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REPORT OF AN EVALUATION OF

THE RURAL HEALTH VISITORS PROGRAMME

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RECOMMENDATIONS

1 During interviews conducted with various community leaders, teachers in RHV areas did not seem to be well informed about the activities of the RHVs. At the same time, RHVs said that they discussed RHV topics with fewer teachers and clergy than with chiefs and traditional healers. When introducing the RHV programme to the chief and community as well as during RHV training, Ministry of Health officials need to stress the fact that teachers and clergy are included in the catchment areas of the RHVs. Teachers and clergy, by virtue of their community positions, are able to influence the community towards following RHV-taught health practices in two ways:

1) by their own exemplary behaviour, and
2) by communicating these ideas to the group they are in contact with.

2 Although the Ministry of Health has guidelines for RHV recruitment, respondents would like to include additional criteria in the selection of RHVs. These additions are: good interpersonal relations, literacy, sobriety and industry.

3 There is an overwhelming response from homesteads, RHVs and health workers alike that RHVs be allowed to learn home deliveries. This additional duty needs to be accompanied by a re-education campaign for the homesteads since nine out of ten homesteads surveyed did not agree that it was best for a mother and child to deliver at home.

4 Instructors in RHV training programmes have, up to now, been mainly recruited from outside the local clinic area. According to the survey results, local clinic staff and health assistants are willing to instruct in areas of their speciality. Involvement of the local staff in the RHV programme in their area would help to create a harmonious relationship which would continue throughout the period of the RHVs' service (or until the local staff were transferred).

5 RHVs do not feel the knowledge they received in their initial training was adequate for their work and have requested refresher courses. The relevant areas in which they feel their expertise is lacking are: child care, community development, environmental protection, child spacing, first aid, ante-natal care, record keeping. These subjects should receive first priority in the planning of any future refresher courses as well as in the revision of the existing RHV curriculum.

6 The average number of homesteads visited by RHVs is slightly lower than the minimum of 40 homesteads suggested by the Ministry of Health. Some RHVs visit as few as 13 homesteads, others as many as 53 homesteads. When adequate supervision of RHVs becomes a reality, family folders of all RHVs need to be inspected for numbers of homesteads visited in relation to type of terrain covered and distance covered and, where relevant, chiefs need to be persuaded to reduce or increase the size of the catchment areas.

7 RHVs have motivated the homesteads towards an awareness of environmental sanitation (including home cleanliness) to the extent that this has become the main RHV duty, according to the majority of the homesteads, RHV and community leader responses. If the RHV is going to be a multi-purpose health motivator, then a target needs to be set in order to steer RHVs towards motivating their communities in other health areas (e.g. aspects of curative/preventative services or health education topics).

8 Health education has had remarkable successes in both the RHV and non-RHV areas, however it has been disappointing that the survey results have shown virtually no differences between these two areas. This suggests that the RHVs are no more effective than other means of educating the community towards better health (e.g. clinic talks, radio programmes or meetings with the DSD). There needs to be a re-thinking about the role of RHVs.

9 The role of the RHV as motivator for extension agent/homestead contact needs to be intensified. Presently, RHVs are not recognised by the communities as catalysts for extension work. This is not unusual, given the relatively short amount of time that is presently devoted to this subject in the RHVs curriculum. If the Ministry of Health feels that the RHVs must continue with this task, then it needs to:

1) increase the amount of instruction in extension related activities,
2) inform the relevant extension agencies about the potential of RHVs as community motivators and disseminate reports to them about RHV activities, and
3) persuade the extension agencies to open up channels of communication between field officers and RHVs.

10 Steps have been taken to correct the recording of information on the daily work sheet, but there still needs to be a procedure by which this information can be put in the hands of the local clinic staff and health inspectorate. Correct recording of the information asked for on the other forms (family folder, confidential record) also needs to be monitored by a supervisor, since present procedures do not allow for any checking of this information once it has been collected by the RHV.

11 Most RHVs feel E40.00 per month is necessary for them to continue in their work. Presently communities are not willing to assist in the payment of RHVs; alternative methods need to be sought.

12 Health workers have noted low morale among RHVs. A system of recognising the RHV efforts needs to be initiated.

13 Recognising the beneficial effects of indigenous medical practices in primary health care, the RHVs should be encouraged to work closely with traditional healers. Research into integration of traditional and western medicines should be carried out with a view to increasing the effectiveness of RHVs.

