

CHAPTER 1

INTRODUCTION

1.1 History, Society, and the Economy

The People of South Africa

The people of South Africa have diverse origins. Ancestors of the Khoisan flourished in Southern Africa for thousands of years as hunter-gatherers. Around 300-500 AD, Bantu-speaking people moved southwards from West Africa bringing Iron Age settlements to Southern Africa. Nguni-speaking people lived in the eastern part and the Sotho-speaking people lived in the northern part. During the 15th century, European explorers came to South Africa. The Dutch East India Trading Company later established an outpost in the Cape to make provisions for the passing sea trade. The British also settled in the Cape. As the settlers moved inland, a series of wars followed leading to the conquest of the Xhosa and later the Zulu peoples and a dispossession of the land. In 1713, the great smallpox epidemic, imported by the settlers, decimated the Khoikhoi who had little resistance to this foreign disease.

The discovery of diamonds in 1867 and gold in 1871 changed the socio-political and economic path of South Africa forever. The mining interests fostered the development of the rail system, electricity, urban concentrations, commercial farming and manufacturing interests in the interior. Control of the riches led to the South African War in 1899. A bitter guerrilla war between the British and the Boers ensued until 1902 when a treaty was signed with the Boers agreeing to come under the sovereignty of Britain. Sugar plantations in Natal recruited labourers from India when local people were not attracted to the difficult and unrewarding conditions. Indentured labourers were brought from Calcutta and given the option of a passage to India or a small grant of land at the end of the contract. 'Passenger' Indians also came to South Africa as merchants.

Apartheid and political changes

The Act of Union brought the four colonies under British rule in 1910 but Africans were generally excluded from this process. It was only in the former Cape Colony that the vote was based on wealth and not on race. However, only men were allowed to vote. In 1913, the Natives' Land Act divided South Africa into 'white' and 'black' areas, forming the cornerstone of Apartheid. The rights of African people were systematically stripped while the political power of the Afrikaners grew. In 1948, a majority of whites voted for Afrikaner nationalism and a series of restrictive laws were introduced to benefit the white minority and ensure inferior amenities for Africans, Asians and Coloureds. In 1950 the Population Registration Act classified people according to race and the Group Areas Act defined where people could or could not live. In a final consolidation of Apartheid, the non-urban 'black' areas were patched together into 'homelands' to create separate 'nation states' for the different ethnic groups. Negotiations between the government and anti-Apartheid groups started in 1990. These culminated in the first national election which ushered in a full democracy in South Africa on the 27 April 1994. Today South Africa is a republic with 9 provinces under a semi-federal system. The administrative capital is Pretoria, the legislative capital is Cape Town and the judicial capital is Bloemfontein.

Population groups

The groups identified by the Population Registration Act were White, Indian, Black and Coloured. While Coloured was often explained as being mixed descent, it included people of Khoisan, Malaysian, Griqua, Indian and Chinese origin. Classification of the population into racial groups under Apartheid had profound economic and social impacts.¹

Culture and religion

The rich heritage of South Africa has resulted in enormous cultural diversity. The new constitution underscores the rights of all to foster their own religion and culture. There are 11 official languages although English is widely used in business and public official activities. The largest organised religion is Christianity. Others include Hinduism, Islam and Judaism. In addition, many people have a 'traditionalist' belief system.

Gender

The position of women in South Africa is intertwined with class and race. The most disadvantaged group in South Africa are the non-urban African women. The social status previously accorded to African women has been undermined as men became migrant labourers. The system of 'customary law', entrenched by the colonialists, ensured that African women held minor status. Since 1994, a strong government policy of gender equality has emerged. The international Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW) was signed without reservation in 1995. A wide range of initiatives include mechanisms to promote women's rights and monitor the impact of government spending on women's lives. The Gender Commission has been set up in terms of the Constitution, as an independent body to promote gender equity in society. The President's Office has established an Office of the Status of Women to ensure that gender issues are incorporated in policy and programmes.

Economy

South Africa is a middle-income country with modern infrastructure and relatively well developed financial, legal, communication, energy and transport systems. It has the largest economy in Africa. However, South Africa has one of the most skewed distributions of income in the world. In 1994 the Government of National Unity entered office with the blueprint for Reconstruction and Development Programme (RDP) which has been supplemented by Growth, Employment and Redistribution (GEAR). Economic growth has been at a level of about 2 percent per annum since 1994, but has been unable to address the high levels of poverty and unemployment.

