THE ROLE OF NON-GOVERNMENTAL ORGANISATIONS IN HEALTH PROMOTION IN SWAZILAND

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Thesis, spring 2011

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ABSTRACT

Karvinen, Suvi.
The Role of Non-Governmental Organisations in Health Promotion in Swaziland.
55 pages. Language: English. Helsinki, Spring 2011.

Diaconia University of Applied Sciences. Degree Programme in Nursing, Option in Health Care. Degree: Nurse.

The purpose of this study was to provide information on the work of non-governmental organisations in the field of health promotion. The main goal was to study the role of non-governmental organisations in relation to the other sectors providing health care services in Swaziland.

The study was conducted in Swaziland during spring 2010 through interviewing altogether seven (N=7) key informants, of which six (N=6) represented non-governmental organisations and one (N=1) the government of Swaziland. In implementing the interviews a semi-structured questionnaire was used. In gathering background data a review on research literature was done.

The gathered data was analysed using an inductive content analysis method. The nature of the study was qualitative with qualities of both phenomenal and ethnographic methodologies.

Results showed that the role of non-governmental organisations both in health promotion and in health care in general was significant. In addition, the results showed that non-governmental organisations had several means of carrying out health promotion actions, such as health education and security issues relating to food production. The need for further improvements concerning the financial, political and co-operational issues in the field of health care also emerged.

Conclusively, the non-governmental organisations play an essential and irreplaceable role in the health care system of Swaziland, yet there is need for improved co-operation between the different quarters in the health sector. The strength of the non-governmental organisations is in community-based and culturally sensitive work.

Madeleine Leininger's theory on transcultural nursing served as a theoretical framework for the thesis. The theory is depicted through the Sunrise Model, which was used in the structuring of the elements of the Swazi society and their influence on the people's environment and health perceptions.

Keywords: non-governmental organisation, health promotion, Swaziland, transcultural nursing

TIIVISTELMÄ

Karvinen, Suvi.
The Role of Non-Governmental Organisations in Health Promotion in Swaziland.
55 sivua. Kieli: englanti. Helsinki, kevät 2011.

Diakonia-ammattikorkeakoulu, Diak Etelä, Helsinki. Hoitotyön koulutusohjelma, sairaanhoitaja (AMK).

Tämän kvalitatiivisen opinnäytetyön tarkoituksena oli tuottaa tutkimuksellista tietoa kansalaisjärjestöjen toiminnasta terveydenhuollossa Swazimaassa. Tarkoituksena oli tarkastella järjestöjen toimintaa suhteessa muihin terveydenhuollon toimijoihin. Työn pääpaino oli kansalaisjärjestöjen terveyden edistämistyössä.

Tutkimusta varten haastateltiin seitsemää (N=7) haastateltavaa, joista kuusi (N=6) edusti Swazimaassa terveyden parissa toimivia kansalaisjärjestöjä ja yksi (N=1) Swazimaan hallitusta. Tutkimusaineiston keruussa käytettiin puolistrukturoitua haastattelukaavaketta sekä oppimispäiväkirjaa. Aineisto analysoitiin käyttämällä induktiivista aineistolähtöistä sisällönanalyysia.

Tutkimus osoitti, että kansalaisjärjestötoiminta niin terveyden edistämistyössä kuin terveydenhuollossa yleensä Swazimaassa on merkittävässä roolissa. Tutkimus osoitti myös, että kansalaisjärjestöt toimivat monella alueella terveyttä edistäen; esimerkiksi toteuttamalla terveysvalistusta sekä turvaamalla ravinnon tuotantoa. Lisäksi tutkimuksen myötä useita kehitystarpeita ja -alueita nousi esiin.

Tulokset osoittivat että kansalaisjärjestöt toimivat laaja-alaisesti julkisia terveyspalveluja täydentäen. Kansalaisjärjestöjen vahvuudeksi ja erikoisosaamiseksi osoittautui yhteisöjen parissa tehtävä työ. Sekä järjestöjen että eri terveysalan toimijoiden välillä on kuitenkin tarvetta kehittää toimivampia ja kattavampia yhteistyöverkostoja.

Tutkimuksen teoreettisena viitekehyksenä käytettiin Madeleine Leiningerin transkulttuurisen hoitotyön teoriaa sekä auringonnousumallia. Mallia käytettiin pyrittäessä jäsentämään swazimaalaisen yhteiskunnan ulottuvuuksia ja niiden vaikutuksia ihmisten ympäristöön sekä heidän käsitykseensä terveydestä ja siihen vaikuttavista tekijöistä.

Asiasanat: kansalaisjärjestöt, terveyden edistäminen, Swazimaa, transkulttuurinen hoitotyö, kvalitatiivinen tutkimus

CONTENT

1 INTRODUCTION

The Kingdom of Swaziland, a country in southern Africa, is facing difficulties at the moment in all the sectors of the society. The country has suffered from extreme drought and common poverty for years, which aggravate the survival of the most disadvantaged people (Finnish Red Cross 2010). Furthermore, the HIV-statistics in Swaziland are sad; nearly 40% of the population is estimated to be infected with the virus (UNDP 2008, xviii). These three issues are entangled: HIV together with poverty result in poverty and deteriorated food production. One-sided and insufficient nutrition then again deteriorates the public's health (Finnish Red Cross 2010).

The rapid increase in HIV occurrence among the population during the past 15 years has resulted in several severe difficulties in health care maintenance. The health system is fighting the situation with low budgets, inadequate and out-of-date health policies and equipment, shortages of trained staff and complex infrastructure. The outburst of HIV has led to the development of the need for new kinds of health services, which the health management systems cannot respond to. (WHO 2009, 20.) According to latest data, the revenue of Swaziland is declining, the country is facing an economic crisis and the government has not taken initiative in trying to increase the level of employment (40% in 2010). This will pose an even greater pressure over the public health care system as well as food production. (IRIN-news 2010 & 2011.) In filling out the gaps in health care, non-governmental organizations (NGOs) play a vital role, yet their work is affected by the deteriorated economic situation as government has decided to cut down its subsidies by 14 % this year (IRIN-news 2011).

In addition to the public and private health sectors, numerous non-governmental organisations take part in planning, carrying out and evaluating different health care and health promotion strategies and programs. The field in which these organisations work together with the public and private health care sectors is enormous and extremely challenging. However, despite the great number of participants in health care there is no relevant information regarding neither the

roles, responsibilities nor the distribution of work among these quarters. This creates an environment of overlapping and disorganisation, which is evidently formed into a barrier to effective, influential and sufficient health care. Conclusively, the need for organised distribution seems of vital importance and is a current issue in today's Swaziland.

The aim of this study is to produce information on the role of non-governmental organisations providing health care services in Swaziland. The focus of the study is on health care services used by local people through the aspects of health promotion and transcultural nursing. The thesis is ispired by the working life as the request for this kind of research has come from the Embassy of Finland in Maputo, Mozambique.

I chose this topic as I spent three months in Swaziland as an exchange student in spring 2010 and I had the desire to attach my thesis to my studies in Swaziland. As a part of my exchange program I did practical placement at a local hospital and attended to an intensive course at the University of Swaziland. In addition, I worked as an exchange student at the University of Swaziland as a part of the North-South-South-programme. The programme is a higher education institution network programme run by the Center of International Mobility (CIMO).

Information prior leaving for Swaziland was collected in forms of studies, research reports, thesis, literature as well as journalistic publications concerning the topic. The data collection was done in the form of interviews in Swaziland during spring 2010. The group of interviewees consisted of members working for different non-governmental organisations in the field of health care as well as one government representative. In implementing the study in Swaziland I received a great amount of help from the staff of the Faculty of Health Sciences at the University of Swaziland. For this I would like to express my deepest gratitude.

During my stay in Swaziland, I noticed that in working in a foreign setting with people from a culturally different background, culturally sensitive skills are

needed. As multiculturalism is a growing trend in our society, I see the management of these skills extremely essential as a future nurse. In this sense I find the topic very contemporary and of great importance.

Madeleine Leininger's culture care theory serves as a theoretical framework for the study. The core elements of the theory are depicted in the Sunrise Model, which has been used in order to analyse the structures of the Swazi society and the environment.

2 THEORETICAL BASIS FOR THE STUDY

2.1 Transcultural Nursing

> *If human beings are to survive and live in a healthy, peaceful and meaningful world, then nurses and other health care providers need to understand the cultural care beliefs, values and life ways of people in order to provide culturally congruent and beneficial health care. Madeleine Leininger, 1978*

When reaching the era of the third millennium in the mid 20th century, the increasing trend towards globalisation as well as the increased cultural diversity worldwide posed a challenge to the existing theories and practices of nursing. Nurses were facing the care of people from a diverse background of culture, beliefs, values and ways of living life as well as considering health. (Leininger 2002, 3.)

In order for this growing need in the field of practice and research in nursing to be answered, Madeleine Leininger founded the theory of transcultural nursing in the mid 1950s. Over the next five decades transcultural nursing continued to grow producing formal programs of education and research and founding a transcultural nursing content. (Leininger 2002, 3; 34.)

The ever increasing cultural diversity worldwide in the form of refugees, immigrants and other people from different cultural backgrounds encouraged nurses to gather and implement information on different cultures locally and worldwide in order to meet their clients' needs holistically. This is precisely where the focus of transcultural nursing lies: in promoting and maintaining the cultural care needs of human beings. Through aiming at this focus nurses can be provided with tools in their everyday work. (Leininger 2002, 3.)

