formulate interventions aimed at improving the utilization of primary health care services by this group of children. Researchers can also use the information generated from this study as a basis for further research.

## **1.6 DEFINITION OF KEY CONCEPTS**

**Barrier/inhibiting factor** referred to those factors that keep children away from access and utilization of primary health services when needed (Andersen 1995).

**Child-headed household** is a household where a child, generally of 18 years and younger takes over as the head and provider for others without any adults to look after them (UNICEF 2013). Similarly, Sloth-Nielsen (2004) defines a child-headed household as a household where the main caregiver is younger than 18 years. In this study a child-headed household referred to household where an adolescent is fending for the family with /without a living adult person.

**Enabling/facilitating factor** referred to those factors that enable or facilitate the use of primary health care services when needed (Andersen 1995).

**Experience** referred to personal feelings and thoughts related to factors influencing primary health care services utilisation by children living in child-headed households.

**Motivating factor** referred to the reasons given by children living in child-headed households for using primary health care services when needed.

**Utilisation of health services** referred to the number of visits to a physician/medical facility for a particular period of time (Hulton, Matthews & Stones 2000).

## **1.7 THEORETICAL FRAMEWORK**

The researcher used Andersen Behavioural model to guide this study. Andersen (1995) behavioural model is a multi-disciplinary model that brings together economic,

health care-related, socio-cultural, and psychological factors to explain access and utilization of health services. According to the model, the utilization of healthcare services occurs in a sequential relationship of predisposing-enabling-need for care determinants.

The predisposing component consists of factors that are considered exogenous and these factors influence service use both directly and indirectly through the enabling and need variables. The enabling component consists of resources that are required to seek and obtain care. Finally, *the medical need* component involves an individual's perception of illness and the limitations that it imposes on daily activity and, if relevant, professional judgment (Hulton, Matthews & Stones 2000).

## **1.8 OVERVIEW OF THE RESEARCH METHOD**

The research used a qualitative descriptive design to address the research objectives. Purposive sampling was used to select the participants. Semi-structured individual interviews were used to generate data from the participants. The ethical principles outlined in the University of South Africa Research Policy as well as the universal ethics principles were followed in this study. Ethical approval was obtained from the Ethics Committees of the University of South Africa and the Ministry of Health of Swaziland. Individual consent was obtained from each participant. Details on ethical considerations are given in Chapter Three.

## **1.9 STRUCTURE OF THE DISSERTATION**

The report of this study was structured into five chapters. A list of references and relevant supporting documents are included as appendixes at the end of the report.

**Chapter One** provided an overview of the study in terms of background and rationale, statement of the research problem, the aim and objectives of the study, the significance of the study, the definition of key concepts, and the theoretical framework that underpinned the study.

**Chapter Two** covered the different studies and documents related to child-headed households and their experiences with regard to accessing PHC services

**Chapter Three** outlined the methodology used in the research.

**Chapter Four** covered the results and the discussion of the main findings of the results.

**Chapter Five** concluded the report with a summary, limitations of the study and recommendations.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

Groove, Burns & Gray (2012) defines literature review as viewing sources that are important in providing in-depth knowledge needed to make changes in practice. Additionally, Jourbet & Ehrlich (2010) defines literature review as a process of taking stock of existing knowledge in order to make informed choices about policy, practice, research direction and resource allocation. Polit and Beck (2012) indicates that, “researchers do not conduct their studies in a vacuum; they conduct literature to gain a full picture of what is and what are to be.” The main purpose of literature review is to discuss diversifying information on particular research topic. It refers to a collection of materials on a topic from different sources. It also provides the reader with an important guide on a particular topic by giving an overview about the topic thereby demonstrating the researcher’s knowledge about the research.

This chapter presented the review of relevant literature on factors influencing the utilisation of healthcare among children living in child-headed households. It provided an overview of the theoretical aspects of the orphans and child-headed households, the factors influencing the emergence of child-headed households, an overview of the vulnerability and psychosocial problems faced by child-headed households; coping and resilience among child-headed households. It is introduced by an overview of the Swaziland healthcare delivery system.

## **2.2 OVERVIEW OF THE HEALTHCARE DELIVERY SYSTEM OF SWAZILAND**

The Kingdom of Swaziland adopted Primary Health Care as a driving philosophy for healthcare delivery system. Several strategies are implemented with the aim of providing services that are affordable and accessible to all. The country's healthcare delivery system is divided into three main levels, namely tertiary, secondary and primary levels. The tertiary level consists of 4 regional hospitals, one specialized hospital and one national referral hospital. The secondary level comprises of 5 health centres that provide in-patient and out-patient and serve as referrals for the primary level. The primary level consists of 242 rural clinics and outreach sites (NTCP 2010). The rural clinics are outreach sites where basic healthcare services, community-based care, support and treatment are provided. The basic healthcare service package includes ante-natal and post-natal care, immunization, family planning, treatment of minor ailments (e.g. diarrhea, respiratory infections), and treatment of sexually transmitted infections (MHSW 2010). Most of these primary level institutions are owned by government and faith-based organisations. Few are owned by the private sector.

However, disparities exist on how resources are distributed between rural and urban health facilities. For examples, 90% of in-patients beds are found in urban facilities while 77% of the population is in rural areas. Health expenditure for urban facilities is three times higher than in rural facilities (Earnshaw 2007). The challenges resulting from healthcare resources distribution coupled with those related to the socio-economic and psycho-social problems facing child-headed households will have

direct impact on the lived experiences of child-headed households with regard to access to healthcare services.

HIV epidemic among the reproductive age population is another major health challenge facing the Kingdom of Swaziland. The HIV prevalence among 15 - 49 years stands at 26.0% (MHSW 2010). This prevalence varied according to age, gender and residential areas. HIV prevalence among youths (15-24 years old) is nearly four times higher (23%) among young women compare to young men (6%). Thirty-seven percent of women in urban areas were HIV-positive compared to 26% of urban men. In rural areas, the HIV prevalence among women was nearly twice (29.0%) than among men (17.0%). The national strategic framework (2014-2018) identifies HIV testing and counselling (HTC), and social behavioural change (SBC) as cross-cutting services in the litigation of HIV and AIDS. While HTC provides a critical entry point to all HIV programmes, the SBC serves as a key strategy for HIV uptake. It encompasses the involvement of civil society organisations and communities, PLWHA, political, religious and community leaders. Similarly, the 2007 National Health Policy Document (MHSW 2007) states that health programmes must "expand treatment and care interventions to PLWHA and mitigate the socioeconomic impact of HIV and AIDS". HIV treatment, care and support for people living with HIV (PLWHA) remain a priority component of the 'Extended Multi-sectectoral Strategic Framework for HIV and AIDS 2014-2018' (MHSW 2014).

## **2.3 ORPHAN CHILDREN AND CHILD-HEADED HOUSEHOLDS**

### **2.3.1 Contextual meaning of a child**

The concept “child” has different meaning according to local, national and international instruments. A child is a boy or a girl up to age of 18 years (Smart 2003). The United Nations drew up the definition of a child that all countries ratified through the international Convention of the right of the child as “a human being below the age of 18 years unless under the law applicable to the child majority is attained earlier” (Sloth-Neilson 2004). This age is generally referred to as the age as the majority, which is attached to certain legal expectations. For example in South Africa, a child can consent for HIV testing without parenteral consent at the age of 14 years. In the context of the definition of a child in Swaziland, a child does not have the legal right to inherit property if he/she was born out of wedlock (Swaziland VAC 2009).

### **2.3.2 Contextual meaning of an orphan child**

Various definitions are used to refer to an orphan. In general an orphan is a child whose mother or father or both parents has died. When a mother dies the child is technically termed maternal orphan and when a father dies the child is called a paternal orphan. When both parents die the child is called a double orphan (Freeman, 2006). UNICEF extends the definition of an orphan child to include children who are abandoned by parents or those who the primary caregiver, usually the grandmother has died. The main reason is because their life style is not different from those whose parents died (UNICEF 2008).

In Swaziland the number of these children is known to exceed that of natural orphan (UNICEF 2008). The organisation argues that children are in such circumstances when parents did not settle for a legal or customary marriage or they are born from one mother with different fathers and stay with the maternal grandmother or with the paternal grandmother. These children are left in the care of elderly people who struggle with little or no support (UNICEF 2008).

The United States Immigration and Nationality Act 159 provide a definition of an orphan for the purposes of immigration as 'the death, disappearance, abandonment, desertion, separation and loss of both parents. The child of an unwed mother or surviving parent may be considered an orphan if that parent is unable to care for the child properly and has, in writing, irrevocably released the child for emigration and adoption. The child of an unwed mother may be considered an orphan, as long as the mother does not marry (which would result in the child's having a stepfather) and as long as the child's biological father has not legitimized the child. If the father legitimises the child or the mother marries, the mother is no longer considered a sole parent. The child of a surviving parent may also be an orphan if the surviving parent has not married since the death of the other parent' (UNESCO 2013).