1.2 Geography

South Africa is situated at the southern tip of the continent of Africa. Covering 1.2 million sq. km, most of the country lies in the sub-tropical region. A large part of the country is on a plateau that rises 1000 m above sea level. Mostly semi-arid, water is scarce except along the east coast. With the exception of the South Cape, which experiences a Mediterranean climate, rainfall generally occurs in summer but is unreliable. Long periods of drought are often experienced and encroaching desert is an

¹ Although people are no longer registered according to a Population Registration Act, it is necessary to collect some statistical data according to self-reported categorisation into these population groups in order to monitor the progress in reducing these social and economic inequalities. In this report, the terms African and Asian are used instead of Black and Indian, however it is recognised that Asian is a broader category, not only including people of Indian descent.

issue in the western part of the country. Irrigation schemes have been set up to support agriculture and industry. One tenth of the land is arable. The main seaports are Durban and Cape Town. These and 5 others serve the mining and industrial hinterland together with a well-developed rail and road transport system. Airports are found in all the provinces and there is an extensive highway system.

South Africa encompasses Swaziland and Lesotho, two land-locked countries that are economically dependent on South Africa. Mozambique, Zimbabwe, Botswana and Namibia neighbour South Africa and have a long and varied history of violations and dependence. A new era of co-operation has begun with the new government of South Africa.

1.3 Demographic Data and Population Policies

During the Apartheid era, demographic data were fragmented and incomplete. While statistics for whites, coloureds and Asians were of reasonable quality, the data for Africans were not adequate. The 1996 census collected information for the whole population and introduced questions for direct and indirect estimation of birth and death rates. Regarding vital statistics, much attention has been given to improving registration of births and deaths. However, it remains a challenge to produce accurate and timely mortality rates.

In response to a growing concern about the rate of growth of the African population, a national family planning programme was set up in 1974 to provide clinic-based contraceptive services. During the 1980s the government established a Population Development Programme (PDP) which undertook an advocacy role with an aim to reduce fertility. In addition to supporting the provision of contraception, the PDP paid attention to selected aspects of socio-economic and community development within the Apartheid framework. South Africa endorsed the United Nations Programme of Action that was adopted at the International Conference on Population Development (ICPD) held in Cairo, 1994. In 1998 a new national population policy was developed within a framework of multi-sectoral and sustainable development (Department of Welfare, 1998).

1.4 Health Policy Goals, Priorities and Programmes

When the Government of National Unity took office in 1994, there was huge fragmentation and gross inequalities in health status, health infrastructure and health services. Since then, there has been an intensive programme of legislative and policy development to reform the health service. Priority programmes have been outlined in the *White Paper for the Transformation of the Health System in South Africa* (Department of Health, 1997). Amongst the priorities are HIV/AIDS, tuberculosis, maternal health, child health and nutrition. Other priorities include the improvement of access to public health facilities and health care, increasing access to medicines, provision of free primary health care for pregnant women and children under the age of six, improvement of childhood nutrition, management of communicable diseases, provision of services in previously neglected areas such as mental health and maintenance of public health infrastructure. Regarding reproductive health, the current health policy focuses on providing adequate information and facilities to empower people to make informed choices about sexual relations, pregnancy and childbearing. The Choice on Termination of Pregnancy Act (Act 92 of 1996) and the Sterilisation Act (Act 44 of 1998) were thus introduced in 1996 and 1998 respectively.

Other areas of extensive legislative changes include the Medical Schemes Act (Act 131 of 1998) for better management of medical schemes and the Medical Dental and the Supplementary Health Services Professions Amendment Act (Act 1 of 1998). The Department of Health continues to support legislation that limits the use of tobacco (Tobacco Control Amendments Act, 1999).

