THE FEMALE CLIENT
and the
HEALTH-CARE PROVIDER

EDITED BY
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Problems of Utilization of Nutritional Rehabilitation Services by Mothers of Malnourished Children in N'Djamena (Chad)

Kaspar Wyss\textsuperscript{1} and Monique Nandjingar\textsuperscript{2}

Summary

This paper reports on a study which explores the difficulties mothers of malnourished children face in utilizing nutritional rehabilitation services in N'Djamena, Chad. The objective, using focus group discussions, was to understand perceptions of malnutrition, to gather information on interactions between the health care workers and the women, and to determine the reasons women abandon the services. The paper then suggests ways to improve the utilization of nutritional rehabilitation services by mothers.

Most women identify diarrhoea and vomiting as the principle causes of malnutrition illness. Quantity and quality of food are rarely mentioned as important elements of health. Other factors mentioned in connection with malnutrition are repeated pregnancies, bitter milk, teething, inflammation of the uvula, and measles; witchcraft and evil spirits are also implicated. Mothers choose multiple treatment options, and often use both "traditional" and "modern" health care, either in parallel or consecutively.

The length of the rehabilitation programme (three months) was rarely mentioned as a problem. On the other hand, long waiting times and the time of day when nutritional supplements are provided are seen major obstacles to utilization, since the women feel that it takes too much time away from their other essential tasks. Some appreciate the nutritional supplements, but others complain that the enriched porridge causes diarrhoea.

Since the children often need treatment for disease as well as nutritional supplements, the lack of drugs available in N'Djamena is perceived as a major problem. The women also complained about the amount and costs of the

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prescriptions. Furthermore, the women are dissatisfied with their reception by the health services personnel, and the incorrect distribution of nutritional supplements.

Principle causes for abandoning the services include the social and economic position of women, difficulties of geographical accessibility, the long waiting periods, unsatisfactory contact with the personnel, and the high costs for drugs.

Health services can improve the utilization of nutritional rehabilitation services by making drugs available through the establishment of a cost recovery system, and by promoting participatory approaches which can establish better communication and exchanges between the women and the personnel of health facilities.

Introduction

For several years, food aid - mainly under famine conditions - has been a frequent topic of discussion, debate, and publication. The "drama" of a hunger catastrophe in a Southern country, often related to a situation of crisis or war, attracts public interest in the North and in international organizations. Apart from these crises, however, persistent malnutrition continues in many countries, particularly among young children. Two anthropometrical studies carried out in N’Djamena, Chad, revealed that malnutrition rates were as high as 8.5% - 10.3% among children aged six months to five years (Ministère de la Santé Publique 1987, 1989). These studies were carried out during a critical period in the year, just before the rainy season, when the availability of food is low and prices high.

In Chad, as elsewhere, first level health centres are responsible for delivering a core package of curative, preventive, and promotional services, including the detection and treatment of child malnutrition (Ministère du Plan et de la Coopération 1993). In N’Djamena, the admission of malnourished children to nutritional services began in 1991 in four of the city’s eleven health centres.

Children are enrolled in the rehabilitation programme when their weight-for-height ratio falls below 80% of the international standard median of NCHS (United States Public Health Service 1976; Waterlow et al. 1977). The duration of treatment is twelve weeks. During the first six weeks, the children must be brought to the health centre each day by their mothers. While there, they receive preparations of milk and a porridge enriched with oil and sugar. During the
following six weeks, if the child's progress is deemed satisfactory, follow-up continues at home. The mother brings the child to the centre once a week for weighing, and to receive the nutritional supplements.

During 1992, 542 children were admitted to the nutritional rehabilitation programme; 31% were withdrawn from treatment before the end of the programme and 14% died during the treatment period (Ministère de la Santé Publique et des Affaires Sociales 1993). Of the children who finished the programme, only 31% fulfilled the criteria for a complete cure (weight/height ≥ 80% of median NCHS standard) after the twelve week period. Similar results have been observed in other African countries (Beau and Sy 1993; Hennart et al. 1987; Van Roosmalen-Wiebenga et al. 1987).