Some authors (Henderson 2006; Nyamukapa et al 2008) extended the definition of an orphan child to include children who have been displaced by wars and those children left alone by parents who migrated from economic reasons. They argue that the living circumstances of such children are similar to natural orphans as they are left to assume the roles of adults at very early ages.

A summary of various meanings of an orphan from selected countries and organisations is provided in Table 2.1. Age and nature of parental loss are common elements of those meanings.

**Table 2.1 Definition of orphan in selected countries and organisations**

<b>Country</b>	<b>Definition</b>
<b>Zimbabwe</b>	A child who has lost either one or both parents.
<b>Swaziland</b>	A child who has lost one or both parents.
<b>Uganda</b>	The basic definition of orphan is a child whose parents are deceased. However, for purposes of interpreting the law, an orphan is a child who has no one to take care of him or her.
<b>Mozambique</b>	A child who has lost one or both parents.
<b>Botswana</b>	A child below 18 years, who has lost one single parent or two, married couples parents biological or adoptive parents.
<b>Namibia</b>	A child under the age of 18 years who has lost a mother or father (or primary care giver due to death or a child who is need of care.
<b>Islamic</b>	A child who has lost one or both parents prior attaining puberty.
<b>United Kingdom</b>	A minor bereaved through death or disappearance of, abandonment, or desertion by, or separation, or loss of both parents.
<b>UNICEF</b>	A child who has lost a mother is a maternal orphan, lost a father is a paternal orphan, lost both parents is a double orphan.

*Adopted from German 2005*

### **2.3.3 Contextual meaning of child-headed households**

UNICEF defines a child-headed household as a household where a child takes over as head of the household and provides for others without an adult looking after them (UNICEF 2010). This definition slightly differs from others; like the Zimbabwean perspective where a child-headed household includes households where children are living with a terminally ill, debilitated, blind, or mentally ill parents, grand-parents or aunts who are not responsible for the daily supervision of the children. Children of economic migrants are also included in this definition.

Sloth-Nielson (2004) defines a child-headed household from the perspective of the functional role in the household. Any household where the main caregiver is a child younger than 18 years old is viewed by Slot-Nielson as a child-headed household. He argued that the functional role of an adult as a head of a household ceases if he/she is unable to provide for the up-keeping of the family. However, Forster and Makufa (2004) differ with this perspective. They argue that the presence of an adult, especially a grand-parent plays a vital role in keeping family ties together and in providing guidance.

The Swazi culture is not different with the other African culture which is unique in placing the value of children and the use of extended families to take responsibilities when parents die. Unfortunately with increasing disintegration of traditional value and deepening poverty due to climatic conditions and socio-economic disparities some parents die leaving their children without a choice but look after themselves.

It is clear that a single definition of child-headed households will not be suitable to accommodate many variations entailed in this group, therefore to be explicit a matrix with all the contextual attributes and characteristics is provided in Table 2.2. This matrix shows that a child-headed household is a household where either parents or alternative caregivers are permanently absent and the person responsible for the day to day management of the entire household is less than 20 years. An adult figure may be present in the family but he/she is not capable of taking adult responsibilities for various reasons.

**Table 2.2 Matrix defining child and adolescent households in various contextual situations**

<b>Household and household head</b>	A household is one or more people who share cooking and eating arrangements together. The household head is a person primarily responsible for the day to day management of the household including child care, breadwinning and household supervision.
<b>Adolescent headed household</b>	A household headed by a 16-20 year old who is not the biological parent of the children in the household. In the event of the adolescent leaving the household for labour ,migration or marriage etc., the household becomes a child-headed household
<b>Child-headed household</b>	A household headed by a person younger than 16 years old. Once such a head turns over 16 years the household automatically becomes an adolescent headed household.(Zimbabwe Child Protection act chapter 5 section 6 defines a child as below 16years)
<b>Accompanied Household</b>	A child or adolescent headed household which includes an adult in need of care such as: <ul style="list-style-type: none"> <li>• An aged grandparent or guardian in need of care and unable to provide child care, income and household supervision.</li> <li>• An adult who is mentally unstable and in need of care.</li> <li>• Any other adult who is unable to provide childcare income or supervision</li> </ul>
	<b>Supported :</b> <ul style="list-style-type: none"> <li>• extended family regularly visit the household</li> <li>• Neighbours support and supervise the family.</li> <li>• a community care programme for orphans provides monitoring and support visits.</li> <li>• household receives ongoing support from local church or philanthropic groups or NGOs</li> </ul>
	<b>Unsupported:</b> <ul style="list-style-type: none"> <li>• household has not link with extended family.</li> <li>• household at most receives sporadic support from neighbours local support groups and NGOs.</li> </ul>
<b>Unaccompanied Household</b>	A child-headed or adolescent headed household where there is no adult residing in the household
	<b>Supported:</b> <ul style="list-style-type: none"> <li>• extended family regularly visits the household.</li> <li>• Neighbours support and supervises the family.</li> <li>• A community care programme for orphans provides monitoring and support visits to the household.</li> <li>• the household receives ongoing support from local church or philanthropic group or from NGOs</li> </ul>
	<b>Unsupported:</b> <ul style="list-style-type: none"> <li>• the household has no link with extended family</li> <li>• the household at most receives sporadic support from neighbours local support groups or NGOs</li> </ul>

*Source: Adopted from Germann (2005)*

## **2.4 FACTORS INFLUENCING EMERGENCE OF CHILD-HEADED HOUSEHOLDS**

HIV and AIDS has seriously altered the demographic structure of households and this has diminished family structures leaving a lot of children without parental care and guidance, compromising supervision and child socialization (Freeman 2006). The following questions continue to linger; why would children stay on their own after the death of parents? Where are the extended family members? Does it mean they do not care about them? Forster et al (1995) argue that the presence of child-headed household does not necessarily mean that extended families are not available and that they do not care. Some do care but they do not have the capacity to provide the necessary care. Nkomo (2006) added that extended families fear the burden of taking care because they are also not sure of what the future holds for them and their children. Ayieko (2003) argued that children grow better in their communities where they have the opportunity to relate to adults and children of similar backgrounds. This would foster their psychosocial development, allow them to be in- touch with their extended families and culture in order to adopt a sense of security and belonging.

This section of the literature looked at the most common reasons that explain the increase of child-headed households in most African countries.

### **2.4.1 The effects of the HIV and AIDS epidemic**

Swaziland is among the world's worst affected countries by the HIV pandemic with an estimated 42.6 percent of the population living with the HIV virus (NCTP 2010). According to SDHS (2006-7) a third of children do not live with both parents. HIV epidemic causes vulnerable children to drop out from formal education in order to

look after the sick parents before they succumb to death. After the death of parents the children are continuously affected by social injustices. They are involved in early sexual debut and when girls are impregnated they produce off springs that are more vulnerable than themselves (Donald et al 2005). The numbers of child-headed households are also on the increase because the extended family safety net is being eroded as grandparents, aunties and uncles succumb to death. The number of Child-headed household is projected to increase as a consequence of high HIV infection among the adult population. Some children, as young as 6 years are forced to look after their fellow brothers and sisters (Kanyongo & Onyango 2006).

Barnett and Whiteside (2003) argued that in African countries, HIV and AIDS epidemic has eaten into the middle generation, altered the demographic structure of societies and led to the breakdown of intergenerational dependency and support. However in economically strong countries this breakdown is compensated by the state or some agency. In poor countries social safety net are largely unaffordable. This has jeopardized the African historical practice of “every child is one’s child”. The emergency of child-headed household is a sign of serious societal changes.

Family conflict following the death of a breadwinner is also attributed to the increase number of child-headed households. Family conflicts always cause disharmony and disrupt family ties (Makame 2003). Bronfenbrenner (2005) model asserts parental conflicts should not be vented on children because they are innocent social beings and are not able to develop without interacting with significant others. The interaction system can be biological, psychological, social, cultural, economic and political.

#### **2.4.2 Societal and cultural factors**

Traditionally, orphans were automatically absorbed by the extended families or the village communities where extended families did not exist (Forster 2004). However modernization linked to urbanization of societies has a direct impact on the extended family structure and changing the social fabric of societies (Nyamukapa et al 2008). Some studies have indicated that children may prefer to stay on their own as a way of retaining ownership of the few resources left by their parents (Hendersen 2006). The same sentiments were expressed by child-headed household participants in a study carried out in Kenya (Ayieko 2008).

In Swaziland when a married woman is at the terminal stage of an illness, she may be forced to go back to her maternal home for care and support. At times frequent illness precipitate economic deterioration and despair and worthlessness and even if they want to stay in their nuptial homes after the death of the husband they are forced to leave the children behind and go to their maternal homes. Others are frustrated by their in-laws by bearing the blame for the death of the husbands and they go home to their parents leaving their children without parental support (Busch et al 2008). In some cultural groupings in Kenya, women whose husbands died are forced to remarry within the extended family regardless of what caused the death of their husbands. When the second husband eventually dies they are labelled as “husband killers”. They are consequently mistreated and forced to leave the nuptial homes and their children alone (Ayieko 2003).