1.5 Objectives and Organisation of the 1998 South Africa Demographic and Health Survey

The aim of the 1998 South Africa Demographic and Health Survey (SADHS) was to collect data as part of the National Health Information System of South Africa (NHIS/SA). The survey results are intended to assist policymakers and programme managers in evaluating and designing programmes and strategies for improving health services in the country. A variety of demographic and health indicators were collected in order to achieve the following general objectives:

- (i) To contribute to the information base for health and population development programme management through accurate and timely data on a range of demographic and health indicators.
- (ii) To provide baseline data for monitoring programmes and future planning.
- (iii) To build research and research management capacity in large-scale national demographic and health surveys.

The primary objective of the SADHS is to provide up-to-date information on:

- basic demographic rates, particularly fertility and childhood mortality levels,
- awareness and use of contraceptive methods,
- breastfeeding practices,
- maternal and child health,
- awareness of HIV/AIDS,
- chronic health conditions among adults,
- lifestyles that affect the health status of adults, and
- anthropometric indicators.

Organisation

The SADHS was a joint effort between various organisations. The Department of Health provided the funds and played an active role in the management of the survey. The Medical Research Council (MRC) co-ordinated the survey, provided technical input and undertook the processing and analysis of the data. MACRO International, funded by USAID, provided technical support in questionnaire design, sample design, field staff training, data processing and analysis. USAID provided additional funds for the sample in the Eastern Cape to be increased from the size in the original survey design. The University of Orange Free State's Centre for Health Systems Research and Development in partnership with King Finance Corporation implemented the fieldwork. The Human Sciences Research Council (HSRC) made technical input on the design and quality control of the survey. Statistics South Africa (SSA) provided sampling details in each of the nine provinces.

Sample design and implementation

The sample for the SADHS was designed to be a nationally representative probability sample of approximately 12,000 completed interviews with women between the ages of 15 and 49. The country was stratified into the nine provinces and each province was further stratified into urban and non-urban areas. In addition the Eastern Cape was stratified into five health regions, with each health region stratified into urban and non-urban areas (See Appendix A for full details). The sampling frame for the SADHS was the list of approximately 86,000 enumeration areas (EAs) created by the Central Statistical Services, now Statistics South Africa (SSA), for the 1996 census. Within each stratum a two-stage sample was selected. The Primary Sampling Units (PSUs) corresponded to the EAs and were selected with probability proportional to size (pps), the size being the number of census visiting

points in the EA. This led to a total of 972 PSUs being selected for the SADHS (690 in urban areas and 282 in non-urban areas). In urban enumeration areas ten households were selected, while in non-urban EAs 20 households were selected. This resulted in a total of 12,860 households being selected throughout the country². Every second household was selected for the adult health survey. In this second household, in addition to interviewing all women aged 15-49, interviewers also interviewed all adults aged 15 and over. It was expected that the sample would yield interviews with approximately 12,000 women aged 15-49 and 13,500 adults. The final sample results are shown in Table 1.1.

Questionnaires

The survey utilised three questionnaires: a Household Questionnaire, a Woman's Questionnaire and an Adult Health Questionnaire. The contents of the first two were adapted from the DHS Model Questionnaires to meet the needs of the national and provincial Departments of Health. The Adult Health Questionnaire was developed to obtain information regarding the health of adults. Indicators listed in the preliminary Year 2000 Goals, Objectives and Indicators document were included where a household survey was the appropriate mechanism for collecting the information.

The Household Questionnaire was used to list all the usual members and visitors in the selected households. Basic information was collected on the characteristics of each person listed, including his/her age, sex, education and relationship to the head of the household. Information was collected about social grants, work status and injuries experienced in the last month. An important purpose of the Household Questionnaire was to identify women and adults who were eligible for interview. In addition, information was collected about the dwelling itself, such as the source of water, type of toilet facilities, material used to construct the house and ownership of various consumer goods.

The Woman's Questionnaire was used to collect information from all women age 15-49. These women were asked questions on the following topics:

- Background characteristics (age, education, race, etc.)
- Pregnancy history
- Knowledge and use of contraceptive methods
- Antenatal and delivery care
- Breastfeeding and weaning practices
- Child health and immunisation
- Marriage and recent sexual activity
- Fertility preferences
- Violence against women
- Knowledge of HIV/AIDS
- Maternal mortality
- Husband's background and respondent's work

In every second household, all men and women aged 15 and above were eligible to be interviewed with the Adult Health Questionnaire. The respondents were asked questions on:

- Recent utilisation of health services,
- Family medical history,
- Clinical conditions,
- Dental health,
- Occupational health,
- Medications taken,

²Interviewers were instructed to include any second household residing on a selected plot, this rule resulted in more than the expected number of 12,540 households selected.