2.1.1 Basis and Principles

In her theory, Madeleine Leininger has defined a group of transcultural nursing principles, which in her consideration serve as guidelines for transcultural nurses' work. They serve as guidance for students, practitioners, administrators and consultants in their thinking as well as decision-making. According to Leininger, it is these principles that lie behind beneficial nursing care practices and interactions. In the following, five core principles are represented. (Leininger 2002, 61-62.)

1. Human caring with a transcultural care focus is essential for the health, healing, and well-being of individuals, families, groups and institutions.
2. Every culture has specific beliefs, values, and patterns of caring and healing that need to be discovered, understood, and used in the care of people of diverse or similar cultures.
3. Transcultural nursing necessitates an understanding of one's self, one's culture and one's ways of entering a different culture and helping others.
4. Generic (emic, folk, lay) and professional (etic) care knowledge and practices often have different knowledge and experience bases that need to be assessed and understood before using the information in client care.
5. Holistic and comprehensive knowledge in transcultural nursing necessitates understanding *emic* and *etic* perspectives related to worldview, language, ethno history, kinship, religion (spirituality), technologies, economic and political factors and specific cultural values, beliefs, and practices bearing upon care, illness and well-being. (Leininger 2002, 62.)

2.1.2 Generic and Professional Care

In transcultural nursing research, Leininger developed the idea of *generic* and *professional* care in order to ease the identification of different kinds of care. The terms of generic and professional care were developed on the bases of *emic* and *etic* care discoveries. These terms aid and serve nurses in recognising care with different sources, meanings and expressions. (Leininger

2002, 60-61.)

By generic (emic) care is referred to folk knowledge and skills used by cultures that are lay, indigenous and largely emic and that are culturally learned and being transmitted. On the contrary, professional (etic) care refers to knowledge and practical skills that have been formally and cognitively learned and been used by faculty and clinical services in order to provide professional care. (Leininger 2002, 61.)

Originally, generic caring knowledge is derived from emic (from the insider's view) or within the culture. Professional caring knowledge on the other hand is derived from professional and institutional sources in an etic (from the outsider's view) way. Both of these caring methods have been shown to work as providers of assistive, supportive and facilitative care for people in their health and well-being as well as in the face of sickness, disabilities and/or death. In the field of global nursing, the use of professional care has been wide in relation to that of generic care. In Leininger's argument, both of these caring methods are to be taught, further researched and brought into caring practices in order to provide preventive, healing and satisfying care for clients from similar or diverse cultures. (Leininger 2002, 61.) In the following, some major differences between generic and professional care are presented.

Table 1.

Generic (Emic) Care	Professional (Etic) Care
• Humanistically oriented • People based with parctical and familiar referents • Focuses on caring, prevention and maintaing lifeways • Uses non-technological methods based on folk remedies and personal relationships	• Scientifically oriented • Clients are acted on unfamiliar techniques and strangers • Focuses on treating diseases, disabilities and pahtologies • Uses technological methods with many diagnostic tests and scientific treatments

(Leininger 2002, 61.)

2.1.3 Cultural Competence

Cultural competence is a term often related to transcultural nursing. The term in itself is wide and complex and should be viewed from several point of views. In nursing science, the term is often referred to actions performed by a health care professional, in which knowledge, attitudes and skills that enhance cross-cultural communication and effective ways of interaction with others occur. Cultural competence can also be referred to as a process in which a health care professional eventually strives towards effective working manners within the cultural context of a patient, thus being culturally competent in the end of the process. (Andrews & Boyle 2003, 15.)

However, Leininger prefers to use the term *culturally congruent care* in addition to cultural competence. In defining culturally congruent care Leininger takes the definition of cultural competence a bit further. Leininger defines culturally congruent care as a set of caring actions which are assistive, supportive, facilitative and/or enabling and which are at the same taking into consideration cultural care values, life ways and beliefs in order to produce care that is both meaningful and fits with cultural beliefs and life ways. The definition is utterly holistic as it takes into consideration all the factors contributing to the experience of culture, such as religion, language, education, politics, law and worldview. In Leininger's mind, these are the factors that culturally congruent care builds on. (Leininger 2002, 12; 58.)

In order to become a culturally competent nurse one must come across cultural self-assessment. Self-awareness of one's own values, attitudes, beliefs and practices is an important tool in becoming aware of the factors dictating the way people see and evaluate health-related issues. Self-assessment can also be seen as a tool for overcoming ethnocentric tendencies and cultural stereotypes. To gain knowledge of the culturally-based, health-related issues of all the patients or customers is in practice impossible as well as appropriate. However, gaining knowledge of some of the cultural backgrounds of clients representing the groups most frequently encountered among health care services is crucial to the process of becoming a culturally competent health care professional. In

addition, striving towards mastering the skills and knowledge associated with cultural assessment is essential to the process. (Andrews & Boyle 2003, 18.)

2.1.4 Culture Care Theory

In order for transcultural nursing to be able to produce tools for the use of practitioners, Leininger developed the idea of Culture Care Theory. The focus of the theory is on culturally congruent care and its clinical use. The aim of the theory is in exploring and indentifying different universal cultural-based care factors that are influencing factors related to health, illness, well-being or death among individuals and groups. The target of the theory is in utilising research findings in order to produce culturally congruent care methods in serving clients regarding their cultural background. (Leininger 2002, 189–190.

The demand for the theory arose from nurses' interest and growing need to discover the factors needed for carrying out culturally congruent care. That is to say: a need to detect cultural care meanings and practices that were being influenced through factors such as religion, history, environment, politics, cultural values, language, gender and others had to be fulfilled. To offer a means for achieving this Leininger developed the Sunrise Model, which is figured below. The model is not trying to act as the theory as a whole, but to depict the core ingredients of the Culture Care theory. (Leininger 2002, 189–190.

The model is frequently used by nursing researchers and health care professionals globally. Leininger offers some tips in using the model for commencing nursing researchers: when utilising the model one usually begins with choosing a group of individuals and a section or sections one prefers to use. One can choose the focus of perception to be either on generic and professional care or on the top part of the model, which observes the different forms of culture. (Leininger 2002, 192.) In this thesis, the model has been used in structuring the Swazi society and way of life through some of the top sections

in the model. This structure is presented in chapter 3 in the context of the study surroundings.

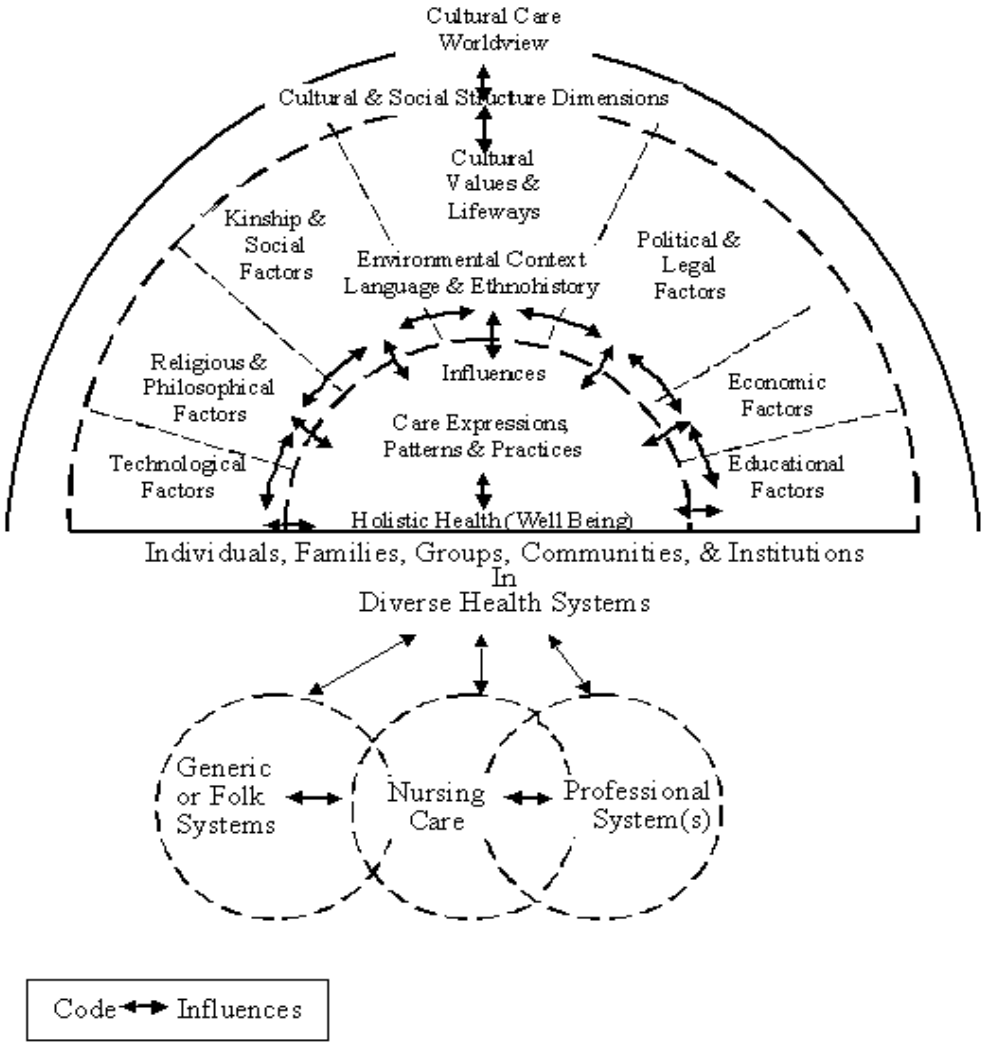

Figure 1. Leininger's Sunrise Model.