### **2.4.3 Fear of abuse and separation from Siblings**

Some children prefer to stay alone to avoid being subjected to abuses by relatives. As discussed earlier, child-headed households are known to be vulnerable to all forms of abuse and exploitations from close relatives (Nkomo 2007). This fear is mainly documented in cases where children have to be placed in foster care or divided among relatives. Some orphans prefer to stay on their own to maintain the family unit (Ayeiko 2003; Awino 2010; Meintjies et al 2010).

### **2.4.4 Parental migration**

Migration, especially economic migration of parents has been identified as contributing to an increase number of child-headed households. In the past decades, large numbers of middle class professionals in low income countries have left to look for better opportunities in other countries leaving children on their own. Although such parents provide financial support to their children, money can never substitute parental guidance (Chawanda et al 2007).

### **2.4.5 NGOs support**

Non-governmental organisations working with the plight of children as external agency are seen as indirectly responsible for an increase in child-headed households. There is a negative relationship between the NGO direct financial support to vulnerable children and community initiative towards child-headed household (Germann 2005). The support provided by NGOs is used as a scape goat by family members to completely abandon the children because children grow better socially, mentally, and emotionally in familiar surrounding with the extended families. The

extended family members may not be able to provide economic support but they are important in providing social support (Donald & Clachety 2005).

It is suggested that the NGOs roles should shift from direct service providers to facilitators and capacity builders of local structures (Forster, Levine & Williamson 2006). From the healthcare perspective, this position concurs with the Alma-Ata declaration which postulates that “people have the right and duty to participate individually and collectively in the planning and implementation of their health care” (Earnshaw 2007). Participation of the community in the care of these child-headed households will guarantee continuity of care in the absence of the helping agencies.

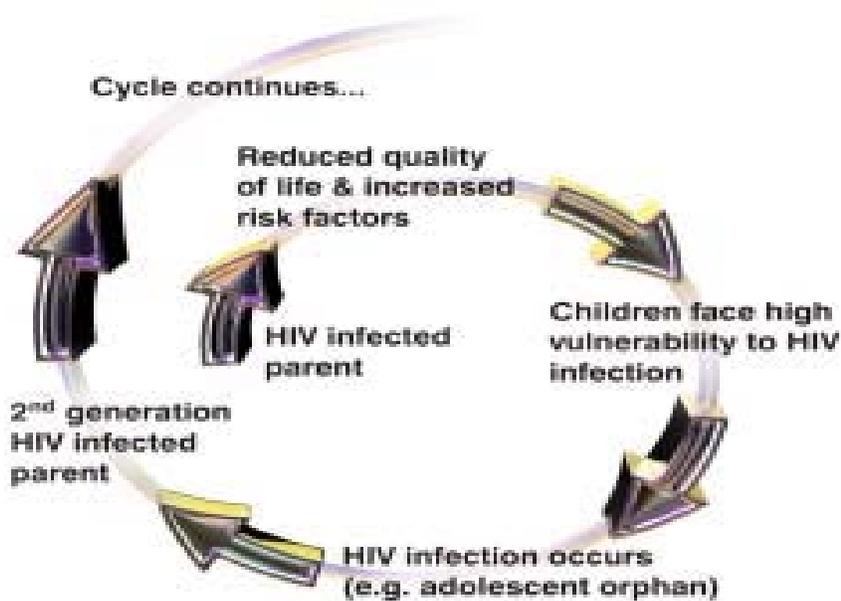
## **2.5 COMMON PSYCHOSOCIAL PROBLEMS FACED BY CHHs**

The compounding effects of parental and caregiver loss and other life stressors experienced during childhood affects the opportunities of child-headed households during adulthood (Nyamukapa et al 2005). For example chronic psychological trauma, low qualification and skills could translate into limited employment prospects early parenting, unstable relationships, social isolation, poverty and behaviours that predispose towards poor health outcomes including HIV infections. Psychosocial distresses which CHH experience during childhood does not capitalize on their occupational and social opportunities only for their survival as they grow into adults, but also has implications for their ability to contribute to national development. Failure to carve out productive lives for themselves will result in their being dependent on government and relatives for health and social services and may mean their children

will endure a further cycle of poverty and ill health (Nyamukapa et al 2008). Inability to cater for their own needs and those of their children would render current generation of orphans a threat to future economic, political and social security. This section discussed some of the most common psychosocial problems.

### **2.5.1 Increased vulnerability**

Vulnerability is a complex concept with different meanings. It is often defined as a state where a person's probability of suffering has been exacerbated by unusual individual or societal circumstances. UNICEF views a vulnerable child as a child who is living in circumstances characterised by high risks and impaired prospects for growth and development (UNICEF 2008). Within the context of HIV and AIDS, children in child-headed households live in a continued cycle of vulnerability. This cycle starts with the lack of community support, which exposes them to HIV acquisition. These children will eventually become HIV infected and give birth to HIV infected children who will also give birth to HIV infected children and the cycle will go on and on restraining the traditional coping mechanisms to a point where the health delivery system will collapse leading to many unprecedented problems (Germann 2005). Figure 2.1 illustrates the vulnerability cycle.



**Figure 2.1 Vulnerability Cycle for Child-headed Households**

*Source: Adopted from Germann (2005)*

In Swaziland orphaned and vulnerable children are estimated at 45 percent of all children in the country (Busch et al 2008). The complexity of the concept of vulnerability and contextual variations surrounding HIV and AIDS have led to multiple terms referring to orphans and children made vulnerable by the scourge of HIV and AIDS pandemic. Table 2.3 provides a list of terms that are commonly in Africa and globally.

Children in child-headed households are known to be more vulnerable to various forms of exploitations and abuse. This is more so, because of the fact that they are left to head households without assets and have few livelihood prospects (Roalkvan 2005). Some community members tend to take advantage of these children's vulnerability to their benefits (Donald & Clachety 2005). Children in child-headed households are often subjected to sexual abuse, child labour, unemployment,

illiteracy, exploitation and emotional abuse perpetrated by close relatives or people living in their communities. Girls are known to be more affected than their males' counterparts (Hunter 2000; Mkwezi et al 2006; Nyamukapa et al 2008).

**Table 2.3 List of terms used for vulnerable children**

<b>Used terms</b>	<b>Meaning</b>
<p><b>Zimbabwe:</b> Children in extreme difficult circumstances (CEDC)</p>	It refers to children whose probability of suffering has been further increased by unusual individual or social circumstances. It includes abused children, working children, street children, and children affected by HIV and AIDS.
<p><b>Kenya:</b> Children in need of special protection (CNSP)</p>	Based on the children's act of Kenya and includes street children, abused children, traumatized children and often children without adult care.
<p><b>South Africa &amp; Zambia:</b> Children in distress (CINDI)</p>	Similar meaning with Kenya
<p><b>Globally:</b> Orphaned and vulnerable children (OVC)</p> <p>Children affected by HIV and AIDS (CABA)</p> <p>Orphans and children made vulnerable by HIV and AIDS (OCVA)</p>	<p>Refers to maternal, paternal or double orphans of all causes and other vulnerable children.</p> <p>A broad term used in relation of children whose lives are affected by HIV and AIDS either by death of a parent or caregiver, or through living with an HIV positive parent.</p> <p>This term refers to vulnerability occurring as a result of HIV and AIDS. It was first used during UNICEF/UNAIDS international technical conference on indicators of Orphans and children made vulnerable by HIV and AIDS.</p>

**Source:** *Adopted from Donald and Clachety (2005)*

Trying to survive and raising younger siblings while attending school may create very serious problems for the child-headed household heads therefore such children eventually drop-out of school. Consequently, they are side-lined and left without the

knowledge necessary for daily living and succumb to infections which could have been prevented (Forster et al 2004; Hayden 2006). In addition, children in child-headed households suffer from stigma and discrimination not only due to HIV and AIDS but also because of the increased poverty, educational deficits, social skill deficits and lack of parental mentoring (Germann 2005). The belief that HIV affects immoral people adds to the burden of stigma. A lot of secrets are still maintained by individuals and families to such an extent that children are not told the truth about the illness or death of their parents. Some children tend to hear about the status of their parents discussed by neighbours and friends and vehemently alienating them from associating with those people due to surmounting anger and hatred (Busch et al 2008). Overtime such children develop a sense of relative deprivation as their poorer circumstances coupled with stigma and discrimination result in reduced access to services and material resources (Forster et al 2004).

### **2.5.2 Inability to access and utilise health services**

The psychological trauma of observing a parent's terminal illness, dealing with death, absence of adult guidance, and the need for love and security make orphans to succumb to the state of depression coupled with suicidal tendencies (Sloth-Nielsen 2004). This is also exacerbated by not having solutions to prevailing problems and not knowing what the future holds for them (Atwine et al 2005; Makame et al 2003).

In Swaziland, 45 percent of children infected by HIV do not access available HIV services (Swaziland Annual Statistics Bulletin 2010). Lack of privacy and confidentiality in health facilities, stigma and discrimination, negative attitudes towards adolescents seeking health services, ignorance about individual rights, socio-

economic reasons, and age differences between adolescents and health care workers are some of the barriers described in the literature (Shabalala 2013).