14 Community leaders are in favour of having more community control of various aspects of the RHV Programme, besides the present level which is restricted to choosing candidates for RHV training, choosing the catchment areas for the RHVs and monitoring the activities of those presently on duty. The Ministry of Health needs to seriously introduce the concept of the Community Health Committee. This would involve members of the community (including RHVs and the clinic nurse) in planning, implementing and evaluating health programmes. It would also create a firm supervisory environment in two ways:

1) through the monitoring of RHV tanks by the community, and
2) through the monitoring of RHV technical expertise by the clinic nurse.

Finally, the Community Health Committee should be in a position of providing the means to decentralise the financial burden of the RHVs and place it squarely in the hands of the community.

RURAL HEALTH VISITOR SURVEY

I BACKGROUND TO THE RHV EVALUATION SURVEY

A - ORIGINS OF THE RHV PROGRAMME

In September 1976 a small group of 40 women in the north of Swaziland completed a two months training programme for Rural Health Visitors (the name for primary health care workers in Swaziland) and set about the task of educating their neighbours towards realising a higher level of health than at present. By 1980 the number of Rural Health Visitors (RHVs) had swelled nearly tenfold to 310 (excluding drop-outs) and were distributed in eight Tinkhundla[1] regions throughout the Kingdom. What the impetus for such a programme was, what the duties of the RHVs were and, most important, what the impact of community-based health workers has been on:

a) their communities, and

b) on the health care system in Swaziland,

will be the focus of this report.

Around 1974 there was a world-wide realisation that curative services provided by most Health Ministries/Departments were inadequate, since these services alone could not result in a healthy population. The member states of the World Health Organisation noted that there was an under-utilisation by most of the world's people of preventative services, such as ante-natal clinics and immunisation against childhood diseases, as well as a basic lack of the knowledge of practices which lead to good health. This state of affairs had been noted even earlier in Swaziland with the publication of the Second National Development Plan (1973-1977). In this document, environmental sanitation and health education were put forth as areas of prime interest in order to reduce "water-borne diseases and diseases of insanitation" so prevalent in the country.

Realizing the inadequacy of the present services in coping with these disease patterns, the Second Development Plan then pointed to a reorientation of priorities:

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1 Tinkhundla (pl), Inkhundla (singl) - refer to administrative districts encompassing several chiefs' areas

away from conventional institutional facilities centres on urban areas and towards different kinds of programmes which are cheaper and more closely geared to the preventative aspects of health so that a wider impact may be achieved on the health problems of the rural population at large

In 1976 there was a WHO workshop on Primary Health Care in which there was a review of existing programmes in such places as Kenya, Tanzania and China. Returning from this workshop, the Swaziland delegation felt it was time to adapt such community health worker schemes to the health needs as well as the socio-economic conditions of the Kingdom.

A series of meetings began to take place in selected clinic areas around the country involving the chiefs, the District Commissioner, the Senior Medical Officer of Health and the Matron, Public Health Unit. The purpose of these meetings were twofold:

1) to discuss with the community the sources of the health problems facing it (e.g. gastroenteritis, early infant mortality), and
2) to arrive at a solution involving community participation, i.e. the community needed to take advantage of their local clinic as well as to build latrines in each homestead and to protect the local water sources from contamination.

It was felt that these projects could be best carried out by training a local cadre of community residents to be known as Rural Health Visitors, to educate the rural population on how to take advantage of the health programmes offered by the different branches of the Ministry of Health, as well as to inform the communities about development programmes carried out by other Ministerial bodies.

RHV Programme as stated in the Curriculum for Rural Health Visitors Course were:

a) To produce rural health visitorsxwho will educate the community on importance of latrines and protected water supply in prevention of communicable diseases.
b) To produce rural health visitors who will educate the community on attending the ante-natal clinic.
c) To educate the families on importance of child welfare services.
d) To educate the families on the importance of family planning services as a means for maintenance of good health of both the mother and the baby.

e) To educate the community on good nutrition for prevention of nutritional diseases by having backyard gardens and fish ponds.

f) To education the families on improving their homes for prevention of communicable infection by having dust pits and by control of house pests.

g) To give immediate care (first aid) to the families in cases of emergencies.

h) To create a cadre of personnel from amongst members of the communities that will be responsible for disease serveillance and will refer to the nearest clinic any serious illness.

i) To provide rural communities with personnel that will supervise home treatment of chronic illness where applicable.

j) To provide rural communities with a co-ordinator (rural health visitor) between ministries involved in rural development.