2.2 Health promotion

When discussing health promotion one must start with viewing health and sickness as concepts that affect human life. The existence of health is often seen merely as the lack or absence of illness, although it is a multidimensional concept that can be assessed as physical, mental and social health. (MacLachlan 2006, 21–22.) Health can also be seen as one of the most important values in people's lives and as a positive dimension in the contrast to the disease-focused view. In this sense, health is often associated with the

terms “well-being” and “quality of life”. (Tones & Green 2004, 8.) One definition of health that has reached popularity, acceptability and world-wide awareness is that of the World Health Organisation (WHO). WHO’s definition of health has a strong non-disease emphasis as well as a positive tone, as it states health as a human right and an absolute value, that should be accessible to all human beings equally. Today, WHO defines health as “a shared responsibility, involving equitable access to essential care and collective defense against transnational threats”. (WHO 2011.) Whatever interpretations on health are viewed, it is clear that health in itself is term that of complexity and richness in nuance.

Health promotion has at least as many definitions as health itself and is alike as complex and subtle as a concept. WHO defines health promotion as a process that enables the abilities of individuals to increase and improve health related factors. The definition enhances the impact of social and environmental factors as well as the importance of community activities in taking strategies into action. (WHO 2010.) Huff & Kline (1999, 4) define health promotion as influencing the health behavior of individuals, families, groups and communities through a different set of activities. Pender, Murdaugh & Parsons (2002, 7) argue that health promotion is behavior that aims towards health by increasing well-being and the ability of human potential over health issues.

Health promotion is often entangled with the concept of *health protection*, although there are some distinguishing factors. The aim of health promotion is at the experience of health, not “illness” or “injury”, whereas health protection is motivated by trying to avoid illness or to maintain function while being sick. Health promotion is driven by “approach” motivated action, whereas health protection is “avoidance” motivated. Health promotion aims towards increasing positive health potential, health protection seeks to prevent threats imposed to health from occurring. (Pender, Murdaugh & Parsons 2002, 7.) For example, an individual can try to expand his/her health potential and well-being in the sense of experiencing vitality and activeness (health promotion) as well as avoid the risk of cardiovascular diseases (health protection) by eating a lot of vegetables.

In practice these two terms often are inseparable; however it is important to note the difference of nuances when discussing them.

As stated before, the context of health is tied to cultural aspects in the sense of behavior, attitudes and beliefs relating to health related issues. Therefore, in order to gain culturally competent health promotion strategies, cultural sensitivity is to be taken into account at every step of the process. (Huff & Kline 1999, 4–7.) Crigger & Holcomb (2007, 70; 73–74) argue that if culturally sensitive factors are not considered when carrying out health care activities in different environments, the result of the process can turn unfavorable for the care receiver. This applies especially to those health related processes that are being carried out in the developing nations.

When planning health promotion activities from a professional care point of view, the existence of traditional caring in many cultures has to be recognised. A good and practical method might be that of suggested by Crigger & Holcomb (2007, 74), where a strategy is planned so that it merges the health practices of different cultures. This was done by utilising the most beneficial practices from one culture and preserving traditional caring methods from the other at the same time.

In addition, cultural competence in health promotion requires self-awareness by the health care professional. The health practitioner carrying out the health promotion activities must be aware of his/her own values, health behavior as well as lifestyle and the influence of these factors in his/her perception of health related issues. Ethnocentric behavior by the health practitioner increases the risk of overlooking, stereotyping and misinterpreting and leads to poor or non-existent outcome. (Huff & Kline 1999, 11–13.)

Health promotion in the Western countries is focused on educational methods that use conventional teaching tools and are based on the hypothesis that individuals can affect or have control over their environment or that they tend to strive towards favorable health behavior patterns. Therefore these programs often are unsuccessful in the mediation of information to individuals who have a

different cultural background or who live in a different environmental and social setting. (Smith, Garbharran, Edwards & O'Hara-Murdock 2004, 63). This is an important argument when viewing health promotion in Africa and in Swaziland.

In Africa, health promotion has gained development and awareness at an accelerating pace, although it is a relatively new concept to the continent. The impact of the existing socio-economic and political environment on health promotion strategies is enhanced in Africa, where health promotion has been formed to serve the people's needs. (Nyamwaya 2003.)

Some features in health promotion thinking are characteristic to Africa. First of all, the existence of cultural and spiritual factors, such as the extensive use of traditional remedies as well as the attitudes towards Western medicine, has been taken into account. Secondly, the impact of community-focused life ways on health related issues has also been recognised. Unlike in the Western countries, health promotion is regarded as a "set of tools" instead of a process. The main task to be carried out through health promotion practices is the dissemination of information and skills onto the communities. (Nyamwaya 2003.)

However, there are features in African health promotion thinking that stand in the way of successful outcomes. These include the lack of integrated theory as well as the low number of professionals in the field. (Nyamwaya 2003.) These notions have to be taken into account when examining the health promotion strategies that are being carried out in Swaziland.

When designing health promotion strategies, the aspects of cultural sensitiveness have to be taken into account. In other words, one cannot overlook neither the impact of religious factors, (social) environment, traditional life ways nor the socio-economic situation of the people that the strategy is being planned for. In addition, in order to gain modification in people's health behavior, one has to identify the factors that can be modified in the framework of the strategy. (Huff & Kline 1999, 5.) Moreover, the needs that rise from the

individual or the community are the key in planning the perspective of the strategy (Smith, Garbharran, Edwards & O'Hara-Murdock 2004, 62).

A good example of a successfully carried out health promotion plan is from South Africa, where a health promotion and disease prevention program for community women was completed through sanitation education. The implementation of the study was planned taking into consideration culturally sensitive issues, such as the environment as well as the educational background of the women. The program succeeded in addressing need related issues and resulted in the increased awareness of how sanitation is related to health. Hence significant increase in the well-being and quality of life took place. (Smith, Garbharran, Edwards & O'Hara-Murdock 2004, 65; 67.)

3 THE STUDY SURROUNDINGS

3.1 Swaziland

In descripting the study surroundings, I have utilised Leininger's Sunrise Model in analysing the Swazi society and life ways characteristic to it. In doing this my aspiration was to further develop my understanding concerning the relationships between the use of professional (etic) and generic (emic) ways of care and the use of health care services. In addition, I utilised the model in perceiving the health behavior and decision-making patterns of the Swazi people. Following Leininger's advice, I have chosen the features adapting the top part of the model in structuring the characteristics of the Swazi society. In addition to referencing I have utilised the notions and observations made during my stay in Swaziland.

Environment and population. The kingdom of Swaziland is located in Southern Africa covering a surface area of 17, 000 square kilometers. Swaziland is surrounded by Mozambique in the east and by South Africa in the west, north and south. The climate differs from tropical to temperate in different parts of the country. Terrain is mostly mountainous and hilly with some sloping plains. Drought is a natural hazard. (CIA 2011.) The land is distributed into four topographic sections; Highveld, Middleveld, Lowveld and and Lubombo. These sections are further divided into four administrative regions; Hhohho, Manzini, Lubombo and Shiselweni. Each of these regions is run by a political appointee, an Administrator. The country is further divided into 55 smaller administrative centers, under which around 200 chieftancies operate. Each of the chieftancies is run by the Chief, who has control over authority and the land in his chieftancy. (Zwane 2005, 12.)

Swaziland has a population of a bit over one million people, from which the majority are peasants living a very traditional form of life. Poverty is common to many Swazis and the lack of food is widely spread. Several years of drought as well as the irregularity of rainfall have increasingly deteriorated the situation.

(BBC 2009.) Although Swaziland in considered as a lower middle income country, the distribution of capital among the population is drastically uneven, resulting in the poverty of the majority of the population (WHO 2009, 16). Over 60% of the population is living below the poverty line and 40% are living without access to pure water (Finnish Ministry of Foreign Affairs 2006).

Political and legal factors. The Kingdom of Swaziland, one of the last absolute monarchies in the world, is Britain's former protectorate that gained independence in 1968. By absolute monarchy is meant the complete rule of a monarch over his land and citizens without the restrictive power of laws or the judiciary. In Swaziland the power has been kept by King Mswati III since the year 1986 after the end of his father King Sobhuza's 61-year-old reign. In 1973, King Sobhuza scuppered the constitution and abolished all political parties. A new constitution came into effect in 2005, but King Mswati III has shown no signs of willingness in sharing his power, despite the objections of trade unions and the abolished opposition parties. (BBC 2009.)

The legal system of Swaziland is a combination of Roman-Dutch Law, the English Common law and the unwritten Swazi law (Zwane 2005 4). The state of human rights in Swaziland can be described as poor. Freedom of speech is limited as the media operates under the control of the state. Open criticism towards the King is not allowed. The government has taken rough actions in order to slow down the voices of those showing criticism towards the King or standing in the opposition. (BBC 2009).