It is argued that healthcare workers assume parental roles instead of professional roles and this deters the health seeking behaviour of adolescents. Others cited the sex of health care providers as having an impact on accessing and utilization of health services. Adolescents felt male health providers are good with adolescent girls and older female health providers were good with male adolescents (Shabalala 2013). After the death of parents, the grandmothers remain the primary care givers of children. These grandparents are often unable to provide guidance on health related issues as they struggle with senile conditions. For children living under those circumstances, healthcare needs are not seen as priorities as they have to take care of their younger siblings and their grand-parents (Busch et al 2008).

### **2.5.3 Loss of inheritance, poverty and struggle to get birth certificates or national identity cards**

The issue of inheritance is very common in the African context. The rules of inheritance in customary law make children vulnerable to being dispossessed of their house and land (Nkomo 2006; Sloth-Nielsen 2004). Child-headed households are especially affected by widespread food insecurity as they frequently depend on neighbours or supplementary food programmes. The political, economic, food, and HIV and AIDS crisis in African countries have direct impacts on children, especially CHHs. Child-headed households continue to struggle for food and this is a key stressor to their coping mechanisms. Food insecurity also has consequences on school performance Children living in child-headed households may struggle to get

births registration, and get health care treatment, social security and other state mechanism which can help them. Failure to acquire such document will make them not eligible to access social grants (Germann 2005).

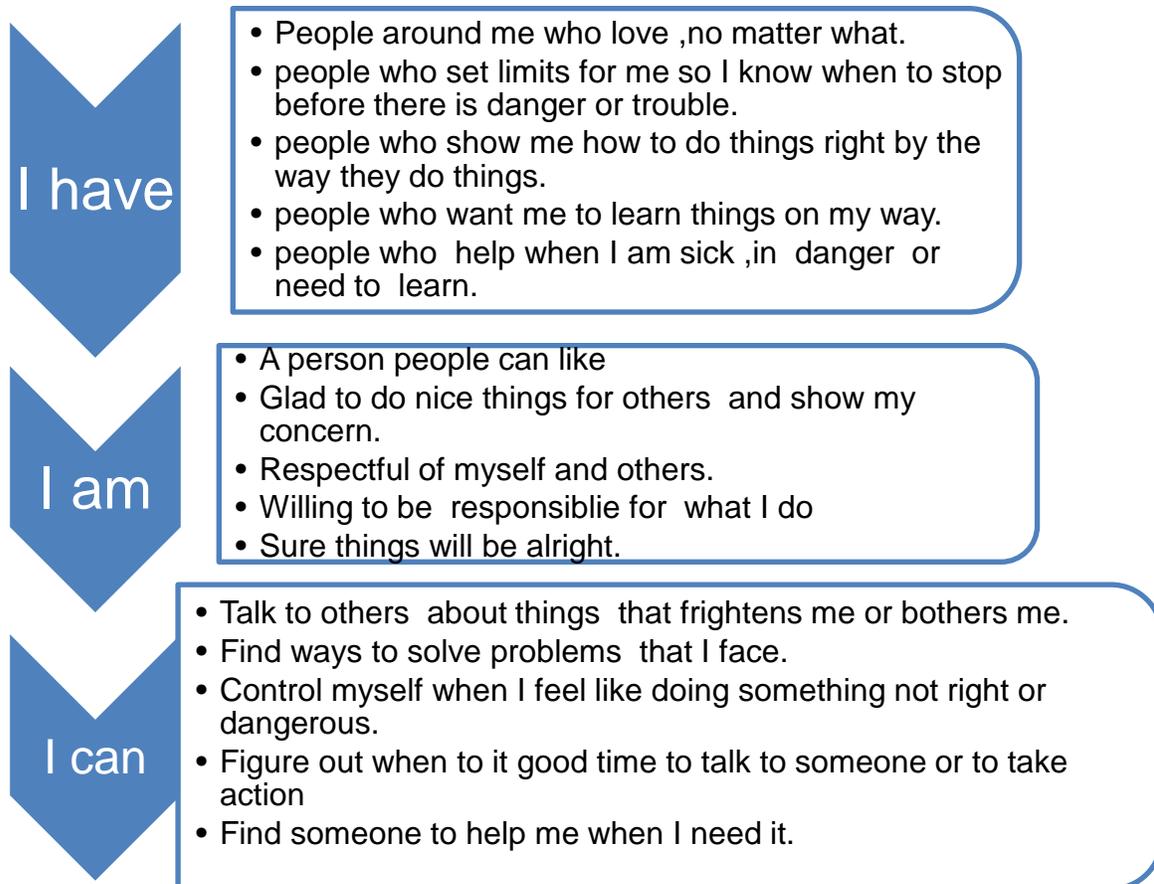
## **2.6 COPING AND RESILIENCE AMONG CHILD-HEADED HOUSEHOLDS**

Resilience in the context of child-headed households is related to individual and household coping. It is a process or capacity for successful adaptation of a person to challenges and severe life threatening circumstances (Germann 2005). Resilience explained why some children exposed to highly stressful situation and conditions do not sustain developmental damage. Some children are known to make use of the difficulty situation to grow stronger. Resilience in this instance is seen to be a useful weapon for survival of child-headed households.

The term remains difficult to define because of its dynamic and characteristic traits. It is defined by experts as 'the universal capacity which allows a person or community to prevent, minimises or overcome damaging effects of adversities. It involves the ability of an individual to overcome adversities' (Rotheram-Borus, Weiss, Alaber & Lester 2005). Mastern (2002) uses a more ecological and culturally sensitive definition which, suggests that resilience is 'both the capacity of individuals to navigate their way to the psychological, social, cultural, and physical resources that sustain their well-being and their capacity individually and collectively to **negotiate** for these resources to be provided in culturally meaningful ways'.

Mastern (2002) definition shifts our understanding of resilience from an individual concept, to a more culturally embedded understanding of well-being. Understood this way, resilience is a social construct that identifies both processes and outcomes associated with what people themselves term 'well-being' (Awino 2010). In this sense, resilience is the result of both successful navigation to resources and negotiation for resources to be provided in meaningful ways. Individuals are only able to manage a certain level of stress in lives and revert from life adversity states to normal levels of functioning (Forster 2006).

Resilience is the ability to “bounce back” from stressful or challenging experiences, such as death of parents and be able to survive and thrive under extreme on-going pressure without acting in dysfunctional ways (Atwine, Cantor, and Bunjunirwe 2005). It does involve one being able to adapt to changes and approach negative life events positively and constructively. Resilience is achieved only when services are provided. In the era of HIV and AIDS pandemic it is of paramount importance to ascertain that these children can access health services like everyone (Forster et al 2004). For one to be resilient the following characteristic traits stipulated by the International Resilience Project facilitated by Bernard Van Leer Foundation needs to be in cooperated such as, “I HAVE, I AM, I CAN”. Figure 2.2 serves as an illustration of their practical application in the life time of these vulnerable children.



**Figure 2.2 Source of Resilience**

Source: [www.resilienceproject .org](http://www.resilienceproject.org)

There is no doubt that the above characteristic traits are mostly western-based and it is of paramount importance to have theoretical models that refine resilience in the Southern Africa context. Resilience may transform or make stronger the lives of those who are already resilient. The resilient behavior may be in response to adversity in the form of maintenance or normal development despite the adversity, or a promoter of growth beyond the present level of functioning. Furthermore, resilience may be

promoted not necessarily because of adversity, but, indeed, may be developed in anticipation of inevitable adversities (UN 2010).

Thus in discussing resilience we have two major factors that play a role, the protective factors and the risk factors (Bronfenbrenner 2005). Risk and protective factors function at different levels at household, community, wider social systems such as culture or government. It is argued that the source of one's rebound and recovery for those who are able to bounce back, are attributed to the protective factors; inner capacity and more so resources such as strong sense of self, good social skills, sense of purpose in life, self-control, individual factors such as genetics, personality, ethnicity, and social factors such as socio-economic background, supportive caregivers and geographical proximity to others, social and community support such as support from family, friends, community and school(Germann 2005).

## **2.7 CONCLUSION**

Literature relating to the study was reviewed seeking to have a concrete understanding of the child-headed households and their livelihoods. The chapter also looked at the initiatives in place for children and how they benefit them. Factors influencing advert of these households, the concepts of coping and resilience were described to provide a framework for the understanding of the living conditions and behaviours of this vulnerable group of children. It also provided the context for the interpretation of the findings of this study.

## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

#### **3.1 INTRODUCTION**

This chapter covered the research design, setting and population of the study, the sample and sampling technique, data collection procedures, data management and analysis, and ethical considerations. A research methodology incorporates all the procedures that have been used, are currently used, or may be used to pursue knowledge (Groove, Burns & Gray 2012).