This ambitious programme was met with a mixed response by the chiefs. Some chiefs refused to co-operate, saying for example that an investment in such an activity as digging latrines was useless in the face of possible community resettlement. On the other hand, enough chiefs showed an interest in this new project to encourage the Ministry of Health to proceed. Funds were obtained from Government to enable the RHVs to be paid for part-time work (i.e. four hours per day, five days a week) at the rate of E20.00 per month.

At that time the Ministry felt that the communities could not afford to subsidise the RHVs and, as one official put it, it was enough that the communities were motivated to accept the programme without having to take on a new financial burden before seeing the results. United Nations Children's Fund was also contacted and agreed to provide funds for training the RHVs.

In August 1976 the first group of 41 trainees, all of whom were women, began their two-months training programme in Entfonjeni. This site was selected for two reasons: there was a good response from the chiefs in that Inkhundla area, already the site of several ambitious development projects; and there were two clinic nurses staffing the Entfonjeni clinic. The latter consideration was important since it was hoped that one nurse would be able to devote part of her duties to supervising the RHVs. All the trainees were recruited from chiefs belonging to that Inkhundla. Ministry

of Health officials stressed that the chiefs should try to send one trainee for every forty to fifty homesteads. This figure was chosen by the Ministry as the optimum number of homesteads that it felt could be visited at least once a month by the RHV.

The bulk of instruction was provided by a nursing sister and a staff nurse from the Public Health Unit, Mbabane, who lived in the area during the duration of the training programme. They were assisted in their teaching by other members of the Ministry of Health and by members of the various extension programmes of the Ministry of Agriculture, by Red Cross officials, by Social Welfare workers and by representatives from Sebenta, the national literacy institute.

By the end of September 1976, 40 Rural Health Visitors had left the training site to begin the task of motivating their neighbours towards realizing the goals of this new programme.

B - RHV TRAINING STATISTICS AND PROJECTIONS

Beginning with the initial Entfonjeni training programme, a total of 325 people have undergone training as RHVs through seven successive programmes. Four dropped out during the training programme, leaving a total of 321 who have become RHVs. The table below shows the distribution of trainees by training site, dates of training, sex of participants, drop-outs during training, total trained for each programme and RHVs presently serving their communities as of February 1981.

Table I - RHV STATISTICS

Place	Date	Women	Men	Drop-outs	Total Trained	No.as of Feb 1981
Entfonjeni	Aug-Sep 1976	41	-	1	40	47
Tikuba	Jun-Jul 1977	30	-	1	29	39
Mangweni	Nov-Dec 1977	33	3	-	36	13
Zombodze	Feb-Mar 1978	44	1	1	44	53
Sipofaneni	Jul-Aug 1978	27	5	-	32	36
Ngwempisi	Feb-Apr 1979	43	3	-	46	41
Lubuli	Jun-Jul 1979	47	3	1	49	33
Maseyisini	Oct-Nov 1979	43	2	-	45	25
	Total:	308	17	4	321	287

The numbers trained in the clinic areas do not always reflect the numbers of RHVs who are serving in those areas at the date this report was written. This discrepancy stems from the fact that there was often training for candidates in an area other than where they were resident. Another factor which accounts for this discrepancy is that some of the RHVs have dropped out or have moved to a new clinic area after training. In the latter case they would cease to function as RHVs for the new community since they were not chosen by people of that community.

By 1988 it is expected that a total of 1,320 Rural Health Visitors will have been trained. This figure will provide adequate coverage of all of the homesteads in the rural areas where 88 per cent of the total population live and is based on two assumptions:

a) each RHV can cover between forty to fifty homesteads per month, and
b) that the training programmes can produce at least 125 RHVs per year.

C - RHV TRAINING PROGRAMME

Recruitment of potential RHVs takes the general form as outlined during the initial series of meetings involving Chiefs, District Commissioners, and officials from the Ministry of Health. Briefly, an area is selected on the basis of the following criteria: endemicity of disease, proximity to nearest health facility, high population of vulnerable groups, and presence of at least two nurses in the health facility (for supervisory duties). Recruitment is initiated by senior Public Health personnel who hold meetings with the chiefs of the selected area. These meetings educate the chiefs about the existing health situation in their areas. The chiefs are then requested to go back and introduce the programme to their communities. It is expected that the chiefs, together with the community (usually adult male members) then select candidates for training as RHVs.