Economic factors. Economically Swaziland is strongly dependent on its neighboring countries, Mozambique and especially South-Africa, which receives nearly half of Swaziland's exports and from which Swaziland receives most of its imports. Swaziland's main exports are sugar cane, cellulose and several minerals. (BBC 2009.) Unemployment has increased strongly during the last few years, being 40% in 2010 (IRIN-news 2010).

In addition to the threat posed to national health by malnutrition, poor sanitary conditions and the lack of pure drinking water, Swaziland has one of highest rates of HIV-infections in the world: as much as nearly 40% of the population has been estimated to be infected with the virus. The amount of infections among the adult population is high: out of all 15-49-year-olds 26% were estimated to be infected in 2006/2007. (UNDP, xvii, 2008). HIV-infections in the adult population have resulted in the death of hundreds of workers and farmers leaving thousands of orphans behind. The life expectancy of women is 45 years and of men 46 years. (BBC 2009.)

Kinship and social factors. The Swazi society as well as the family concept is very hierarchic: in a Swazi family, the husband is the indisputable head of the family, under whose command live the wife or wives (polygamy is acceptable) and the children. The head of the family is expected to act as a role model and to be responsible of all the fields of life. The house ruler is in charge of all the decision-making often together with the elderly of the family. In the Swazi society, women continue to be legal minors who are most often economically and socially dependent on their husbands (Zwane 2005, 7). Gender-based violence is reported as being a major social and public health problem in the country (USAID 2010). Therefore, women have very few means of affecting their lives in terms of decision-making and sovereignty over their own environment, health and political rights. (UNDP 2008, 1.)

In the Swazi society, children are seen as a source of social security and furthermore, as a proof of male fertility. As a sign of this, women are considered to bear as many children as possible and to start childbearing at a young age. The question of fertility is socially highly emphasized since infertility is seen as disgraceful and stigmatising. (Ziyane & Ehlers 2007, 10.) These factors impact not only on the reproductive health and sexual self-determination of women, but also on the general attitudes towards contraceptives. In addition, these are major issues influencing public health in general and especially in terms of the HIV pandemic.

Urbanisation together with growing development has resulted in the formation of new, non-traditional family forms, such as one-parent families and families lead by grandparents or even older children. The latter have been formed as a result of the country's HIV-situation. The society is facing a new challenge in front of the disappearance of traditional, communal family concepts. At the same time the social contacts and safety nets provided by these traditional family forms are being lost. (UNDP 2008, 1.)

The hierarchy could be observed at all levels of the Swazi society: in upbringing of children, at working places, educational institutes, everywhere where social intercourse occurred. Obedience to the authorities and fear of making mistakes was widespread among people. Questioning or challenging the authorities was very unusual. This created an atmosphere where people are not keen in taking responsibility or making decisions on their own. The indecisiveness and buck-passing were characteristic qualities in the society. (Karvinen 2010.)

Religious factors. Majority of the population (40%) are Zionist, which is a form of Christianity with features of indigenous ancestral worship. Other larger religious groups are the Roman Catholics (20%) and the Muslims (10%). (CIA 2011.) The presence of religion and the impact of it on people's lives could be seen everywhere in the country. The idea of not believing in a higher power or in a Creator was unknown in Swaziland: religious atmosphere was present at working places, shopping malls, public transportation vehicles, schools, hospitals. (Karvinen 2010.)

Fatalism (faith that one's life is predestined by a higher power) was very widespread and could be seen in the way people perceived life and death. Fatalism impacted on the health attitudes of people in many ways. It was common that people sought medical attention in the very last resort. Fatalism can also be considered as one of the reasons why preventative or prophylactic health activities have not gained ground in the country. (Karvinen 2010.)

Technological factors. The use of modern technology is heavily centered in the urbanised area of the country. Furthermore, means of accessing information are

quite few: approximately 10% of the population has access to the internet and the TV- and radio-stations are state-owned. (CIA 2011.) This poses the people living in the rural areas in a quite disadvantaged situation as they have no means of reaching health-related, updated information. In addition, accessing knowledge is also a major theme regarding health attitudes, as the lack of knowledge increases the amount of misunderstandings, misconceptions, and beliefs.

Educational factors. The educational system comprises of preschool, primary school, secondary school and academic levels. The system is liable for charge except for academic level. In 2004, the literacy rate was 88% and primary school enrolment rate 81.9%. However, out of the students starting first grade 40% fail to finish their primary education. The funding of academic education on the expense of the primary education sets the poor part of the population in a very disadvantaged situation by aggravating the accessibility of primary education and making it practically impossible for the majority of the population to ever reach an academic degree. Yet it is acknowledged that securing primary education is one of the most efficient ways of reducing poverty. (UNDP 2008, 33.)

The drop-out rate from primary education is a major concern especially in the frequent HIV situation. Poverty itself acts as an obstacle to accessing and completing primary education and is now re-enforced by the relevance of HIV. Due to the pandemic, many children have lost one or both parents and are forced to drop out. This is because they might have to take care of younger siblings, their sick parents or complement the household living by going to work. (UNDP 2008, 33.)

Conclusively, there are several factors in the Swazi culture and society that impact the experience of health, health behavior as well as the possibilities of an individual to have influence over health related factors. Due to their disadvantaged situation in the society, women and children have even fewer means of influencing health and having self-determination over their body. Furthermore, this takes place in an environment where not even the basic

needs of people can be satisfied and decision-making is in the hands of few social groups. Understanding the underlying social, political and economical factors is crucial when examining the health system of the country. In the following, the effects of the HIV pandemic as well as the structure of health care services are further observed.

3.2 HIV pandemic

Although the HIV situation in Swaziland is not the main focus of this thesis, a general view on the prevalence and the impact of the virus in people's lives is necessary in order to understand the effect of the situation in the whole society. The United Nations Development Programme (UNDP) has reported the pandemic as being an obstacle to national human development in the country undermining people's possibilities of living a long and healthy life, of gaining education and of achieving a decent standard in the quality of life (UNDP 2008, 71). Therefore, the effects of the HIV and AIDS prevalence can be seen at all sectors of the society; health, economy, infrastructure and education.

As stated before, the HIV prevalence among the population in Swaziland is the highest in the world, being around 40 % of the whole population (UNDP 2008, xviii). This poses ever-increasing pressure to the country's health system which is already in difficulties due to low budgets, shortage of staff, inadequate equipment and underdeveloped infrastructure (WHO 2009, 7). The increased appearance of HIV related opportunistic infections, such as tuberculosis (TB) adds the severity of the situation (UNDP 2008, 58). In 2009 tuberculosis was the main reason behind morbidity and mortality in Swaziland; it was also estimated to cause 50% of the death of HIV-positive and to cause 25% of all hospital admissions (WHO 2009, 3.)

Due to the social norms, gender-based violence as well as gender inequality in the country, women are in a much higher risk of getting infected with HIV than men. In 2007, for every two HIV-positive adult men, there were three HIV-positive adult women. The majority, more than 60%, of new infections also

occured in women. This disproportional relationship can be explained by the prevalence of polygamy, extramarital relationships, intergenerational relationships and earlier sexual debut among girls. The dominance of men over women in every sector of the society exposes women to unwanted and/or unprotected sexual intercourse. (USAID 2010.) Additionally, especially in the case of women, the prevalence of other sexually transmitted infections (STIs) multiplies the risk of getting infected with HIV. Treating STIs has also been shown to reduce the transmission of HIV. (WHO 2006.) In Swaziland in 1998, estimated 47.6% of patients with STIs were also infected with HIV (The Ministry of Social and Health, The Government of Swaziland 2001, 3).

The impact of the HIV pandemic on the education system of the country as well as on the possibilities of people getting educated is significant. The mortal rates among young adults have resulted in the creation of thousands of orphans (estimated 63, 000). Most of these children are being taken care of by their grandparents, who are not capable of paying school fees or travelling long school ways. In addition, the mortality among young adults results in the distortion of the population structure so that the largest population groups are children and elderly. The sickness and mortality rates among children and teachers are high as well. These factors together may lead to a situation where the demand for educational services is greatly reduced. (UNDP 2008, 61–63; 66.)

The economy is being hard hit by the pandemic both at micro- and macro-levels. At micro-level, the increased morbidity and mortality rates add the risk of households suffering from poverty as the virus strikes the breadwinners of the family leaving the rest of the family (often children and elderly) in charge of the household economy. At macro-level, the pandemic has lead to the significant reduction in productivity, increase of production costs and the disruption of business operations. The high level of workers being either killed or disabled by the virus has lead to the increased loss of both labour and skills. (UNDP 2008, 69.)

Despite the widespread relevance of HIV, the country's attitude environment towards the virus contains heavy aspects of stigmatisation. In spite of the educative and sensitising campaigns, the concepts of stigma, silence and denial are still widely spread among all age groups in the society. (UNDP 2008, 8.) Falling ill with HIV is regarded as disgraceful: people can be secluded from their communities on the basis of having HIV. Hence many living with the virus are forced to conceal the fact from their fellow-men, even from their spouse. (IRIN-news 2011.) The attitude of denial inhibits people seeking treatment and the authorities addressing the gravity of the problem. This can also be seen as one of the reasons why people seek the aid of traditional healers prior to that of professionals. (UNDP 2008, 8.)