#### **3.2 RESEARCH DESIGN**

The researcher used a qualitative descriptive, exploratory design to gain an understanding of the views of children living in child-headed households' regarding factors influencing their utilization of PHC services. A qualitative research is a systematic, interactive, and subjective approach that allows the researcher to explore and describe life experiences of the participants and to present those experiences in a meaningful way (Babbie & Mouton 2011). The exploratory nature of the qualitative descriptive design is mostly related to the inquisitiveness of the researcher, and his/her determination to gain an understanding of the phenomenon (Creswell 2013).

#### **3.3 SETTING AND POPULATION**

The study was conducted at Matsanjani area of the Shiselweni Region in Swaziland. As stated earlier, Matsanjani is a remote rural area which is often affected by drought

and characterized by severe poverty. It has the highest HIV and AIDS prevalence in the country (estimated at 26.4% according to 2011 DHS).

Babbie & Mouton (2011) define a population as a “theoretically specified aggregation of study elements or the object of study. The population of the study consisted of children responsible for taking care of other siblings and were the most senior children in child-headed- households.

### **3.4 SAMPLING AND SAMPLE SIZE**

The researcher used snowballing to select participants (Polit & Beck 2012). The researcher used the chief man to assist in identifying the first participant who then referred the researcher to a similar child at the end of the interview. At each household, the interview was conducted with the most senior child who is taking care of others. The final sample consisted of 20 participants. This number was determined by data saturation. It is argued that the sample size in qualitative study can be determined by data saturation. The researcher stopped data collection when there was no more new information coming up from the participants, which means that data had reached saturation point (Kumar 2011).

### **3.5 DATA COLLECTION METHOD AND PROCEDURES**

The researcher used semi-structured individual interviews to collect data. Semi-structured interviews are flexible interviews in which the interviewer follows an interview guide. The semi-structured interview gives people the freedom to respond to questions in their own words, to provide as much details as they wish, and to offer

illustrations and explanations (Polit& Beck 2012). The semi-structured interview was more relevant to the objectives of the study. It allowed the researcher to structure the questions according to the objectives of the study while allowing the participants to express their personal experiences within these structured questions (see Appendix 1).

Before the interview, the researcher reviews the participant information sheet with each participant (see Appendix 4) and explained the interview process. An appointment was scheduled thereafter with the time and venue for the interview. On the day of the interview, the same information contained in the participant information sheet was repeated. After the above review, the participants were requested to sign the assent or consent form depending on the age (see Appendix 5). The researcher secured the services of a clinical psychologist from doctors' without borders to deal with psychological distress if occurred. However, no child showed sign of psychological distress during the interview. The participants were articulated enough and able to share information without fear of being approached by total strangers.

Interviews were conducted in various locations to suit the needs of the participants. However, most of the participants opted to be interviewed at their houses. The researcher began each interview on a friendly note by greeting and asking general questions in order to allow the informants to settle down. This was followed by the three main questions of the study, which was done intermittently with probing questions to allow the informants to answer the main questions. Probes are prompts to obtain response clarity, helping the participants to elaborate on their responses of the main question (Creswell 2013). The probing questions were not the same for

each interviewee, and did not follow any order and was used where appropriate to facilitate the flow of information. The local languages (siSwati) was used during interviews to allow the participants to be able to express their views.

Field notes were also used to document all relevant non-verbal expressions and reactions that were observed from the participants during the interviews. Field notes ensured that reflective ideas that evolve during the interviews and analysis of data are documented as a continuous process (Polit & Beck 2012). Questions were sometimes explained further where the researcher thought that the informant required further explanation, and where the informant requested for further clarification of a question. Each interview lasted about 30 minutes.

In order to familiarize herself with the interview schedule and the interviewing techniques, the researcher conducted three pilot interviews with three children living in child-headed household. These interviews were tape-recorded and transcribed verbatim by the researcher. The transcripts were discussed with the research supervisor. Appropriate corrections were done on the satisfaction of the research supervisor.

### **3.6 DATA MANAGEMENT AND ANALYSIS**

Data management and analysis began during the data collection process. Data management as the first step of data analysis involves transcribing, organizing, developing categories and coding data (Creswell 2013). Transcription of data was done within 24 hours of each interview. After each interview, the researcher

transcribed the audio-recorded data verbatim into written text. Transcription of data assisted the researcher to immerse herself into the data and to organize the data.

Field notes of non-verbal communication codes, such as nodding, silence, body language were later added to the transcripts. The researcher transferred the recorded audio data onto a laptop computer, while an ear piece was used to listen to each respondent's data again in order to compare it to the written documents. The researcher made all the necessary corrections and kept the same codes that were used on the original manuscripts. The capturing and typing of data was done according to the order of questions on the interview schedule and related probing questions.

After capturing data into MSWord, the researcher created folders corresponding to the components of the experience of care that was used as a framework for the study. Information in each folder was further organized and captured into a table format, which contained five columns. The informants' answers with the corresponding code were captured in the first column. The informants' answers were copied from their transcribed manuscripts and pasted into this column with the probing questions. Thereafter, the researcher reviewed the documents and proceeded with cleaning the data.

Data analysis started after the cleaning process. The researcher used the Thematic Content Approach as a framework to guide the data analysis process. Following the cleaning of data, the researcher studied the data in order to identify concepts that emerged from data by using an inductive approach. Similar concepts were highlighted with the same colour. The quotes from which the concept emerged were also given

the same colour. At the end of this exercise, the identified concepts were copied and pasted into the second column of the table. Similar concepts were grouped together in the third column. The fourth column contains the number of times that a concept emerged from the data. These groups of concepts were examined to derive possible subthemes, which were captured in the fifth column. Each subtheme was captured with the emerged concepts. In the last column, the researcher captured possible theme with the related interpretation after consulting the literature.

### **3.7 ETHICAL CONSIDERATIONS**

This study was conducted according to the ethical principles outlined in the University of South Africa Research Policy as well as universal ethics principles. Ethical approval was obtained from the Ethics Committees of the University and the Ministry of Health of the Kingdom of Swaziland. Verbal permission to enter the community was obtained from the chiefs. The researcher adhered to the ethical principles of autonomy, rights to confidentiality and privacy, justice, and protection from risk and harm throughout the research process.

The principle of autonomy stressed the voluntary nature of the participation to the research project. It is argued that research participation must be completely voluntary and the participants should be well informed and understand what is involved in the study (Babbie & Mouton 2011). The autonomy of the participants was ensured through informed consent. The information about the study was contained in the participant information sheet attached to the consent form. The researcher reviewed the information sheet with the participants before the interviews. Each participant was

offered the opportunity to ask questions of clarification. The participants were also informed about their rights to withdraw from the study at any time. They were assured that refusing to participate or withdrawing from the study will have no adverse effects on them as the researcher was working in the same setting. Thereafter, they were requested to sign the written consent form.

Confidentiality refers to an agreement with the research investigator about what can be done with the information obtained about a participant, meaning that the participant's identity is not revealed to anyone other than the researcher and his or her staff (Polit & Beck 2012). In this study the researcher conducted the interviews in place and time that were convenient to the participants, while data management, analysis and reporting were handled in a way that no other person was able to link the descriptions to individual participants' results. The researcher did not collect any other data outside of the scope of this study, and all the informants were treated equally during the interview process. Informants' names were substituted with codes in the interview transcripts, and the audio records were strictly handled by the researcher.

According to Kumar (2011), harm includes not only hazardous medical experiments but also any social research that might involve such things as discomfort, anxiety, harassment, invasion of privacy or demeaning or dehumanising procedures. This study did not have any potential to cause physical or psychological harm to the participants. The study did not have any potential risks. However, the researcher ensured that interview questions were carefully phrased and that participants were offered an opportunity to ask questions at the end of the interviews.

### **3.8 SCIENTIFIC RIGOUR OR TRUSTWORTHINESS**

Rigor refers to the steps taken to ensure trustworthiness of the research results. It involved achieving excellence in research through the use of discipline, adherence to detail and strict accuracy (Polit & Beck 2012). In this study, scientific rigour or trustworthiness was achieved through confirmability, dependability, credibility, and transferability.

Confirmability refers to the degree of the objectivity of the results, recommendations, and conclusion as well as the neutrality of the researcher in the research process (Kumar 2011). Confirmability, this study was achieved through the ethical clearance process and the researcher adherence to the approved research proposal.

Dependability is concerned with whether similar results would be obtained with similar participants in a similar context (Kumar (2011). In this study, dependability was observed by providing detailed description of the data management and analysis procedures in the report.

Transferability is defined as the extent to which the results of a qualitative study can be generalized or transferred to other settings (Kumar 2011). Transferability in this study was ensured by providing detailed descriptions of the informants' characteristics, the informants' description of the phenomenon, as well as the researcher's observations in reporting the findings.

Credibility refers to confidence in the truth of the data and data interpretation. It means that the researcher attempts to demonstrate that a true picture of phenomenon under scrutiny is being presented (Kumar 2011). In this study, credibility was ensured through multiple reviews of the field notes and audiotapes; the neutrality of the researcher during the interviews, member checking, careful handling of emotional expressions, and the examination of findings by the supervisor.