The relatively high percentage of withdrawal - nearly one third of the children - indicates that accessibility of nutritional services is only partially guaranteed. What are the problems with which the women of the children using the services are confronted? Are they related to the socio-cultural acceptability of health centres in general and of malnutrition programmes in particular? Or are the barriers tied to the behaviour of health service personnel (reception, communication, and so on)? In this study we set out to answer some of these questions, trying to understand the problems that mothers of malnourished children face in utilizing nutritional rehabilitation services. The objectives were to look at the way women perceive malnutrition in children; to obtain information on the interactions between the health care provider and the patients; to investigate the reasons for the abandonment of rehabilitation services; and to suggest means of improving the accessibility of nutritional rehabilitation services for the mothers of malnourished children.

**Methods**

To understand women's problems related to the utilization of health services, focus group discussions were used (Basch 1987; Dawson et al. 1992; Khan and Manderson 1992). In focus groups, participants are assembled on the basis of a topic of common interest, with the intention of promoting discussion between them. The interactions within the group are considered to be an important element for comprehending the way they think about the topic.

In all, eight groups were formed, six with women using the centres and two with personnel providing the services. Of the women's groups, two were composed of mothers who had continued with the treatment of their child until
it was finished, and two with mothers who had abandoned the treatment. Two groups were heterogeneous, with some women who had terminated treatment and others who had abandoned it.

The discussions took place between December 1992 and March 1993. Mothers of malnourished children were identified by nutritional assistants at the health centres or from the consultation register, and were invited to participate. The discussions were held at a place completely independent of the health centre, usually in the courtyard of the compound where one of the mothers lived. Attempts were made to ensure that there was no direct connection with the health centres - none of the persons present during the discussion worked in a centre - and that a stimulating ambience for a free exchange was present. The discussions with the personnel took place at their place of work. In each group, between 6 and 12 women participated. The duration of each discussion was between one and two hours. and they took place in the local languages, Arabic, Sara (or N’Gambia, a local dialect of Sara), or in other languages. The discussions were later translated into French.

The discussions were guided by a female animator, who raised the questions and tried to ensure a natural conversation. The questions were focused on perceptions of children’s malnutrition, the centre’s treatment programme, and the reasons for abandoning the treatment. The animator used a pre-prepared interview guide which was oriented towards the principle questions to be raised during the discussion.

At the beginning of the discussion, the animator showed two photographs, one of a malnourished child and one of a child in good health. The participants were asked to describe what they saw in the pictures. The animator then guided the discussion towards the reasons for abandoning the centres. In addition to the animator and the participants, a woman observer was present during the discussion. Her task was to note the exchanges between the participants (attitudes, gestures) and the principal topics of the discussion. She was also responsible for tape-recording the conversation.

The discussions were analysed on the basis of the transcription, as proposed by the Focus Group Manual (Dawson et al. 1992): the elements of the text were classified, and the terms or topics used by the participants were identified. The content of the speeches was then examined.
**Results**

**Living Conditions**

Women participating in the discussions were living in different neighbourhoods of N’Djamena (principally Farcha, Madjorio, Moursal, Chagoua, Dembé) and in villages around the city. They had different ethnic (Arab, Gabi, Haoussa, Bornou, Ouaddai, Sara, N’Gambaï, Lélé, Gore) and religious (Islamic, Protestant, Catholic) backgrounds, and were aged between 18 and 40. The length of time they had lived in N’Djamena was also variable; some were born in the city and others had arrived recently. Most of the women had never been to school, though some had received some primary education.

The women using the nutritional rehabilitation services are confronted with problems common to most women in N’Djamena: the general living conditions are poor and their socio-economic situation is difficult. The gender division of work - still present even in the urban context - allocates to women the domestic tasks and the care of the children. At the household level the woman has multiple duties: she is responsible for the availability of water, the cleanliness of the household, the organisation of marketing, the preparation of food, and the health of the children. "A housewife doesn't lack work." Furthermore, many women are in a situation where the husband (if there is one) is earning nothing, or not enough to guarantee a minimal basis for existence. The incomes of women therefore become indispensable to the functioning of the household. The women have various coping mechanisms; often they engage in petty trade, frequently in the food sector. "If I got a small scale trade, I could give my child what he needs; what his heart desires."