The national response to the pandemic started initially in 1987, although it gained momentum only in 1999, when the king Mswati III declared the pandemic as a national disaster (UNDP 2008, 72). In 1999, several committees on HIV response were set up while the Ministry of Health implemented activities (USAID 2010). During the decades that followed the response has grown from prevention-based and health sector driven into being comprehensive and multi-sector focused today (UNDP 2008, 72). However, these implementations cannot be regarded neither as sufficient nor effective enough since the HIV morbidity has continued its growth at an accelerating pace.

Nevertheless, the government has taken some successful actions in addressing the HIV situation over the past years: the antiretroviral therapy (ART) program offering free antiretroviral treatment has reached the public well (85% of HIV-positive in the need of ART were receiving it), so has the Prevention of Mother-to-Child Transmission Program (PMTCT), as 69% of pregnant women were on antiretroviral drugs (ARVs) in 2010 (USAID 2010). In response to the growing number of orphans, a program for orphan and vulnerable children (OVC) was also set up focusing primarily on food security. UNDP has considered the OVC Programme as one of the most promising in the country. (UNDP 2008, 83.)

The vastness of the HIV pandemic has overshadowed the existence of non-communicable diseases (NCD), such as diabetes, high blood pressure, cardiac

condition and mental disorders. Yet there is data showing that the occurrence of these conditions is on the increase. Relevant data on cancer prevalence does not exist. The scale of the HIV pandemic has led to the disproportional distribution of the available resources in health care. (WHO 2009, 6; 8.)

3.3 Health care in Swaziland

The health care system of Swaziland comprises of the public, private and third sector. Majority of the funding of Swaziland's health services comes from the government except for the deal of HIV related work, which receives funding from several development partners such as the European Union, Global Fund, the Government of the United States and the United Nations agencies (WHO 2009, 20).

The government of Swaziland has the primary responsibility of maintaining health care services that are accessible and of good quality. Health is considered conditional to economic growth, development and poverty reduction. The health services provided by the government are based on the principles of the Primary Health Care (PHC), which serves as a basis for the maintenance and development of the health care system. On the basis of the PHC, the national health care services of the country build on three levels: the primary, secondary and tertiary levels. These levels are stated to provide curative, preventative and rehabilitative services. On the basis of the PHC the government has also aimed in the decentralisation of health services so that they would be accessible to all Swazis. This has been done through the Regional Management Committees, which are tasked to run health centers and clinics in all of the four regions of the country. (Zwane 2005, 34.)

The public health services of the country are operated through three main levels: state clinics, health centers and hospitals. The clinic is a primary health unit and a first level contact, health centers and public health units are at second level and the hospital is a third level contact. (Zwane 2005, 4–5.) In 2005, the public sector operated altogether six hospitals, eight public health

units and five health centers that offered both preventive and curative services. Community-based care operated through 89 health clinics and 174 outreach clinics. (Kober & Van Damme 2006.) All public health services are liable to charge, even emergency related services (Zwane 2005, 35).

The health care system is managed by The Ministry of Health and Social Welfare at the central level and by the regional health management teams at the regional level (Zwane 2005, 5). The government states that by 2015, it aims to develop the public sector into an “efficient and effective service” that targets to create an environment where the people of Swaziland are able to “live longer, healthier and socially fulfilling lives” (The Ministry of Social and Health, The Government of Swaziland 2011).

The provision of community-based care is operated through the Rural Health Motivators (RHM), who assist local communities by managing health problems and promoting health care. The motivators, usually older women, undergo a 10-week training where they are trained in recognising common conditions and managing basic home based care skills (IRIN-news 2004). In the communities, the Motivators carry out tasks such as health talks, condom distribution and referral planning. The RHMs also advise communities of issues such as environmental sanitation, breastfeeding and prevention of several diseases. (Zwane 2005, 4.) Therefore, the RHMs can be seen as major implementers of health promotion acts. In 2004, there were about 4, 000 RHMs in Swaziland (IRIN-news 2004).

The current accessibility and affordability of public services is not known. In 2005, Zwane’s study findings indicated that there was need to increase the amount of services in the communities. Accessibility was endangered due to long distances and occasionally bad means of communications (e.g. bad roads during the rainy season). In terms of affordability, the chargeability of the services aggravated and in some cases hindered the use of the services. (Zwane 2005, 35.)

The private sector of the country's health care is divided into the non-profit and for-profit facilitators. Most of the non-profit organisations are funded through mission programs, yet they receive funding from the government. In 2005, the private sector operated more than 50 clinics. (Kober & Van Damme 2006.) However, the private sector is not regulated in terms of health care facility maintenance. This is why the private sector in most cases does not meet the national guidelines and technical requirements. (WHO 2009, 7.)

One of the latest threats being posed to the Swazi health care system is the lack of trained professional staff and even more the flee of those who still work in the field of health care. In the Swazi culture, the role of care givers is traditionally and still most often carried out by women (UNDP 2008, 9). This combined with the subordinate position of women in the society has led to the undervaluation and backwardness of the entire health system as well as the striking movements of nurses (IRIN-news 2011). According to Kober & Van Damme (2006) the greatest reasons behind the "brain drain" are emigration to other countries (mainly South Africa), as well as the exhaustion and burn-out of trained staff due to the ever-increasing number of patients.

In Swaziland, the impact of traditional health care forms as well as the community care giving cannot be left without consideration. Both UNDP (2008, 83) and WHO (2009) have stated the practice of traditional medicine having an informal status and not being regulated by any means (WHO 2009, 7), although it was early recognised as a part of the national response to the HIV pandemic. In fact, traditional medicine practitioners have been to some extent familiarised with the basic information on HIV and AIDS and other sexually transmitted infections. However, this intervention became a low priority as the national response progressed. (UNDP 2008, 83.)

Despite the informal status of traditional medicine, it is highly usual that people see a traditional healer prior to seeking professional help. Traditional remedies and ways of healing are seen as familiar and safe. (UNDP 2008, 9.) The lack of knowledge concerning modern (Western) medicine is common in the Swazi society, which often leads to negative attitudes, misconceptions and fears

regarding the use of modern treatment. Modern contraception, for instance, is seen as unsafe and unreliable by Swazi men, whereas traditional contraceptive methods are regarded as safe and effective with no side effects (Ziyane & Ehlers 2007, 8). Yet the formal health care system run by the government emphasises the use of biomedical health systems over that of the traditional ones (Thwala, Jones & Holroyd 2011).

This suggests that the usage of both professional and generic use of medicine and means of health care exists in today's Swaziland. As to what extent, where and by whom these forms of care are being used, no exact and relevant data can be found. What can be suggested on the basis of the previous examples is that the meaning and emphasis of the traditional medicine is strong, especially in some specific areas of health. This is noteworthy when carrying out health care and health promotion plans especially in the rural areas, where people still lead traditional ways of life and are not familiar to urbanisation and modern technology. Therefore, this is an area where successful outcomes most likely require the implementation of culturally sensitive care.

In perceiving the health care network of Swaziland, the traditional role of communities as safety nets and care givers has to be noted. Traditionally, the communities were considered to have a social responsibility towards the wellbeing of their members. Communities provided safety and security for those in need. As the trends of urbanisation and modernisation have gained ground in today's Swazi society, this form of traditional lifestyle has been jeopardised and to some extent even disappeared. The responsibilities of the communities have been passed on to different institutions, such as schools, hospitals and other service providers. However, these institutions are often driven by commercial interests, which leave the ideas of voluntarism and moral sense of obligation secondary. (UNDP 2008, 11.)

3.4 Non-governmental organisations

Actors in the third sector of Swaziland's health care are foundations, trusts (Kober & Van Damme 2006) and a set of different organisations. Non-governmental organisations represent a way of performing civic activity in between the public and private sectors. Most often NGOs work where the public services fail to reach people or provide them with sufficient care and support. In several cases, that is looking after the underprivileged parts of the population. NGOs are most often non-profit driven and can work as a part of foundations or funds.

In Swaziland, there are many internationally based and extensive organisations, such as World Vision and International Red Cross. These organisations work among issues related to food security, financial security and health care. In addition, environmental and gender based issues are core functions. Through these organisations people have been provided with resources and support related to their environment and health. This support can appear in the form of setting up backyard gardens as well as offering health related councelling. In implementing these functions these organisations work in co-operation with volunteers and communities. (Finnish Red Cross 2010 & Word Vision 2011.)

In 2008, UNDP evaluated that non-governmental and community-based organisations play an important role in the field of health care in Swaziland. The effort of NGO-based work was noted especially regarding the work done within the communities. In fact, NGOs were seen as having created the re-activation of the traditional community safety nets to some extent. (UNDP 2008, 106; 11).

Despite this acknowledgement, there is very little information available neither on the field of NGOs nor on the work done by these organisations in Swaziland. An umbrella organisation, CANGO (Coordinating Assembly of Non-Governmental Organisations in Swaziland), is based in the country's capital and has over 60 organisations in its records (CANGO 2010). Yet extensive information on the work profiles and efforts of these organisations is not available.

4 IMPLEMENTION OF THE STUDY

4.1 Aim and research problems

The aim of this study was to come to an understanding of the role and significance of the work done by non-governmental organisations in the field of health promotion in Swaziland.

The research problems of the study are:

1. What is the role of non-governmental organisations in providing health care services in Swaziland?
2. What are the means used by non-governmental organisations in implementing health promotion actions?
3. What should be done in order to develop health care services and in what ways?