### **3.9 CONCLUSION**

This chapter outlined the methodology that guided this study. It explained why these particular design and techniques of data collection were used. It also examined how data were processed in the study and how the ethical principles were observed.

## **CHAPTER 4**

### **PRESENTATION AND DISCUSSION OF THE RESULTS**

#### **4.1 INTRODUCTION**

As stated in Chapter one, the objectives of this study were to explore and describe (1) factors that positively influence (enablers) PHC services utilisation by children living in child-headed households in a rural community of Swaziland; (2) factors that negatively (inhibiting factors) influence PHC services utilisation by children living in child-headed households in a rural community of Swaziland. Saturation was reached after 20 individual semi-structure interviews.

The results were presented and discussed according to the study objectives. The researcher used the literature to organise the concepts that emerged from the thematic content analysis of the generated data.

#### **4.2 CHARACTERISTICS OF THE PARTICIPANTS**

The participants were described according to age, sex, and school attendance, duration of heading a household and household size. Table 4.1 provides a summary of the participants' characteristics.

Participants' age varied from 9 to 18 years old; 65.0% were females; and all of them were educated. The highest level of education among the participants was Form 3 and the lowest was Grade 3s.

**Table 4.1 Characteristics of the participants**

<b>Variables</b>	<b>Frequency</b>	<b>Percentage (%)</b>
<b>Age in years:</b>		
• 9 – 14	12	60
• 15 – 17	5	25
• 18	3	15
<b>Sex:</b>		
• Female	13	65
• Male	7	35
<b>School attendance:</b>		
• Still schooling	14	70
• Drop-out	6	30
<b>Length of heading a household:</b>		
• 0 – 6 months	3	15
• 7 months – 5 years	17	75
<b>Size of household:</b>		
• 2 members	4	20
• 3 – 6 members	16	80
<b>Use of primary health facilities in the last six months:</b>		
	20	100
• Yes	0	0.0
• No		

Those who dropped out of school gave various reasons including family responsibilities, poor school performances, poor socio-economic status and pregnancy as illustrated with the extracts below.

*I was not coping with school and family responsibilities hence I decided to stop schooling in order to look for piece jobs and fend for the family.*

*I dropped from school because I got pregnant and had more responsibilities of taking care of the small baby and my siblings.*

The duration for heading a household ranged from 6 months to 5 years. The largest household consisted of 6 members and the smallest had 2 members. All 20 participants indicated having used primary health care facilities in the last six months.

The characteristics of the respondents as described above are in line with the existing literature related to the profile of child-headed household. Gender differences remain a hallmark in the African society. Meintjies et al (2010) argued that girls are better at nurturing and sustaining households because they would have assumed the duties even at an earlier age before their parents passes away. Ayeiko (2003) also affirms that girl as young as nine years assume mother roles of housekeeping from the time mothers become bedridden. The feminist theory postulates that girls take the roles of care givers because they are caught up by the socio-cultural construct of gender roles at a tender age when older boys are in the household and risk abuse (Anfred et al 2004). Girls are automatically expected to be submissive and assume nurturing activities at an earlier age. Boys who take the leadership roles tend to over-exercise their authority and rule with a heavy hand because of ignorance and immaturity (Ayieko 2003).

The fact that all the participants attended school reflects the national trend. The UNESCO (2013) Swaziland reported a school enrolment of 98% up to 12 years old and 52% for above 12-18 years old. Approximately 17.4% (between 13 and 17 years old) stopped going to school because they became pregnant (UNICEF 2013). Sloth-Nielsen (2004) highlights more problems encountered by child-headed households members at schools, such as suspension from schools, being punished, being prevented from moving to the next grade, not allowed to write exams and not getting transfers due to non-payment of school fees. The government of Swaziland has taken a serious stance on creating a grant for OVCs under the DPMs office (National Strategic Framework 2009).

#### **4.3 FACTORS THAT POSITIVELY INFLUENCE (ENABLERS) PHC SERVICES UTILISATION BY CHILDREN LIVING IN CHILD-HEADED HOUSEHOLDS**

As stated in Chapter one, enabling factor referred to those factors that enable or facilitate the use of primary health care services when needed (Andersen 1995).

##### **4.3.1 Main findings**

Four themes emerged as enablers of PHC services utilisation by children living in child-headed households: fear for developing a deadly disease, perceived seriousness of the disease, compliance to treatment, and community support. These themes are illustrated in Table 4.2 with the number of participants of mentioned the theme.

**Table 4.2 Factors enabling PHC services utilisation by children in child-headed households**

#	Themes	Number of participants who mentioned the theme
1	Fear for developing a deadly disease	20
2	Perceived seriousness of the disease	13
3	Compliance to treatment	10
4	Community support	20

***Theme 1: Fear to develop a deadly disease***

Fear to develop a deadly disease as an enabling factor was associated with the family medical history. Participants were motivated to use the PHC services because of fear to develop the same disease that killed their parents. It was well expressed by the following extract:

*My parents passed away from TB so when I started coughing, not eating well, losing weight and sweating at night I knew I had the same signs. I visited the health facility to be tested because I did not want to die young.*

***Theme 2: Perceived seriousness of the disease or the condition***

The perceived seriousness of the diseases was associated with the perceived dangerousness of the causal agent and the severity symptoms. The snake bite was frequently mentioned by participants as a serious condition that needed urgent medical attention.

*This place is full of dangerous snakes hence there are many snake bites around... I only visited the clinic in the last 6 months when I was bitten by a mamba snake. This is a dangerous snake and I did not take any chances.*

<The participant gave this description with her body shaking as if the snake was within proximity>.

*We visited the health facility when my young sister was too sick and not showing signs of improvement and I had to rush with her to the health centre.*

### **Theme 3: Compliance to treatment**

It emerged from participants who were on anti-retroviral therapy and TB treatment. They associated the use of PHC services with the compliance to treatment as illustrated below.

*The health care workers give us dates to come for our monthly supply of ART which we have to honour every month.*

*The fact that my child and myself are living with HIV we visit the health facilities on our appointed review dates or when we have diseases that come as a result of a poor immunity' e.g. diarrhoea, headaches, numbness of feet and hands, dizziness, and general body weakness.*

### **Theme 4: Community support**

Community support derived from neighbours and people living with HIV and AIDS. According to participants, community members' act as facilitators in ensuring that they make use of PHC services when needed. The community support assists

children living in child-headed households to overcome barriers to PHC services utilisation.

*A neighbour who is also on ART requested the health worker to schedule his monthly review on the same date with my young sibling who is also on ART so that he travels with him to the health facility. This has completely solved our transport cost problems.*

#### **4.3.2 Discussions**

It is clear that children decision to use or not to use primary health care services is positively influenced by what they believed about the condition and not on their inability to perform the activities of daily living. The four themes identified as positively influencing the participants' decision to use PHC facilities are congruent with the profile of the respondents and the vulnerability associated with their profile. As stated in Chapters one and two of this report, children living in child-headed households in this rural community are orphaned by HIV and AIDS related diseases or TB. These two conditions are viewed as "the horrible couple" because they are devastating and known for causing most HIV related death. HIV destroys the immune system and exposes people to opportunistic infections. TB is the most common opportunistic infection that leads to high mortality of people living with HIV. The use of PHC services among these children can be explained by the fact that some of them have contracted the disease from their parents (WHO 2007).

In addition, these enabling factors are related to the need for care component of Andersen behavioural model (1995). The model argues that the need for care such as chronic diseases and inability to attend to the activities of daily living act as motivating factors for the use of health services. As it emerged in this study, participants who attended primary health care services were influenced by existing medical conditions and their inability to perform activities of daily living due to medical conditions.

Andersen (1995) behavioural model of healthcare services utilisation recognizes the role of community support system in increasing the likelihood of individual to use the health services when needed. For children living in child-headed households, this role cannot be overemphasised. In the context of children living in child-headed households, many of whom are orphaned by HIV and AIDS which is still associated with stigma, the support provided by the community system needs to be given serious attention.

Community support as an enabling factor for primary health care services utilisation could also be attributed to the fact that the study took place in rural communities where the traditional cultural values are still maintained. As argued by Forster et al (2003) in traditional African societies orphan were automatically absorbed by the extended family or the village communities where extended families do not exist. Studies looking at the orphan and vulnerable children in Swaziland have indicated that community based family care – kinship and extended family placement is preferred than alternative care placement for these vulnerable children living without

parents. This preference is in line with a SiSwati adage that says “ *banftwana ligugu lemmango*” (children are a treasure to the community), places a paramount importance for extended families and traditional structures to provide all forms of support (spiritual, social, emotional, moral, cognitive and mental) to children( UNICEF 2013).

#### **4.4 FACTORS THAT NEGATIVELY INFLUENCE (INHIBITING) PHC SERVICES UTILISATION BY CHILDREN LIVING IN CHILD-HEADED HOUSEHOLDS**

As stated in Chapter one, inhibiting factors referred to those factors that keep children away from PHC services utilisation when needed (Andersen 1995).