The number of trainees selected depends on the total population of homesteads[2] in each chief's area, as RHVs are expected to be responsible for forty to fifty homesteads. As each homestead consists of, on average, seven persons[3], the total number of people reached by one RHV is estimated to be from 280 to 350.

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2 Homestead refers to a residence unit comprising one or more families, usually related to the senior adult.

3 1976 Swaziland Census figures.

The criteria for selection of trainees follows these guidelines as set out by the Ministry of Health:

a) persons of either sex between the ages of 25 and 45 years,
b) married,
c) respected by the community,
d) responsible for his or her own work,
e) literate enough to fill out monthly reports,
f) able to communicate easily with other community members, and
g) has knowledge of common health problems facing the community.

An RHV curriculum was developed by the Public Health Unit after a series of consultations with other agencies involved in Primary Health Care (e.g. Ministry of Agriculture, Red Cross, Sebenta). The curriculum consists of the following topics: Communicable Diseases, Nutrition, Maternal Care, Child Care, Elementary Sociology, Community Health, Community Development, First Aid, Home Economics, Women's Role in Development, Agriculture, Adult Literacy. The following table illustrates the time spent on subjects and the agency involved in instruction.

The initial training at Entfonjeni was administrated by one Public Health nurse from the Public Health Unit, Mbabane. She then taught four other Public Health nurses during the second training programme. Since that time two Public Health nurses have been responsible for running the course, with guest lecturers invited from the Ministry of Health and other relevant agencies to speak on their speciality training is conducted in siSwati by Swazi nationals.

/TABLE II....

Table II - RHV CURRICULUM

Subject	Time Spent	Agency
Communicable diseases	25 hrs	Ministry of Health
Nutrition	20 hrs	Ditto
Maternal Care/Family Planning	12 hrs	Ditto
Child Care	12 hrs	Ditto
Elementary Sociology	5 hrs	Ditto
Community Health	18 hrs	Ditto
Community Development	10 hrs	Community Development/ Ministry of Agriculture
First Aid	15 hrs	Red Cross
Home Economics	6 hrs	Home Economics Unit/ Ministry of Agriculture
Women's Role in Development	1 hr	Home Economics Unit/ Ministry of Agriculture
Agriculture	3 hrs	Agriculture Extension/ Ministry of Agriculture
Adult Literacy	1 hr	Sebenta National Institute

Trainees are accommodated at any available facility large enough to handle their numbers. The only requirement is that it be near a clinic, preferably the main clinic in that Inkhundla area. The trainees are provided with food and beds and in addition are given E20.00 per month. This payment has continued to date.

Instruction in the curriculum subjects through lectures supplemented by visual aids takes up the first six weeks of the course. The seventh week is a field period conducted in the homesteads in the vicinity of the clinic. The trainees are instructed how to introduce themselves to a homestead as well as how to interview homestead members. At this time the trainees are evaluated on their ability to educate the community on various curriculum subjects as well as their ability to gain entry into the homestead.

During this same period of training the trainees are shown how to keep various health records. There are three forms which the trainees must learn to master: a family folder (one per homestead), an individual card (one for each member of the household) and a daily record form. The family

folder contains an up-to-date census of the members of the homestead, along with other information such as: number and construction type of buildings, source of potable water, methods of cooking, trash disposal and waste disposal, as well as a census of livestock belonging to the homestead. The individual card contains the personal health record of the individual, including dates of immunisations received. The daily record form contains spaces for recording the number of people seen per day and the reason for seeing them.

In the eighth week the trainees return to their areas where, in a community meeting, they are officially introduced as Rural Health Visitors. They must then demonstrate their knowledge of health principles and the means of establishing rapport with their clients which they have learned in the previous weeks. At this time the community has a chance to criticise any aspect of the training in the presence of the trainers.

Upon graduation the new Rural Health Visitors each receive an RHV bag on the outside of which is written: "Nansi Impilo" ("Here is Health"). This serves to identify the RHV to the community as well as to transport medical equipment needed for this work. The following are included in the kit:
bandages for wounds, wound medicine, burn medicine, anti-malaria tablets (in malarial areas), statistical forms, pain tablets, rehydration salts, an armband for measuring infant malnutrition and a measuring tape for locating an area in the homestead where a toilet is to be constructed.