The research problems were formed based on the discussions with my directors prior to my leaving for Swaziland. Throughout the research problems the aim of the study clarified and directed the structure of the interviews. On the basis of the research questions three contextual themes were formed that were presented in the questionnaires. The presentation secured that the themes were covered in every interview that was carried out. These themes included covering the work profiles and fields of the organisations, the roles of the organisations in relation to other quarters in health care and the sectors of health care that needed further development.

4.2 Study approach and method

This thesis has a qualitative approach with qualities of both phenomenal and ethnographic methodologies. The qualitative approach regards reality as a variable that is dependent on the context and the perceiver. The approach is

holistic as it aims at perceiving the subject as a whole, not as a set of different functions. The approach is intense and the role of the researcher is to be subjective and involving as a means of increasing understanding. (Tarling & Crofts 2002, 76–77.) In nursing, through qualitative study the different occurrence of life processes can be revealed in order to gain deeper understanding and means to develop interventions that increase the well-being and quality of life of individuals (Lo-Biondo-Wood & Haber 1998, 221).

Phenomenal methodology is based on the assumption that human behaviour can be understood holistically only by taking into consideration the historical and existential context. Through this methodology the way of people's interpretations of the world and how it affects their interactions can be studied. Ethnographic methodology uses the same holistic approach having the emphasis on trying to understand the patterns of behavior related to a particular culture. (Tarling & Crofts 2002, 77.) The focus of ethnographic methodology is in trying to explicate the emic (insider's) view of the world and reality. In nursing, the methodology is used in studying cultural variations and their affect on the experience of health. (Lo-Biondo-Wood & Haber 1998, 229). In this study, the nature of the difference in cultural backgrounds of the researcher and the study participants has to be taken into account.

The techniques of naturalistic observation as well as semi-structured interviewing were used in the data collection. Naturalistic observation was used in the form of a research diary, where general notions on the culture and the environment were done. Naturalistic observation was also used in the case where I had the opportunity to follow the work of one employee of a non-governmental organisation during his working day. Semi- structured interviews were used in order to gain information on the subject under study and to aid in covering all the areas of study during the interviewing sessions. Semi structured form was also used so that there was room for complementary questions and free conversation if the need arose. The study process took place through identifying the phenomenon, structuring the study, gathering and analysing the data and finally describing the findings.

4.3 Data collection and analysis

The interviews were carried out in between my practical placement working days. The interviewing sessions were sometimes behind an enormous amount of time, persuasion and paper work, at times they were arranged so quickly that there was no time for preparation. I quickly learned to carry all the necessary equipment with me at all times as well as learned the questions of my questionnaire at heart. Some of the interviews were done in city centers, some in the rural areas of Swaziland. The infrastructure of Swaziland is to some extent underdeveloped and some of the roads in bad shape, hence time for moving from one place to another had to be made. The way people perceive time in general in Swaziland differs greatly from that of the Western world. If an appointment had been made at a precise hour, you had to be prepared for delays, taking sometimes for hours. Therefore, making an interview could easily take up your whole day.

All together seven (N=7) informants were interviewed, from which the data of all interviews (N=7) was utilised in the thesis. Six (N= 6) of the interviewees represented non-governmental organisations and one (N=1) was an official of an health department working for the government of Swaziland. The views and opinions stated by the interviewees do not necessarily represent the standing point of their employers, but that of theirs as individuals. Therefore, the persons interviewed are referred to as interviewees or informatnts in the text. The organisations interviewed were all workers among the country's field of health care; that was the only criteria that had to be met. The interviewees represented the field of non-governmental organisations in Swaziland from small and regional all the way to large and international. All of the organisations had HIV related projects, although all weren't prime HIV organisations. In addition to HIV related work, many worked either/and within orphan care and food security.

In finding and reaching the interviewees I received a huge amount of help from the staff of the University of Swaziland, for which I am ever grateful. In addition, the parent organisation of all non-governmental organisations, CANGO (Co-coordinating Assembly of Non-governmental Organisations in Swaziland),

provided me with a great amount of information and contact details, for which I am very grateful alike.

The emphasis of health promotion's viewpoint was strengthened after carrying out of the interviews, which is why it is not emphasised to a greater extent in the questionnaire. The selection of only such NGOs that are primarily focused in health promotion would have been ideal for the study's outcome, yet it would have been impossible to carry out in the study environment. No data regarding the work distribution of Swazi NGOs concerning health promotion exists, neither would it have been realistic to reach only NGOs with such an emphasis.

The data analysis was done through three stages. In the first stage, the data was reduced by lettering the recording tapes of the interviews and the notes made on the base of the interviews. Three (N=3) of the interviews were recorded and on four (N=4) interviews only notes were made. All irrelevant and/or worthless data to the study was cut down already in the first stage. In the second stage, the data was further reduced by creating different categories and gathering suitable data under each category. The categories were formed according to the research problems. In the formation stage three, the data was coloured in three different colours according to the suitability to the categories. For every category a different colour was chosen. In the third stage the data was even more reduced by creating subcategories under each main category. These categories consisted of quotes, utterances and/or single words that described the category in place. This is how answers to the research questions were found and the study findings were ready to be represented.

4.4 Ethicality and reliability

The general basis of ethical research practice consists of the notions of beneficence, non-malevolence and the respect for autonomy (Tarling & Crofts 2002, 107). The ethical issues concerning this thesis have to do with the protection of privacy, confidentiality, the voluntariness of participation and the consciousness of the study's purpose.

Causing harm to an individual by conducting research is generally considered as unethical (Tarling & Crofts 2002, 108). In this study, the possibility of causing harm had to do with the sensitivity of covered issues as well as the participants' protection of intimacy. Some participants wished to stay anonymous due to the sensitivity of some areas covered in the interviews. The areas concerning development needs as well as the role of non-governmental organisations were seen as sensitive by some of the participants. Regarding the position of some participants in their working environments, performing as their selves would have posed them to threat to some extent. To ensure the privacy of these participants no names of individuals, organisations or interviewing sites have been announced in the study. Due to the sensitiveness of some areas covered during the interviews, the questionnaire is not presented in detail in the study.

By autonomy is meant the freedom and capacity to make decisions independently on the basis of thought. In order to ensure and respect the study participant's autonomy, information regarding the study has to be openly available and the voluntariness of participation clearly brought out. (Tarling & Crofts 2002, 108.) The purpose of the study was explained to all of the participants prior to the interviews. If possible in terms of time and technology, the research plan was e-mailed to the participants before the interview took place. Voluntariness at all stages of the interview was presented and the right to withdraw from the study at any phase was given. The approval for the use of a tape recorder was asked and the right to deny its use at any phase of the interview was given. The participants were informed on note-making as being a tool for the researcher and that the notes would not be used by anyone but the researcher and in a context that is relevant only to the study.

However, conducting a study in naturalistic setting set the need to gain consent questionable. Using naturalistic observation as a data collection method rarely enables gaining consent from all those being observed. (Lo-Biondo-Wood & Haber 1998, 236.) This came into effect also in conducting this study.

In evaluating the reliability of a qualitative data, the concepts of credibility, auditability and fittingness are to be considered. In qualitative research, the researcher is the study instrument collecting data and interpreting the participant's reality. In order to remain true to the data the researcher must be aware of any personal bias that might influence the interpreting of participant's reality. (Lo-Biondo-Wood & Haber 1998, 236–237.) This does not necessarily add to the unreliability of the study, for different interpretations only make the phenomenon under research more versatile. In qualitative study, this is appropriate.

In the context of this study, the unfamiliarity of the research environment has to be noted. Furthermore, in this study, the difference in the cultural backgrounds of both the researcher and the participants and the effect of this on the study's outcome must be acknowledged. This has to be considered in the sense of interpreting the reality of the participant as well as in the conceptualisation of terminology used in the study. In addition, the use of English as the study's language has to be noted as it is neither the mother tongue of the researcher nor majority of the participants. Only one of the participants spoke English as mother tongue. In order to deliver the perceptions of the participants as authentic as possible, sensitivity in conceptualisation was regarded.

In order for a research to be valid and reliable, the use of extensive as well as versatile background information is required (Silverman 2005, 211). In conducting this study, meeting this standard was to some extent challenging. Information regarding the topics of this study neither existed in a wide scale, nor was easily accessible. As the topic has not been under research before, using a comparative method was not possible. The sources used are mainly in English, with the exception of two Finnish sources. Through using mostly English source material I wanted to contribute to the credibility and the usability of the study.

Auditability refers to the adequacy of representing the study phases from the formation of the research question all the way to the conclusions (Lo-Biondo-Wood & Haber 1998, 238). In order to achieve this, the process of conducting the study step by step has been described. Especially in describing the phases of data analysis preciseness and versatility has been aspired, so that the means of achieving the study findings would appear transparent and understandable to the reader. In addition, by using authentic expressions from the data in presenting the study findings, glimpses of the raw data have been introduced to the reader. Transparency of all the working phases adds to the reliability and credibility of the study.

By suitability of the study is meant that the study is described in enough detail so that its findings can be of use to other researchers and practitioners in other environments (Lo-Biondo-Wood & Haber 1998, 238). In representing the study findings and drawing conclusions the concept of fittingness has been considered so that the material would be appropriate to further use. The environment in which the study was conducted naturally sets its own requirements for the further usage of the study material.