##### **4.4.1 Main findings**

Seven themes emerged from the description of participants: lack of money, ignorance, shortage of healthcare professionals, negative behaviour and attitude of health professionals, long waiting hours, unreliable public transportation system, and long distance. These themes are illustrated in Table 4.3 with the number of participants of mentioned the theme.

**Table 4.3 Factors inhibiting PHC services utilisation by children in child-headed households**

#	Themes	Number of participants who mentioned the theme
1	Lack of money	20
2	Ignorance	11
3	Shortage of healthcare professionals	6
4	Negative behaviour and attitude of healthcare professionals	18
5	Long waiting hours	13
6	Unreliable public transportation system	15
7	Long distance	12

***Theme 1: Lack of money***

Children living in child-headed households viewed the lack of money or financial constrain as an inhibiting factor even in the face of their willingness and need to use PHC services. The lack of money involved the money for transportation and the money to pay for the health services. Some did not see going to the health facilities as a priority as they have to strive to meet the basic need by looking for piece jobs.

*Although we have seen the need to take a sibling for health services it took about four months to go for health because we do not have the money for transport.*

*We do not have money for transport and we always borrow from neighbours and at times they also do not have.*

*Although the health centre has doctors sometimes you are referred to a big hospital for specialist care and transport is not provided, hence we do not have the money to go.*

## **Theme 2: Ignorance**

Ignorance as a barrier was associated with the nature of the disease as well as certain cultural health belief. It was mainly associated with the delay in using PHC services when needed. Ignorance was also associated with the lack of awareness about the various services provided at the nearest facilities. Although the participants knew about HIV and AIDS related services available at their nearest facilities, they had no idea about other services provided at these facilities.

*We did not seek medical assistance immediately because a relative came to tell us that liphika (difficulty in breathing) will dissolve on its own' until Rural Health Worker told us to go to the health centre and it was quite after some time.*

*It took a long time almost 2 months to seek health services because we did not know the gravity of the illness when my sibling was ill.*

### **Theme 3: Shortage of staff**

Participants were discouraged to go to PHC facilities because of the number of qualified nurses on duty.

*There is always one qualified nurse on duty consulting a lot of patients. Although they try to work hard to serve everyone, you can see that she is overworked and tired. This discouraged one to attend the clinics.*

*We prefer not to go there (referring to the PHC facilities) because of the number of health workers on duty. They are so few in every department and it takes you the whole day if you go there.*

### **Theme 4: Negative behaviour and attitude of health professionals**

Participants strongly felt that health professionals' behaviour and attitude toward their work and toward the children discourage them from using the health facilities.

*Nurses are not time sensitive. They report on duty late and when they come they start with health talks which take ample time and they start the actual work after an hour or two. It discourages some of us to go there unless you really have to.*

*A health worker made a very bad comment to me when I presented with sexually transmitted diseases. She said "Kusho kutsi uyalala wena" (meaning "So, you are already having sex?"). Can you believe that? How can one return when she knows that she will be treated in the same way?*

Few participants described similar behaviour from nurses even when they brought their siblings or children as captured by the two extracts below involved a child living in a child-headed household who visited the facility with her own child who was sick and another one who brought a sibling who needed an admission.

*Kwentiwayini kutsi usheshe kube nemfwana usemcane? Meaning 'Why did you have a child at such a young age'.*

The informant expressed disgruntlement at such comments so much that she feared going to health facilities.

*I was told that my seriously sick young brother was not going to be admitted if I do not stay to assist him with the toilet, feeding, giving medications, changing the linen and bathing him. I had to stay with my young brother for more than a week and at the same time I was missing school lessons and to make matters worse I had left my other younger siblings alone.*

#### ***Theme 5: Long waiting hours before being attended***

Long waiting hours before being attended to by a health professional was associated with nurses' behaviour toward their jobs. Nurses were perceived as being lazy and not observing working hours. These behaviours were viewed as responsible for the long waiting hours and consequently contributing to non-utilisation of PHC services.

*The health workers are very lazy they take a lot of time with one client before they call you in.*

*Health care workers are known for taking extended break times for tea and lunch while delaying us from getting service.'*

#### **Theme 6: Unreliable public transportation system**

Public transportation system between the residential areas and the health facilities was described as unreliable. This unreliability was viewed as inhibiting the use of primary health care services.

*There is one bus that goes in the morning and returns in the evening...we have to wake up odd hours of the morning to get this because once you miss it the journey is over for that day because there is no other transport to ferry you.*

#### **Theme 7: Long distance between residential areas and the nearest facility**

Some child-headed household expressed inability to access health services because they stay in mountainous areas where the road network is poor. Other household who stay near the river also expressed inability to cross the river during the rainy seasons as the areas have no bridge to connect them to the other side where health facilities are located.

*Although there are local buses to ferry us to the health facilities we certainly have to wake up as early as 4 am and walk for approximately 2-3 hours to get the bus.*

#### **4.4.2 Discussions**

Lack of money and ignorance as individual factors are intertwined and inextricably linked to the rest of inhibiting factors. Previous studies (Bredesen 2013; Ganga-

Limando et al 2013; van Eijk et al 2006) conducted in similar communities have identified lack of money and ignorance as barriers to health services utilisation. The lack of money and ignorance are indicators of the socio-economic status and education level of these children. In the revised model of health services utilisation, Andersen (1995) argued that certain individual socio-economic characteristics influence the utilisation of health services. The author argued that poor socio-economic situation and low level of education act as barriers to health services utilisation.

In addition, the lack of money and ignorance as individual inhibiting factors to health services utilisation should be understood within the context of Swaziland. Although children living in child-headed households have access to school support grant provided by government to all orphan and vulnerable children, children living in child-headed households have no other form of grants that cushion their other needs. The socioeconomic conditions in which these children live may not permit for them to prioritise health needs (SPRASP 2011; UNICEF 2013).

Shortage of health professionals, negative behaviour and attitude of health professionals, long waiting hours, unreliable public transport system and long distance between the residential areas and health facilities as barriers to health services utilisation among poor communities are well documented in the literature (Bredesen 2013; Ensor & Cooper 2004; Ganga-Limando, Moleki & Modiba 2014; Germann 2006; van Eijk, Bles, Odhiambo, Ayisi, Blokland, Rosen, Adazu, Slutsker & Lindblade 2006).

Shortage of staff, long waiting hours and negative behaviour and attitude of health professionals are all human resources related matters that are common in public health facilities in the country. Long waiting hours and negative behaviour and attitude of health professionals are exacerbated by the shortage of personnel. In response to the shortage of health professionals, the government of Swaziland implemented task shifting strategies where some of the doctor's duties are shifted to professional nurses and some of the professional nurses' duties are shifted to the lay counsellors and expert clients to reduce the work load from qualified personnel (Extended National Strategic Framework 2014-2018). However, report indicates that the work load of nurses remain overwhelming because there are specific duties that these lay people cannot do. This also correlates with the long waiting hours and long queues that child-headed household alluded to.

Unreliable public transportation and long distance as barriers to health services utilisation are linked with the lack of money. Authors (Ensor & Cooper 2004) refer to these factors as supplier barriers, their effect on health services utilisation can be mitigated by the availability of financial resources.

## **CHAPTER 5**

### **SUMMARY, RECOMMENDATIONS AND LIMITATIONS**

#### **5.1 SUMMARY**

The aim of this study as described in chapter one was to explore and describe the views of children living in child-headed households in a rural community of Swaziland regarding factors influencing their utilization of PHC services. The study was based on the understanding that certain factors may positively or negatively influence the health services utilisation behaviour of children living in child-headed households. The researcher was specifically interested in identifying the enabling and inhibiting factors and the emerged data fit into the behavioural model of health services utilisation.

The researcher used qualitative descriptive design with semi-structured individual face-to-face interviews to address the research objectives. These interviews were conducted with the most senior child of the households as described in chapter three. Data saturation was reached after 20 interviews. The age of the children interviewed ranged from 9 to 18 years. The generated data was analysed through thematic content analysis. Table 4.1 presented the summary of the characteristics of the 20 children interviewed. The results of the two objectives of the study were summarised in Tables 4.2 and 4.3 in chapter four.

The findings of this study suggest that children decision to go to health facilities when needed is dictated by their beliefs about that specific condition as translated by fear of

dying, perceived seriousness of the condition, compliance to treatment, and community support. While lack of money, ignorance, shortage of health professionals, negative behaviour and attitude of health professionals, long waiting hours, unreliable transport system, and long distance were identified as inhibiting or barriers to primary health care services utilisation.

As articulated in the statement of the research problem in chapter one, it was clear to the researcher that children in child-headed households at Matsanjeni are living in conditions that are known for increasing people vulnerable to diseases and hindering access and utilization of health services and that these children do attend the PHC services on regular basis. What was not clear which warranted this study was the understanding of factors that influence these children' utilization of the primary health care services within the above context. While most of the enabling and inhibiting factors identified in this study are documented in previous studies, the results of this study provide a new insight about what factor influence the decision of children living in child-headed households to use primary health care services when needed. This decision is not influenced by the health need or condition but by their belief about the condition and the availability of their community support. These two factors are important in understanding health care services utilisation among children living in child-headed households in similar rural communities of Swaziland.