D - THE RHV IN THE COMMUNITY

The trainees, now fully-fledged RHVs, return to their communities to educate them about improving their standard of living through adopting better health measures. This includes not only adopting preventative aspects of health (such as digging toilets and sending their children to the clinic) but also includes informing the homesteads about services which other extension agents (e.g. home economists, crops extension agents) can provide. The RHV then acts as a conduit to motivate the homesteads to contact people who will be able to help them meet their development needs.

Specifically, the RHV is expected to fulfill a minimum of tasks: to visit the 40 homesteads, to keep up-to-date statistics on the health of the individual members and to attend a monthly meeting at the "mother" clinic.

E - RHV/MINISTRY OF HEALTH LINKS

Contact between the Rural Health Visitor and the other health workers from the Ministry continues in several ways long after the training programme has ended. The RHVs assemble every month at a designated clinic (often the training clinic) in the Inkhundla area[4]. They are met by a Public Health nurse who is not resident in the clinic area, but comes from a regional health centre specifically for this meeting. This nurse collects the daily record sheets and gives the RHVs the E20.00 payment. In addition, she informs the RHVs about any new health developments in the Kingdom and discusses any administrative or technical problems the RHVs might have encountered during their previous month's work.

Other regular contact occurs between members of the Health Inspectorate: the Health Assistants and, if it is a malarial area, meetings with the Malaria Control Workers. The Health Assistants are called when a homestead needs a toilet slab to be laid on the premises, or a spring to be protected. Having motivated the homestead towards desiring one of these services, the RHV then attends and assists the Health Assistant. The Malaria Control Worker uses the RHV to help find suspected cases of malaria and often meets with the RHVs in the area for that purpose, as well as to supply anti-malaria drugs.

Besides this frequent contact there is also occasional contact in the form of a one-day area seminar. These are held in order to refresh the RHV's general knowledge and to acknowledge the work they are doing in the community. Personnel attending such seminars include: the clinic nurses, Domestic Science Demonstrator (home economist), Agricultural Extension Officer, Community Development Officer, Health Workers and such community leaders as the Chief or one of his officials.

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4 This clinic is identical to "Nearest Health Unit" (VAR006 in the RHV Schedule).

In addition to these seminars which involve personnel from only a specific clinic/Inkhundla area, there was a countrywide workshop in August 1980. Conducted by members of the Centre for Population Activities and Swaziland Government, this workshop specifically dealt with population issues. Although it was located in the Entfonjeni area, RHVs from other clinic/Inkhundla areas were invited to attend. Those attending were selected by public health and clinic nurses in their local communities and were expected to take their skills learned at this workshop back to the other RHVs.

II PURPOSE OF THE SURVEY

A - EXISTING PROBLEMS OF RURAL HEALTH VISITOR PROGRAMME

Since the inception of the Rural Health Visitors Programme in 1976 there has been no systematic evaluation undertaken in order to determine the degree to which the programme's objectives have been reached. Information about the activities of the RHVs has generally been collected in a regular but unsystematic fashion in two ways:

1) from oral reports given by the RHVs themselves to the public health nurse during the payment period, and
2) through observations of the interaction between the RHV and the clients by health assistants in the course of their duties.

Up until 1980 enough information had reached the Ministry of Health to enable officials there to note tentative achievements as well as some serious problems. The achievements noted by the Ministry are that there seems to be an increase in the amount of health information being taught to the homesteads by the RHVs, and a concomitant rise in clinic attendance, as well as an increased co-ordination with the field officers in the other ministries, especially with the field staff of the Ministry of Agriculture. On the other hand, certain problems have arisen in the running of the four-year long programme. The most critical of these problems are:

(a) The motivation to dig toilet pits has not been able to keep up with the resources (i.e. toilet slabs). As a result the uncovered pits pose a menace to both human and animal life in the homesteads, not to mention the bad name this gives all the members of the Ministry of Health;

(b) Outside of the monthly visit by the District Public Health Nurse, there is no regular supervision of the RHVs. The nurses in the clinics to which the RHVs are supposed to report each month do not supervise them and often cannot even identify the RHVs. As a result of this lack of supervision it is impossible to determine the basic information concerning size of catchment area (number of homesteads assigned to the RHV), frequency of visitations and subjects discussed by the RHV during these visits;

(c) As the number of RHVs expands to the target of 1320 the strain is beginning to be felt in the finances of the Ministry of Health. While there has been concern expressed that the communities must begin to take financial responsibility for the RHVs, no plan has been offered as to how this transition should be made.