In evaluating the credibility of the study the study process has to be brought out. I started out with the study by myself, until I was joined by another nursing student leaving to Swaziland as an exchange student. Our collaboration started out well: we gathered information prior to leaving for Swaziland and completed the interviews together. However, due to personal reasons and separate views we decided to share the subject but produce two separate studies. This happened prior to data analysis. In analysing the data, I have utilised the notes and letterings only of my origin.

5 STUDY FINDINGS

On the basis of the gathered data three categorical themes emerged in order to describe the study findings. The formation of the themes was directed through the research problems. These themes include: the role of the non-governmental organisations in the field of health promotion, the means of implementing health promotion actions by non-governmental organisations and the factors among health care that need further improving and development. In the following, the study findings are represented through these categories.

5.1 Non-governmental organisations as health promoters

Regarding the responsibilities, roles and work distribution among different actors in the field of health promotion and health services in general, the role of the non-governmental organisations was seen as significant by all of the informants.

> *Very significant.*
>
> *NGOs are the people in the forefront.*
>
> *The role of non-governmental organisations in health promotion as well as in health care in general is imperative.*

Co-operation with the government at all sectors of health care was brought out by nearly all of the informants. However, a contradictory finding emerged: co-operation was seen as successful by the government official, whereas the other informants regarded the involvement and control of the government sometimes as a drag on implementing health promotion actions. According to one interviewee, the government lacked interest in doing co-operation with non-governmental organisations. Some interviewees also reported as not being linked with the government, which was seen as a confusing factor in terms of co-operation. In order to be able to review the differences and similarities of the

different informants, the quotes belonging to the government official have initials (GO) after the quote.

> *NGOs are always in co-operation with the government.* (GO)
>
> *…an auxiliary working in co-operation with the Ministry of Health.*
>
> *So we…do not function on our own, even though we are offering the health services…it's not like, we're just doing things on our own, we have to involve them (the government). Whatever services we want to offer, then we would have to consult with them and…it has to meet the standards…with the Ministry of Health*
>
> *There's no will for co-operation from the government.*
>
> *The government is in control over everything.*

However, there seemed to be organised activities between NGOs themselves as some of the organizations seemed to be linked with each other. One informant reported their organisation to have gathered data and updated a list of all the organisations involved in HIV related work. Another informant also reported that a municipal structure (Municipal HIV and AIDS Team) gathering all the HIV organisations together some times a year has been maintained. The purpose of the gatherings is to update progress and to make sure that there is no overlapping in the work done by the parties.

The role of the non-governmental organisations was seen as vital especially when it comes to complementing the work in the public health sector. The non-governmental organisations were seen as an auxiliary of the government especially in reaching the people and in bringing the services accessible to the people, even in the remote and rural areas. This standpoint was enhanced especially in responding to the growing need of health care services due to the HIV pandemic.

> *Doing the work where government has gaps.*
>
> *NGOs are the extended hand of the government.*
>
> *Without NGOs government would not cope.*

> *Vital role, great and essential key position, especially, because we have HIV and AIDS now.*
>
> *A great responsibility as people working with the communities*.
>
> *…when it comes to reaching out people from the communities the NGOs are really helpful. (GO)*
>
> *NGOs come in when government cannot reach the public. (GO)*

When regarding the work done in health promotion the non-governmental organisations were seen as the main actors. This point of view was recognised also in improving and developing health promotion programmes. The reason behind this is in the relationships, connections and co-operation that the non-governmental organisations were reported to have with the communities.

> *I think we have a great…and essential role when it comes to improving health care systems in the country.*
>
> *…most of the things, most of the health promotion, are done by NGOs, most of it. Especially the social marketing, the promotion…*
>
> *The NGOs are doing most of the work. And I think that because they are more closer to the people because government is central, you see. NGOs are more closer to the people. And maybe that's why they…are in the forefront.*

5.2 The means of implementing health promotion actions by non-governmental organisations

The data showed that non-governmental organisations were active in several fields of health promotion and health care. Due to the rapid emerge of the wide HIV pandemic, a lot of the resources of the organisations were canalised in to the response to the pandemic. This could be seen in the work profile of the organisations. The interviews showed, that the health promotion work carried out by organisations comprised of several areas in health care, including work related to HIV and AIDS, community based care, food security, supporting acts and health education. Several of the informants reported their organisation having both clinical and home based care functions.

In relation to HIV the work field of the organisations was wide. The organisations reported carrying out all functions from HIV testing and counseling to ART provision. In addition, they carried out follow-ups for those on ARVs as well as managed palliative last-phase care. Moreover, follow-ups for patients who have not showed for their clinical meetings or test result hearings were arranged. The HIV and AIDS related work was carried out in clinics as well as in home based care.

All of the informants reported their organisation having volunteers, through which the organisations were able to reach and provide care to the people in rural and remote settings. Some of the volunteers were trained health care professionals, able to carry out clinical tasks or provide people with information regarding the protection from and treating HIV and AIDS. Some volunteers were merely used as a linkage between the organisation and the communities. The volunteers acted as a linkage to the community leaders, who were in charge of the events taking place in the communities. For instance, if an organisation wished to set up a clinic at some rural community, the community leader's acceptance was required.

In several cases, the volunteers acted as support persons for people living with HIV. They took care of the person's follow-up and provided the person's family with information and ways of treating HIV and AIDS. Therefore, in several cases, the volunteers acted as securers of successful treatment. The impact of the volunteer-based work in the communities was seen as the key factor in reaching people.

Some informants reported their organisation having set up community gardens as a part of their food security programs. This was seen as an important means to provide people with a more balanced diet and to give them the feeling of taking control over their own lives, hence create a feeling of empowerment. This can be seen as an effective form of health promotion in the sense of increasing the well-being and health of people.

Health education in the sense of community mobilisation was reported as one of the most important actions carried out by the organisations. The government official stated that the government arranged mass education happenings in co-operation with the non-governmental organisations. Other informants reported arranging health talks and sessions regarding health related issues among all age groups. One interviewee also reported their organisation having arranged health sessions at different formations, such at work places, churches and sport clubs. The same interviewee reported their organisation also utilising the national official days, such as Mother's Day or Valentine's Day, in order to reach as many people as possible. During these days people are on the move, which offers a great opportunity for arranging health sessions. All health education reported to have been carried out by the organisations was at least to some extent HIV related.

5.3 Need for improvements and development

In evaluating the consistency and functionality of the health care system of Swaziland, several factors were introduced. The greatest areas in need of improving were regarded as relating to financial or resource related issues, co-operational and organisational issues, culture related issues and policy related issues.

The greatest sector of improvement was clearly that of financial issues and resources. All of the informants reported their organisation having limited resources and funding. The government official reported also being in need of increased resources in their department. The lack of resources was seen as having led to increased insecurity and complications in planning for the future and designing new strategies. The concept of health promotion was reported as being new and unknown in Swaziland to some extent, and the need for making its mark was noted. This was seen as a difficult goal in terms of weak funding.

A great shortage of trained health care professionals among all areas of health care was reported. The health facilities were regarded as insufficient and partly

outdated to meet the standards and the need of today's health services. The ones that were running were stated to be overcrowded by patients and understaffed.

> *We have a need of highly trained staff.*
>
> *…need for trained people…*
>
> *… (clinics) understaffed and because of that, you find that they (nurses) are usually burned out and they seem not to care…*

Some interviewees evaluated the lack of main resources, such as pure water and food, as well as the lack of adequate living conditions, to be the main reason behind failure of health care and health promotion plans.

> *…main reason is the lack of food and poor living conditions.*
>
> *How do you expect someone with no food to have the energy to pick up their medication from the service points?*

Some informatns, as well as the government official, pointed out that the government is not posing health care as a priority. This was seen as a reason to the lack of resources and funding.

> *The government is not taking health care as a priority.*
>
> *Need for resources, money…money. Our government is not taking health care as a priority. They'd rather be interested in roads, infrastructure, you know, some education…not health care.*
>
> *The government hasn't taken any initiatives to strengthen the health departments. (GO)*

The need to develop issues relating to co-operation between the different quarters in health care was seen important. A need for better organisation in the field also emerged. Clear formalisations and strategies in co-operative actions were missing but needed. The lack of proper organisation in planning the fund distribution and the misusage of funds by some organisations was also noted.

We need a clear vision and a sense of logistics.

There's a need for formalization in co-operation. (GO)

There's nothing actually on paper (regarding co-operation). (GO)

Some issues related to culture were also seen as areas of development. The indecisiveness as well as the shirking from responsibility that are both characteristic features of the Swazi culture were noted as barriers or hinderers to many actions in health care in general. One informant also reported of the lack of respect and recognition towards the work done by the non-Swazis, that is to say Western people. Then again the importance of having local people who are familiar to the language, environment and the society was noted as being great.

Issues relating to health care policies were also brought up. The health care policies used were regarded as outdated and not responding to the modern needs of the health care facilities. There was a strong request on the policies to be updated in order to address the contemporary issues in health care. The base of good policies was seen as the initiative for planning health promotion and health care services.

Health care policies need to be updated!

…you just have to start with a base of good policies, so that we can be able to take programs from good policies and, you know, take them out to the communities.

In every way, not only in health care, in the health sector, our policies are just outdated. Yet that is where we have to start if we want to develop.