A multitude of extra tasks arises with the illness of one or several of the children. The responsibility for health and care of the children places new demands on the mother. These demands are considerable for severe or long-lasting conditions such as malnutrition. "When a mother has a very sick child, she has no rest day and night."

Although the female staff members of the health centres live and work under similar conditions, they showed little or no understanding of the social and economic situation of the mothers. As one social worker expressed: 

Women like that always have problems. A child gets sick, then maybe they don't sleep peacefully at night; they aren't at their husband's side but are disturbed by that child and preoccupied with it. So they always have a problem - basically, it's all psychological.
The views of the medical staff about the patients are often dominated by the conviction that ignorance is at the roots of disease. "The mothers of malnourished children are negligent mothers". There is very little recognition on the part of the health personnel of the mother's functions and obligations.

**The Child's Illness**

When the photograph showing the malnourished child was presented to the mothers, they recognized the child as being sick, as suffering from the same disease as their own. "That child really has a wicked illness. He is between the hands of death. My child was exactly like this one." Even though the child in the picture was perceived as being gravely ill, the term "malnourished" was never used by the women. In fact, it is a word that does not exist in the vernacular languages of Chad.

Some mothers do talk about nutrition and vitamin deficiency in connection with the child: "It's the hunger. When a child is sick and his mother doesn't give him enough to eat, he will suffer from hunger on top of the illness. That can kill a child." As another mother explains: "But just being hungry doesn't make a child look like that. There has to be diarrhoea and vomiting at the same time."

In fact, diarrhoea and vomiting are identified by the women as the main causes of malnutrition. The mothers complain that diarrhoea and vomiting are accompanied by additional problems. "She had diarrhoea and vomiting. She suffers a lot. She's more than a year old, but she's never been healthy. She has all kinds of problems." Other factors such as measles, teething, and inflammation of the uvula are also identified as sources of childhood malnutrition.

Several women said "Bitter milk is my problem; my milk is not good." However, not everyone accepts the idea of "bitter milk". "The women talk about amboula (bitter milk) but in medicine this doesn't exist. The old people say that it is the bad milk that gives the child diarrhoea." Sometimes a new pregnancy is seen as the cause of the milk being bitter. "The child has diarrhoea and vomits because the milk doesn't belong to it, and because its mother is pregnant with another baby." The negative consequences of frequent pregnancies are connected with malnutrition. "You have a child in your arms, you're pregnant again, and the other child has diarrhoea all the time. Repeated pregnancies are bad."

Sometimes the women ascribe malnutrition to supernatural forces: angry spirits of the ancestors, evil spirits, and the effects of witchcraft. They are thought to have a negative influence on the health of the child.
In contrast to the mothers, the health professionals describe the malnourished child as an object, using technical and technocratic expressions. "This child is dehydrated /marasmic/has kwashiorkor. It has oedema, it's a malnourished child, dehydrated."

**The Quest for Therapy**

The women often have recourse to several forms of therapy, and both "modern" and "traditional" forms may be used either consecutively or in parallel. "There are children who are lucky enough to be cured rapidly, and there are others you are forced to take to the marabout. It may be witchcraft." The health personnel confirms that "[t]here are mothers who disappear and then appear again saying «I did a traditional cure, now I think your porridge is better»".

The quest for therapy for the malnourished child takes the mothers on a pilgrimage from one health facility to another until they finally arrive at the nutritional service.

*This child! I went with him to the Central Hospital - no improvement; to Asiam Vantou - no better; to the Polyclinic - still no improvement. And I was tired. Finally I took him to the nutritional rehabilitation service until he was able to walk. If I had got tired on the road to the porridge, my child would have died.*

The mothers of the malnourished children had rarely known about the nutritional rehabilitation services beforehand. Sometimes it was a neighbour who had made the suggestion. "*My child was so sick, that he even couldn't sleep at night. One day, one of my neighbours came and advised me take him to the centre. I was accepted at the centre and I went there morning and evening.*" The referral system between the different health facilities of the city and those offering nutritional rehabilitation services is not well established. "*I waited around in the hospitals for several months before I discovered the centre where my child could be treated.*" The situation is the same concerning the relationship between preventive consultations for children and the rehabilitation services: malnourished children are not identified and not referred correctly by the city's health services. Finances pose a serious constraint to women who are forced to go from one service to another. They often they have to pay for consultations and for drugs.