B - PURPOSE OF EVALUATION - EXPECTED RESPONSE OF THE MINISTRY OF HEALTH

Early in 1980 there was a series of meetings held at Ministry of Health headquarters among high-level officials of the headquarters staff and the Public Health Unit. It was subsequently decided to hold an evaluation of the "status, function, impact or achievements of the RHVs in the areas they serve".

The purpose of this evaluation therefore can be stated in the form of a set of general objectives:

1) To determine the coverage of the RHVs (i.e. REV population ratio and their composition depending on sex and age);

2) To determine the status and acceptability of the RHVs in the various communities they serve and also to determine additional services required of them by the communities they serve;

3) To determine the socio-economic changes caused by the existence of RHVs in the communities they serve;

4) To determine the problems faced by RHVs at field level and in general.

The information obtained from this evaluation will be used by the Public Health Unit, as the responsible agency, to review existing policies and, if necessary, propose changes in the programme. Areas of the programme which are of special concern are: recruitment of candidates by the local communities, curriculum used in the training programme, motivation of the RHVs in their duties, size of catchment area of the RHV, and supervision of the RHVs by local communities.

III METHODOLOGY

A - FORMATION OF SURVEY COMMITTEE

As a direct outgrowth of the series of Ministry of Health/Public Health Unit meetings held in February 1980 an evaluation committee was set up to determine the content of the evaluation, to oversee its progress and to present a report including recommendations. The members of the committee were as follows: a UNICEF Programme Assistant, a Public Health Medical Officer, the Principal of the Institute of Health Sciences, a WHO Health Educator, a Health Statistician, a representative from the Ministry of Education in charge of non-formal education, a Staff Nurse/Trainer with expertise in several RHV training programmes and a medical sociologist recruited through UNICEF.

This committee was requested to base the evaluation on a series of proposals from the Ministry of Health. These proposals took the form of the general objectives as outlined above.

The sociologist and the RHV trainer were chosen by the committee to act as survey co-ordinators. Their specific tasks were:

1) To conduct the necessary preparatory work including selection of sample areas, questionnaire design, training of interviewers and pilot survey;
2) To carry out the survey in the selected areas;
3) To analyse the results and prepare a detailed report of the findings including recommendations for the future development of the programme.

B - SPECIFIC OBJECTIVES OF RHV SURVEY

In order to lend direction to the survey a series of specific objectives were agreed upon by the members of the committee. These objectives (which stemmed from the general objectives outlined above) are listed below, together with the criteria used to measure them (in parentheses):

1) To identify changes made in environmental sanitation by the existence of RHVs in the areas they serve, taking into consideration the protection of springs or construction of water wells, construction of latrines and waste disposal pits (Enumeration of facilities designed to improve the environmental sanitation of each homestead);

2) To identify the extent of motivation provided by RHVs in environmental sanitation as per specific objective No. 1 (Enumeration as well as identification of source of motivation to construct said facility in the sets of questions asked of homesteads and community leaders);

3) To identify the extent of motivation by RHVs for community utilisation of existing health services. The specific utilisation of health services will include:

   (a) immunisation,
   (b) nutrition education,
   (c) ante-natal care,
   (d) hospital deliveries,
   (e) post-natal care, and
   (f) family planning.

   (Identification of the source of motivation for the above services in the sets of questions asked of homesteads and community leaders, as well as finding the specific information provided by the RHV in order to motivate the community);

4) To identify the degree of team work between RHVs and other field workers including community leaders from Home Economics Department, Community Development Officer, Sebenta, Agriculture, Animal Husbandry Officer, traditional healers and the

department of Social Welfare.
(Identification of nature and frequency of contact between RHV and the particular extension officer, and identifying contact in the sets of questions asked of homesteads and community leaders);

5) To identify the various problems faced by RHVs in relation to the recruitment, training, support from health personnel, coverage, salaries and the reporting system.
(Discovering the number and kind of problems faced by both the RHVs and the health workers with whom they regularly come into contact);

6) To identify indicators which denote the willingness of the communities to take over the payment of the RHVs.
(Ascertaining the satisfaction or dissatisfaction of the community and its leaders with the work of the RHVs; questioning community leaders, homesteads, health workers and the RHVs about the ability of the community to make a financial, or otherwise, contribution).