Habits and lifestyles,
Anthropometric measurements, and,
Blood pressure and lung function test.

Pilot Study

Pilot studies were carried out in November 1996 in non-urban and urban areas. The questionnaires were adapted and finalised on the basis of the results of the pilot study. The instructions and questions in the questionnaires were translated and produced in all official languages in South Africa (English, Afrikaans, isiXhosa, isiZulu, Sesotho, Setswana, Sepedi, SiSwati, TshiVenda, Xitsonga and isiNdebele).

Training and Fieldwork

The training of field workers was conducted by personnel from the MRC, HSRC, Free State University (Centre for Health Systems Research and Development) and Macro International. Training consisted of plenary sessions on more general issues like contraceptive methods conducted for the whole group in one venue and more specific discussions by section for each of the nine provinces in separate venues. There was also intensive training in adult anthropometric measurements, taking blood pressure and measuring lung capacity.

Some 175 candidates were recruited for field work. Each province had 1 or 2 managers who were responsible, under the supervision of 2 part-time regional managers, for the fieldwork operation in that province. Each province had 3 teams of female interviewers who were selected on the basis of education, maturity, field experience and language spoken. The Eastern Cape had 7 teams and KwaZulu-Natal had 5 teams as they had larger sample sizes. Team leaders supervised the teams and ensured the work flow. Each province had 2 centrally based editors who screened all the questionnaires before they were submitted to the office for processing.

Fieldwork commenced in late January 1998 and was completed in September 1998. Immediately before the fieldwork, information about the survey was released through the national media including TV, radio and newspapers. A community liaison strategy was developed in each province using local media to precede work in the different areas.

Quality control

In the course of the fieldwork, quality control measures were instituted at three levels. First, field team leaders and editors were trained to identify the enumerator areas included in the sample and guide interviewers in the selection of dwellings for interviews. Secondly, approximately 10 percent of the sample were re-visited in the months of the interview to ensure that the appropriate dwellings were selected and interviewed. Thirdly, a team consisting of staff from the HSRC carried out independent quality control visits to check questionnaires for errors, quality of identification and interviews at the enumerator area and dwelling levels.

Data processing

The questionnaires were processed at the Medical Research Council offices in Cape Town. Office editors checked the clusters for completeness and open-ended questions were coded. The completeness and consistency of the information was checked before the data were entered onto the computer using ISSA (Integrated System for Survey Analysis). A small proportion of the questionnaires were returned to the field to complete missing information.

Response rate

Of the total 972 PSUs that were selected, fieldwork was not implemented in three PSUs due to concerns about the safety of the interviewers and the questionnaires for another three PSUs were lost in transit. The data file contains information for a total of 966 PSUs. A total of 12,860 households was selected for the sample and 12,247 were successfully interviewed. The shortfall is primarily due to refusals and to dwellings that were vacant or in which the inhabitants had left for an extended period at the time they were visited by interviewing teams. Of the 12,638 households occupied 97 percent were successfully interviewed. In these households, 12,327 women were identified as eligible for the individual women's interview

(15-49) and interviews were completed with 11,735 or 95 percent of them. In the one half of the households that were selected for inclusion in the adult health survey 14,928 eligible adults age 15 and over were identified of which 13,827 or 93 percent were interviewed. The principal reason for non-response among eligible women and men was the failure to find them at home despite repeated visits to the household. The refusal rate was about 2 percent.

Result	Number	Percent
Households selected	12,860	100.0
Households occupied	12,638	98.3
Households absent for extended period	76	0.6
Dwelling vacant/destroyed	146	1.1
Households occupied	12,638	100.0
Households interviewed	12,247	96.9
Households not interviewed	391	3.1
Eligible women	12,327	100.0
Women interviewed	11,735	95.2
Women not interviewed	592	4.8
Eligible adults	14,928	100.0
Adults interviewed	13,827	92.6
Adults not interviewed	1,101	7.4