*Every time you have to pay 100 francs for this, 100 francs for that. If you multiply these 100 francs by the number of times you go to hospital, you are not able to find the necessary money. And so we are obliged to make debts.*
Admission and Waiting

The three month treatment programme seems to many staff to be too long, believing that it poses a barrier to some mothers. "This duration of twelve weeks is much too long, because some women live far away." The women, however, rarely criticize the programme's duration. Several women, in fact, express the wish to stay longer. "I thought I would be at the centre for two years." The women are puzzled that no follow-up is guaranteed after the end of the treatment. "When the centre let us go, all the children got ill again." Relapses are frequent, as has been reported in other studies (Beau and Sy 1993; Hennart et al. 1987; Van Roosmalen-Wiebenga et al. 1987). Several women mentioned that they had stayed twice for three months at the rehabilitation service. "After three months at the centre the treatment is terminated. But when the child is weighed and he is too weak, we go for another three months."

In contrast to the total duration of the treatment programme, the time spent each day waiting for the distribution of the porridge and the milk is a frequently-mentioned problem. "It's not that it takes so long, but having to wait till 11 o'clock makes it seem a terribly long time." With the women's numerous obligations, waiting poses a series constraint to the morning's smooth organisation, and few can afford to wait for several hours. "What we receive is fine. But why so late? We've got other children at home waiting for us. They have to go to school and we have to go to the market." The fact that it is impossible for the women to wait for a long time leads to conflicts with the personnel, who have very little appreciation of the women's daily tasks. "They would like to be here at 8 a.m. to leave again at 9 a.m. for the market. This is their real problem."

The Lack of drugs and the Quality of the Porridge

One of the most sensitive points for the women is the lack of drugs available through the health services of N'Djamena. "Hospitals were created for the children and when we visit them there are no drugs." The women also make complaints about the prescriptions.

If you don't take your sick child to the hospital, the family thinks you are negligent. And if you go to the hospital, there are plenty of problems. Always a prescription. To go to the hospital and then to come back to purchase the drugs isn't worth the effort.

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Women have to spend huge sums to purchase the drugs. Within a context where money is lacking, prescriptions are absolutely not appreciated. "A man to whom you present every day a prescription will get tired. Furthermore, when he has no work..." The health professionals face a difficult problem: despite the lack of drugs and other materials, they are expected to offer continuous, high-quality care. In the absence of drugs, the staff are doubtful of the efficacy of care they can provide for the malnourished children:

There are women who say «my child is sick; giving him just porridge is not enough, you also have to cure him. » The mothers haven’t the financial means to purchase the drugs. We can’t offer any antibiotics in the health centre and this delays the success of the treatment.

The staff may go to some lengths to satisfy the women.

There are mothers who are satisfied. But sometimes there are mothers who say that their children are sick, and if they don’t get any treatment they will be disappointed. Given the porridge without anything, they aren’t satisfied. So we take some vitamins and put them into the porridge and the mothers think it’s a drug.

The porridge and the milk offered by the nutritional rehabilitation services cannot fill the crucial role played by drugs, to which the women attribute the efficiency of the therapy. Opinions on the quality of the porridge are ambiguous. Some women appreciate it, "[m]y child gulps down the porridge"; others think there is a connection between the consumption of the porridge and the child’s diarrhoea. "The porridge makes my child swell up and increases the diarrhoea." Sometimes the women just speak about the bad taste of the porridge. "My child thought the porridge at the centre was disgusting." Several times the women mentioned the lack of variety of the food.

During some discussions, the mother’s demands focused on material assistance. "Because it’s cold, the centre has to give us pullovers so that we are able to protect our children." For these women, the nutritional rehabilitation service’s purpose is to distribute nutritional, material, and economic hand-cuts.