6 CONCLUSIONS

The study showed that non-governmental organisations in Swaziland work mainly in those areas of health care that cannot be covered by the public health sector. In Swaziland, these areas were particularly situated among the most vulnerable groups of the population: the poor, the elderly, the children and the sick. Non-governmental organisations were in several cases devoted to finding the people who otherwise would not reach any health services due to lack of resources (money, food, water) or long distances. The majority of the services provided by the NGOs were free of charge. In reaching the people, whether it was in the rural areas or in urban settings, the NGOs were pioneers. In this sense they can be viewed as having carried out the key method of African health promotion, as argued by Nyamwaya (2003): the dissemination of information and skills onto the communities.

Focusing on the underprivileged members of the society indicates that NGOs in Swaziland have the same qualities and purposes as non-governmental organisations in general. In addition, the need for such a great devotion to out-reach work supports the argument of Zwane (2005), that government-run services are centralised and fail to reach the people in the rural settings of the country. The community-focused emphasis of NGOs support the view of UNDP (2008), arguing that the work of NGOs in the communities is notable. One of the strengths of non-governmental work was the recognition of the importance of implementing out-reach activities in order to make health care services accessible to all those in need.

On the basis of the study findings the role of non-governmental organisations in the health system of the country appeared as significant, vital and imperative. These descriptions can be considered as biased coming from the NGO-representatives' viewpoint. However, the similar standpoint of the government official makes the arguments more valid and unbiased. The standpoint is also supported by the perception of the UNDP (2008) arguing that NGOs play an important part in the field of health care in Swaziland. In addition, the argument

is supported by the latest information on the situation of the country's health system and the response to the HIV pandemic. In a situation where the pandemic continues to accelerate, health care facilities are crowded with people and suffer from chronic staff-shortage, it is clear that the government cannot support the functioning of the health care system on its own. This is where the work of the NGOs is irreplaceable.

In carrying health promotion actions the non-governmental organisations appeared to work in a very wide field of implementations. These included actions such as health education, food security and supportive care. The utilisation of volunteer-based work was noteworthy in its wideness and methodicalness. It was also noted as one of the most efficient ways of reaching people and doing community mobilisation. Although the work of the participant NGOs seemed well organised and reasonable, the field of the country's NGO-led work is extremely wide. Therefore, unorganised, insufficient and unreasoned activity most likely occurs as well. As stated by one of the informants, some organisations are very small, hence incapable of implementing efficient activities. The misusage and unevenness of resources were also brought up.

Nyamwaya argued already in 2003 that there are two factors related to African health promotion that stand in the way of successful outcomes: the lack of integrated theory as well as the low number of professionals in the field. These two factors showed to be still contemporary in Swaziland. NGOs appeared to be quite organised in their own areas of work, especially regarding that of HIV related work. In this area NGOs were organised at national level (through CANGO) as well as at regional level (Municipal HIV and AIDS Team). However, large-scale organised and managed structures as well as the need for trained staff were noted by nearly all informants. Improved organisation would reduce the amount of overlapping work, hence help in allocating the services for those in need. In addition, by creating more organised work structures the allocation of insufficient resources (financial and physical) would be more effective. In order to construct better organisational structures, further research on the country's health actors would be needed. Updating health policies would most

likely increase the conditions of implementing more efficient health care and health promotion actions.

When designing and implementing health promotion strategies, the aspects of cultural sensitiveness have to be taken into account (Huff & Kline 1999, 5). Moreover, the needs that rise from the individual or the community are the key in planning the perspective of the strategy (Smith, Garbharran, Edwards & O'Hara-Murdock 2004, 62). In doing this non-governmental organisations seemed to have been successful. This has been achieved by successfully merging qualities from both generic and professional care forms. Through this people have been provided with efficient care on many occasions. Examples of such implementations, among others, are as follows: working with the traditional leaders and using volunteers from communities to reach even the remotest places. The understanding of the effects of cultural issues to many health related questions is crucial in providing culturally sensitive and effective care.
Working with the traditional leaders and using volunteers are signs of understanding the value of history, customs, language and social norms in people's responsiveness. NGOs seem to have realised the contradictory attitudes of the society regarding traditional and modern medicine and ways of treatment. As a solution they have used the people from the communities (traditional leaders and volunteers) as their messengers and in that sense approached the people on the people's terms. Bringing the service accessible to the people in their own environment instead of waiting for the people to show up for the clinical settings is also an indication of culturally sensitive thinking. Understanding that culture-related factors can also act as efficient barriers to managing health care is one of the NGOs' strengths.

Health promotion in the Western countries is based on the hypothesis that individuals can affect or have control over their environment or that they tend to strive towards favorable health behavior patterns (Smith, Garbharran, Edwards & O'Hara-Murdock 2004, 63). In Swaziland, the possibilities of the majority of the people in controlling their environment or promoting their health are extremely limited. These limitations are due to a various set of political,

economical, social and environmental factors. Therefore, health promotion in the Swazi context has to be perceived from a different point of view.

According to Nyamwaya (2003) health promotion is seen as a set of tools rather than a process from the African perception. This point of view came into effect in the implementation of health promotion actions carried out by the NGOs. Whether it was planting maize, distributing condoms or briefing people on the importance of hand-washing, the focus was on increasing the well-being of people, not changing their environments.

Finally, the study showed that the concept of health promotion is indeed quite unfamiliar and unknown to many Swazis. Furthermore, what must be understood is that what might not seem as health promotion in a Western world setting might well be it in another environment. This came into effect in Swaziland, where health promotion had to be regarded as any health care act that increases peoples' well-being and quality of life. In that sense the concept of health promotion can be considered to be quite widespread and in practical use in the country. In implementing these practices non-governmental organisations are in the forefront.

It is clear that on data based on such a small group of informants, inaccurate generalisations are possible. Therefore the field of Swaziland's health care should be further examined in order to be able to create extensive and universal perceptions. On the basis of these perceptions further plans and implementations regarding the work distribution and responsibilities of different sectors could be made. Organised collaboration would lead to the increased and more secured provision of effective, sufficient and cost efficient health care services as well as the promotion of health.

Conducting the study also showed that relevant and updated information on Swaziland is not easy to find. Either the information does not exist or it is not made accessible to those seeking it. The same argument has been announced by The World Health Organisation in 2009. This indicates that the means of producing, managing as well as implementing research literature and

information still need to be developed further. This would not only ease the conduction of research but improve the health information systems of the country. This would contribute to the planning, managing and maintaining health care policies that would serve the public in a more sufficient and effective manner.

7 DISCUSSION

At the beginning of the research process in spring 2009, I did not know where Swaziland existed. Neither did I know about transcultural nursing practices, life in a developing country, the treatment of HIV nor the efforts made by non-governmental organisations all over the world. Today, as the end of the process looms ahead, I can acclaim myself to have gained quite an amount of know-how concerning all these issues.

During the process the principles of transcultural nursing and its implementation to practice have become familiar and rewarding. To be able to use the theory as means of interpreting and exploring people's lives, culture and environment has given me a great feeling of content. The impact of the environment to an individual's health has become visible. In addition, the factors behind an individual's possibilities in making health-related decisions have become understandable. Something that earlier existed as letters on the pages of a book has now become practical tools in both nursing research and practice. Our society is facing multiculturalism at an accelerating pace and so are nurses with their clients, whatever the working environment. In this sense I see the skills of implementing culturally sensitive and congruent care essential in today's nursing. In practicing to manage these skills I have been given a good start.

In addition to gaining skills in culturally sensitive nursing I have increased my skills in conducting research and research ethics. The skills of information retrieval as well as critical evaluation have increased as well. I am assured that reading and going through research literature will run more smoothly in the future. Through examining the topic I have also come to understand that the experience of health, health care and health promotion are issues that must be perceived in the context of their environment. If one tries to seek health promotion actions from Swaziland on the basis of those carried out in Finland, one ends up not finding much. In this sense I can evaluate my thinking to have developed into a less ethnocentric form.

More importantly, through conducting the study process I became more and more interested in scientific and reseach related work. Nursing science, health sciences as well as social and cultural anthropology all appear as extremely fascinating. Indeed, I am convinced that in the future I am going to work among one or several of these fields.

As I look back to the study process, many things could have been carried out more thoughtfully. Firstly, the poor cooperation with my former partner hindered the process for too long. I feel I should have been more honest and addressed the problems we had earlier. This would have eased the work load greatly and clarified the distribution of work. Secondly, the questionnaire's emphasis on health promotion as well as on the other sectors of health care in Swaziland could have been brought out to a greater extent. Representatives from other sectors of health care (public and private) could have been interviewed in order to gain a more thorough picture of the field of health care in Swaziland. In addition, I feel that gathering more information prior to leaving for Swaziland would have contributed to the benefit of the study.

Writing the study in English was my priority from the very beginning of the process. Through using English I wanted to assure that the study would be accessible to the potential users, that is to say the people in Swaziland. Although I was already familiar in using English in my studies, I have to admit that at times, the use of a foreign language has restricted my ways of expression and set challenges in terms of control over research terminology. Nevertheless, I have not regretted my decision at any phase of the working process. All in all, I am contented with the accomplishments achieved and the skills gained through this process.

Furthermore, my deepest hope is that this study will be of use to those whom it would best serve – the people of Swaziland. This I hope will take action through the working life partners of this study, the Embassy of Finland in Mozambique as well as the University of Swaziland. Through these sectors I also hope that this study will reach the people working in and among non-governmental organisations in Swaziland.

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