## 5.2 RECOMMENDATIONS

Understanding factors that influence primary health care utilisation behaviour of children living in child-headed households within poverty stricken communities is important in assisting to formulate child-centred interventions that are aimed at improving their utilization of health services. In view of the results of the main findings of this study, it is recommended that:

1. Belief about the medical condition or health needs should be core to any behavioural interventions aimed at enhancing primary health care services utilisation by children living in child-headed households at poverty stricken communities.
2. Community support should be strengthened in order to facilitate primary health care utilisation by children living in child-headed households at poverty stricken communities.
3. Socio-economic and cultural interventions are needed to address the individual factors inhibiting the utilisation of primary health care services by children living in child-headed households at poverty stricken communities.
4. In-service training sessions on the management of orphan and vulnerable children are needed at health facilities levels to address the negative behaviour and attitude of health professionals towards this group of clients.
5. Health care managers should explore the possibilities of implementing case management approach to care for children living in child-headed households.

6. Future research should focus on understanding the lived experiences of these children and the impacts of the inhibiting factors identified in this study on the mental and psychosocial well-being of these children.

### **5.3 LIMITATIONS OF THE STUDY**

The results of this study should be interpreted within the limitations of the qualitative descriptive design and the use of semi-structured interviews. The use of qualitative descriptive design and semi-structured interviews does not allow for a deeper and full exploration of the phenomenon as the interviewee is guided by a semi-fluid structure. The inclusion of other members of the households in addition to the most senior member of the household could have added more insight into the study.

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## LIST OF APPENDIXES

### APPENDIX 1: INTERVIEW GUIDE

Title of the study: **Factors Influencing Primary Health Care Services Utilisation by Children living in Child-headed Households in a Rural Community of Swaziland**

**Date of Interview:**.....

**Place of the interview:**.....

**Code:**.....

#### **Section A**

Age of the interviewee (in years):.....

Sex:            Male            Female

Level of Education of the interviewee:.....

How long have you been heading this household:.....

Number of people living in the household:.....

#### **Section B**

1. Have you or any of your siblings been to the clinics, health centres or any other health facilities in the past six months?
2. Can you tell me about what influenced your decision to go to the above facilities for care?
3. From your experience, what made it easy for you to go for care in the above health facilities?

*Example of probing:*

What would you say facilitate the utilization of PHC services by children living in child-headed households at Matsanjeni?

4. From your experience, what made it difficult for you or any members of your household to go to for treatment at any PHC services when needed?

*Example of probing:*

What do you as barriers to the utilization of PHC services by children living in child-headed households at Matsanjeni?

## APPENDIX 2: ETHICAL CLEARANCE



**UNIVERSITY OF SOUTH AFRICA  
Health Studies Higher Degrees Committee  
College of Human Sciences  
ETHICAL CLEARANCE CERTIFICATE**

**HS HDC/312/2014**

Date: 19 February 2014 Student No: 4558-569-5  
Project Title: Factors influencing Primary Health Care services utilization by children living in child-headed-households in a rural community of Swaziland.  
Researcher: Joyce Sibanda  
Degree: Masters in Public Health Code: DLMPH95  
Supervisor: Dr M Ganga-Limando  
Qualification: PhD  
Joint Supervisor: -

**DECISION OF COMMITTEE**

Approved

Conditionally Approved

**Prof L Roets  
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE**

**Prof MM Moleki  
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES**

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

## **APPENDIX 3: MINISTRY OF HEALTH ETHICAL CLEARANCE**

Telegrams:  
Telex:  
Telephone: (+268 404 2431)  
Fax: (+268 404 2092)



MINISTRY OF HEALTH  
P.O. BOX 5  
MBABANE  
SWAZILAND

**THE KINGDOM OF SWAZILAND**

**FROM:** The Chairman  
Scientific and Ethics Committee  
Ministry of Health  
P. O. Box 5  
Mbabane

**TO:** Ms. Joyce Sibanda  
Principal Investigator

**DATE:** 13<sup>th</sup> February 2014

**REF:** MH/599C/ FWA 000 15267/IRB 0000 9688

Challenges And Prospects Of Child Headed Households In Accessing Primary Health Services  
in Matsanjeni, Shiselweni Region.

The committee thanks you for your submission to the Swaziland Scientific and Ethics Committee, an Expedited review was conducted.

**In view of the importance of the study and the fact that the study is in accordance with ethical and scientific standards, the committee therefore grants you authority to conduct the study. You are requested to adhere to the specific topic and inform the committee through the chairperson of any changes that might occur in the duration of the study which are not in this present arrangement.**

The committee requests that you ensure that you submit the findings of this study (Electronic and hard copy) to the Secretariat of the SEC committee.

**The committee further requests that you add the SEC Secretariat as a point of contact if there are any questions about the study on 24047712/24045469.**

The committee wishes you the best and is eagerly awaiting findings of the study to inform proper planning and programming to use for analysis

Sincerely,

A handwritten signature in black ink, appearing to read 'Dr S.M. Zwane'.

**Dr S.M. Zwane**  
DIRECTOR OF HEALTH SERVICES  
(THE CHAIRMAN)  
cc: SEC members



## APPENDIX 4: PARTICIPANT INFORMATION SHEET

**Project Title:** Access and Utilization of Health Services by Child-headed Households in Matsanjeni, Swaziland

### **What is the research about?**

This is a research being conducted by **JOYCE SIBANDA**, a Master student at the University of South Africa. You are invited to participate in this research because you are the head of a child-headed household at Matsanjeni. The purpose of this study is to describe and explore the experiences of child-headed households with regard to access and utilization of primary health care services at Matsanjeni area, with the view of making recommendations to support their access and utilization of primary health care services.

### **What will I be asked to do if I agree to participate?**

You will be asked to answer questions which will be asked by the researcher. The researcher will schedule an individual interview with you, on time and place convenient to you. During this one on one interview, you will be given the opportunity to share your personal experiences with regard to your motivation to use primary health care services, your views on what facilitate AND hinder the utilization of primary health care services by you and the members of your household. The interview will not take more than one hour. The interview will be conducted by the researcher. The interview will be audio-taped and notes will also be taken in order to allow the researcher to analyse and write the final report for the study.

### **Would my participation in this study be kept confidential?**

The information you will share with the researcher will be kept confidential as much as possible. Your name or address is not required. The tape will be locked away by the researcher for a period of three years. No individual names or identity will be used in the report. Should an article be written about this research project, your identity will be protected to the maximum extent possible.

### **What are the risks of this research?**

There are no known risks associated with your participation in this research. However, the researcher understands that during the course of the interview, you may recall experiences that may be stressful to you. Should this happen, the researcher will refer you to the appropriate service for counseling. In case you prefer the interview to be held outside of your house, the researcher will cover your transport cost.

### **What are the benefits of this research?**

This research will not have any monetary benefit to you as a participant. However, your experiences will assist the researcher to make recommendation for improvement regarding access and utilisation of PHC services among child-headed households in our communities.

### **Do I have to be in this research and may I stop participating at any time?**

Your participation in this research is completely voluntary. You may choose not to take part in the research. You may choose to withdraw your participation at any time should you decide to participate in the research and you will not be penalized or lose any benefits which you otherwise qualify for.

### **What if I have questions?**

If you have any questions about the study itself, please contact me (**Joyce Sibanda**) on Telephone: 076457276 or on Email: [48057584@mylife.unisa.ac.za](mailto:48057584@mylife.unisa.ac.za)

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact: The Research Supervisor at +27-(12)-4294131; E-mail: [gangam@unisa.ac.za](mailto:gangam@unisa.ac.za)

This research has been approved by the Higher Degree Research Committee and Ethics Committee of the Department of Health Studies, University of South Africa.

## APPENDIX 5: ASSENT AND CONSCENT FORMS

### ASSENT FORM (under 18 years)

The researcher has explained to me the purpose of the study and that I have fully understood what is expected of me and my benefits for participating. I understood that my name or family name will not be published in any report. I also have the right to participate or not to participate.

I am allowed to stop the conversation at any time when I feel uncomfortable or upset with the interview session. I am allowed to ask as many questions as I wish during the interview session.

Participant 's Name :

Participant's Signature:

Researcher's Name:

I hereby confirm that the afore-mentioned participant has been informed what the study is all about and has fully understood the purpose of the study and information gained will be used to benefit this vulnerable group.

Guardian \_\_\_\_\_  
/Witness 'Name  
Print

Relationship to household/children \_\_\_\_\_

Guardian /Witness' Signature \_\_\_\_\_

Date .....Place.....

## CONSENT FORM

The researcher has explained to me the purpose of the study and that I have fully understood what is expected of me and my benefits for participating. I understood that my name or family name will not be published in any report. I also have the right to participate or not to participate.

I am allowed to stop the conversation at any time when I feel uncomfortable or upset with the interview session. I am allowed to ask as many questions as I wish during the interview session.

Participant's Name :

Participant's Signature:

Researcher's Name:

Participant 's Signature :

Date .....Place.....