Relationships with the Health Personnel

The women’s feelings about the personnel of the health centres were divided. The reception by the nutritional rehabilitation centre staff is a topic of intensive discussion. Some mothers are satisfied: "There is no problem. We are received kindly, there is an awning to sit down under..it’s OK." Other women deplore the attitudes of the health personnel.
The centre is supposed to be here to accommodate the sick children. But then the staff just say mean things. How can the child get better? When we leave the centre we grumble about it on the way home.

The women don't hesitate to accuse the personnel. "Several children have died because of the behaviour of the staff." A woman who spoke the Haoussa dialect said about the attitude of the personnel: "I don't understand either French or Arabic. So how can I understand the insults? I'm going there for my child. Even if they strike and beat me I'll still go, to get the porridge for my child."

The women also complain that service staff show them no respect. They feel that the relationship between them does not correspond to the kind of contract that should exist between one who has the power to cure and one who is asking to be cured. "They are like our godparents, who profit from us".

The personnel, on their side, rarely discuss the importance of the reception of the mothers and their social relationships with them. The person in charge of one centre said:

Concerning the reception, we ourselves are trying to make things better. If the attitudes of the staff have not been good, we will try and improve them.

However, no woman has ever left the centre because of the reception...

The strained relationships between the mothers and the personnel is aggravated by the fact that some staff members do not hand over all the nutritional supplements to the beneficiaries. They are accused of not providing the right quantity of porridge or tins of sardines (given by the "Programme Alimentaire Mondiale" (PAM)). The women say that the personnel distribute just a fraction, and that they give the rest to their own family members.

To those they called, they gave four spoonfuls of porridge, but to us they gave just a little bit, just one spoonful. To their family members they hand over masses of tins of sardines, but for us they keep only a few.

The women are aware how much should be distributed to them, and are very observant of any malpractice. "On the day of distribution, the traders come to buy the food in big quantities. To us they hand over just one tin."

During 1992 and 1993, repeated strikes immobilized the health facilities, including the nutritional rehabilitation services. However, this temporary stoppage of health care provision did not arise as an element in the discussions.

Reasons for Abandoning Treatment

The women gave diverse reasons for abandoning treatment: the quality of the porridge, the duration of waiting, the distance to the health centre, the expenditures for drugs, and the socio-economic obligations of the women.
Sometimes the quality of the porridge is considered to be so bad that it is an argument for abandoning treatment. "I was asked to stay for three months. After one month my child refused to eat the porridge. I don't know whether she just began to find it disgusting."

During the discussions, the lack of drugs for the treatment of malnourished children appeared as an argument. "When you have got a sick child, no drugs are given, and every day you have to go to the health centre. Then it's normal that you're getting tired. Because of this, some women refused to return."

The situations under which the women live may make it impossible for them to make use of the nutritional rehabilitation services. "We refused to go to the centre because we have to much do at home." The women must consider whether the benefits they hope to gain from using the centre justify the expenditure of time and energy that are badly needed for other essential activities. "I'm trader and they want that I lose my time at the centre - and meanwhile other children wait at home. My commercial activities are more important."

The personnel confirm that withdrawal is often due to the social obligations of the women:

Generally mothers say that they are busy, that they aren't able to come, that they have to travel or that they are traders. They also say that their business nourishes the whole family and that they cannot neglect all the children just for one.

The staff members also believe that the main reasons for withdrawal focused on the poor geographical accessibility of the services and the long duration of waiting.

The women have to get up early, to prepare the breakfast and then come here and go home again. It really is hard work. They think that all this going to and fro takes so much energy that it's tiring for the child. They think that if they are making all this effort just to get a few spoonfuls of porridge, it would be better to keep the child at home and treat it there. Often the women don't like to stay from 8 a.m. to 11 a.m. every day for several weeks. So they abandon the treatment.

It is interesting to note that the women rarely mentioned distance as a barrier to health centre accessibility. The staff also believed that a preference for "traditional" therapies was a cause for withdrawal by some women from the programme. "Some mothers come two or three times, and then say that the illness of their children is not malnutrition. They want to go to the marabout, because they say it's witchcraft."
Conclusions

One of the problems of the nutritional rehabilitation services for malnourished children is, in N’Djamena as elsewhere, that the mothers of malnourished children frequently abandon the centre before the treatment is finished. It is important to understand the reasons for this in order to increase the effectiveness of the services. In public health and tropical disease research, an increasing interest is being shown in rapid assessment methodologies (Anker 1991; Vlassoff and Tanner 1992; Manderson and Aaby 1992), and especially in the methodology of focus group discussions (Khan and Manderson 1992). In Chad, focus group discussions have rarely been used. Only one study, in fact, has used this methodology to investigate the demand for family planning services, the perceived benefits, and barriers against their utilization (Ministère de la Santé Publique 1988). Elsewhere in Africa, focus groups have been used to study problems related to AIDS (Irwin et al. 1991), barriers to the utilization of obstetrical emergency services (The Prevention of Maternal Mortality Network 1992), and perceptions of goitre (Andrien et al. 1993).

The discussions in N’Djamena highlighted that the domestic situation and the socio-economic environment of the women utilizing the health centres is difficult. The division of work by gender allocates a multiplicity of tasks to them, and they are often also responsible for the family’s income. With the illness of a child, the women’s obligations increase. Most women identified diarrhoea and vomiting as major causes of malnutrition, and realized that they should seek treatment. However, the final decision about whether to use a nutritional rehabilitation service or some other kind of therapy results from the interaction between the desired benefits and a variety of social, spatial, financial, and cultural constraints.

A more detailed analysis of these constraints would require quantitative as well as qualitative techniques. The findings of focus group discussions alone are not a sufficient basis for making a detailed situational appraisal of the problems of women and their malnourished children in the urban context of N’Djamena. A more comprehensive assessment would encompass both quantitative and qualitative analyses, including gender roles, the food available for the household, and living conditions as a whole. Quantitative data could be obtained through household surveys focusing on the social, environmental, and economic situation of women, on gender roles and family structure, and on the food available for children. Qualitative methods (observations, interviews) could supply indepth
information on attitudes to child nutrition. It would also be interesting to assess in detail the frequency of relapses in N’Djamena, which are reported from studies in other countries to be quite high, in order to evaluate the efficacy of the nutritional rehabilitation services. Nevertheless, the present study shows that the focus group technique can provide insights into the perception of malnutrition by the mothers of malnourished children, their interaction with health care providers, and the causes for their abandoning treatment.

Though nutritional interventions can be implemented through vertical programmes (Pelletier and Shrimpton 1994), they are most effective if they are integrated into the country’s PHC provisions. In Chad, the integration of nutritional rehabilitation services into the globality of health care offered is not satisfactory. The detection and referral of malnourished children is the task of first level health centres, but communication between the curative and preventive services of health centres is weak, and most women have to pass through several different health facilities to find therapy for their child. An operational referral system, including referrals from preventive to curative services, could facilitate the utilization of rehabilitation centres.

The abandonment of treatment once started is another problem. Principle causes in N’Djamena are loss of time, which is needed for other household duties and for economic activity, the behaviour of the personnel, and the availability of drugs. The time of distribution of supplementary food, and the long waiting period are also major problems for the mothers. The three month duration of the programme is rarely mentioned as a barrier for the nutritional rehabilitation.

The lack of drugs available through the public health services in N’Djamena is perceived as an immense weakness; the women disapprove of the frequency of prescriptions for drugs that they have to buy at great expense from private suppliers, and the staff members are dissatisfied because they are expected to provide health care without being in a position to supply drugs. Some women are satisfied with their reception by the health centre staff, but others find the attitude of the personnel unsympathetic or even insulting.

Improved utilization of nutritional rehabilitation services by women could be achieved by diminishing the daily time of waiting, by improving the availability of drugs, and by promoting better communication between the providers and the women. A reduction of the waiting time could easily be achieved through a quicker distribution of the nutritional supplements. Drugs could be made available through the establishment of a cost-recovery system. Finally, communication could be improved through the promotion of participatory approaches. Communication between the providers and the users of health
services must to be perceived as a resource and an opportunity which will allow better management of health for all. A rehabilitation centre, where the mothers attend regularly for a long period, offers excellent opportunities to increase understanding and cooperation between the health professionals and the women who carry a large amount of the responsibility for the health of their families.

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