C - THE POPULATION OF RESPONDENTS

As can be seen from the previous section several categories of respondents were identified. Separate schedules were prepared for each category, namely: Homestead, Community Leader in an area with Rural Health Visitors, Community Leader in an area without Rural Health Visitors, Health Workers and the RHVs themselves. Community leaders included the local leaders, chiefs, tindvuna, and where possible, the indvuna yenkhundla. Headmasters and teachers from local schools were also included in this category. Health Workers were defined as any person involved directly in dispensing curative or preventative services to the community. These were mainly personnel attached to the Ministry of Health (e.g. Medical Officers, Matrons of hospitals, Nursing Sisters, Nurses, Health Inspectors, Health Assistants, Malaria Control Workers), as well as Red Cross Volunteers. In addition, interviews were to be conducted with key officials in the Ministry of Health, Ministry of Agriculture, Red Cross and Sebenta.

D - SELECTION OF SURVEY AREAS

A UNICEF Regional Adviser in Statistics arrived in March 1980 to assist in getting the evaluation underway. Given the amount of money donated by UNICEF, it was decided to plan for a six-months evaluation period. Twenty survey areas could be adequately covered during this time; ten of the areas to be chosen from areas served by RHVs while the remaining ten areas would be areas without RHVs (control areas). At a meeting of the full committee criteria for the definition of survey areas were specified. Since the unit of selection of the candidate to become an RHV is the chief's area, and since the RHV is responsible later to that chief, it was decided that a survey area (or community) would be defined as the area under the authority of a particular chief. Furthermore, it was realised that survey areas are not homogeneous and criteria needed to be established in order to reflect this heterogeneity. These criteria were:

(a) distance of area from nearest health facility,
(b) elapsed time of at least one year since the training of the RHVs for that area, and
(c) disease pattern of the community.

Out of the eight Tinkhundla areas in which RHVs were operating, only six fulfilled the first criterion of RHVs with over one year's experience. Each of those areas was then visited by the survey co-ordinators who familiarised themselves with the area-to-clinic distance, conducted formal interviews with the clinic staff about disease patterns, and sounded out the possibility of accommodation for the survey team. Subsequently the following major survey areas (Tinkhundla areas) were chosen by disease pattern (in parentheses):

(a) Entfonjeni - Mangweni (bilharzia, diarrhoea),
(b) Siphofaneni - Mankayane (tuberculosis, diarrhoea), and
(c) Tikuba - Zombodze (typhoid, gastro-enteritis).

Each of these Inkhundla areas furthermore, was stratified with respect to distance from clinic. In this case "clinic" was taken to mean any full-time or part-time, i.e. mobile, health facility, whether under the jurisdiction of the Swaziland Government, a Church Mission or a private company. Distances were measured using 1:50,000 scale maps, however the physiography

of the area was also taken into account in determining "contiguous area", "middle area" and "far area". "Contiguous" referred to those survey areas which had a clinic within their boundaries. "Far" referred to either the area located at the furthest distance from the clinic according to the map, or which was located in difficult terrain, e.g. in a very hilly area. "Middle" referred to those areas contiguous to a "contiguous area". Middle areas always turned out to be valley areas as opposed to far areas which were invariably more mountainous.

Using a random numbers table, three survey areas (chiefs areas) were chosen from the Entfonjeni - Mangweni and Tinkuba - Zombodze Tinkhundla areas, while four survey areas were selected from the Siphofaneni - Mankayane Tinkhundla. Four areas were chosen from the latter Tinkhundla since that region had more chiefs by far than the others (fourteen versus eleven for Entfonjeni - Mangweni, and eight for Tikuba - Zombodze). Selection of those areas without RHVs was as follows: after determining the survey area with RHVs the nearest chief's area without RHVs was selected. In the case of some regions where the nearest areas were not chief's areas, but freehold land, an area under the control of a different indvuna attached to the same chief was chosen as the control area. This area of course did not have RHV contact. The following survey areas were thus chosen, with control area in parenthesis:

(a) Entfonjeni/Mangweni Tinkhundla:

Contiguous - Chief Mukhovu (Chief Mnikwa)
Middle - Chief Magungwane (Chief Mancibane)
Far - Chief Mahhebeni (Chief Gija)

(b) Siphofaneni/Mankayane Tinkhundla:

Contiguous - Chief Mhawu (Chief Mhawu)
Chief Mhlaba (Chief Mzolimi)
Middle - Chief Mahlabandzaba (Chief Sibengwane)
Far - Chief Hhabela (Chief Maja)

(c) Tikuba/Zombodze Tinkhundla:

Contiguous - Chief Ncephu (Chief Mlimi)
Middle - Chief Makoloza (Chief Mdokwana)
Far - Chief Lusekwane (Chief Mpini)

E - NUMBER OF RESPONDENTS

Given the time restraint of the survey, it was decided to sample fifty homesteads from each of the survey areas, for a target of 1,000 homesteads. The actual number of homesteads interviewed was 1,041. As far as was possible, given the few days in each area, every RHV operating in that area was interviewed. The total number of RHVs interviewed was 40. One day was set aside when all the RHVs were asked to report to a convenient centre, usually the clinic in the Unkhundla area from which they were paid, and one or two enumerators interviewed the RHVs there. Attempts were made to reach every chief. Usually this interview occurred on the day when the survey co-ordinators entered his area to ask permission to conduct the survey there. At the same time local schools were contacted in order to interview the headmaster, and if possible one or two teachers. A total of 37 community leaders (21 from RHV areas and 16 from areas without RHVs) were contacted. Finally, 45 health workers were interviewed. Some were interviewed at clinics, others at their homes, while others graciously journeyed to the field quarters of the survey team to be interviewed there after working hours.

In-depth interviews were conducted by the UNICEF sociologist with senior personnel in the Ministries of Health and Agriculture, as well as in the Red Cross and Sebenta. A total of 15 officials were contacted including:

Ministry of Health: the Honourable Minister of Health, Director of Medical Services, Chief Nursing Officer, Matron Public Health, Health Planner, Principal Institute of Health Sciences, Senior Health Inspector, two Trainers RHV Training Programme.

Ministry of Agriculture: Senior Home Economics Officer, Senior Community Development Officer, Senior Agricultural Extension Officer.

Baphalali (Red Cross): Director - Baphalali.

Sebenta National Literacy Institute: Public Relations Officer.

In addition, one survey co-ordinator, the RHV trainer, spent two days total observing RHVs on a daily round of homestead visits. The results of one of these day's observations are included as an appendix to this report (not attached hereto for UNICEF workshop purposes).

F - INTERVIEW SCHEDULES

As noted earlier, five interview schedules were prepared for the five different categories of informant: Homestead, RHV, Community Leader with RHV, Community Leader without RHV, Health Worker. Some of the Schedules were designed to be administered in all areas, while others contained questions for specific situations. The Homestead and Health Workers' schedules were designed for administration in areas with and without RHVs, however one section in the Homestead schedule was only given to respondents who had been in contact with RHVs. One section in the Health Workers schedule was also reserved for a specific set of respondents; those clinic nurses in RHV areas were asked to report on the impact of the RHVs on clinic use by the community. The remaining three schedules were specifically designed for use in either RHV or no RHV areas. The RHV schedule was, of course, administered only to RHVs. The two Community Leaders' schedules shared a common biographical and community health awareness section, but thereafter differed sharply. The Community Leader with RHVs schedule concentrated on assessment of RHV duties in the area, while the Community Leader without RHVs schedule focused on extension agent activity in topics normally covered by RHVs. These schedules were constructed by the survey co-ordinators and vetted by members of the entire committee. The final draft of each of the schedules, produced by late July 1980, was a product of this consultation. All questions were typed and administered in siSwati, with the exception of the Health Worker's schedule. It was felt that it should be in English for two reasons: all health workers should have a reasonable command of English at the level of being able to discuss the technical nature of their jobs, and secondly this schedule was to be administered by the UNICEF sociologist who is not a native siSwati speaker.

The format of the interview schedules included both open-ended and fixed alternative questions. There was also a series of attitude questions in both the homestead and community leaders' schedules. The right-hand margin of all schedules consisted of boxes reserved for the coding of the answers for computerization.

G - PRE-TEST OF THE INTERVIEW SCHEDULES

A pre-test was conducted in early July 1980 in an RHV area not chosen for the survey. All schedules were pretested and the questions were checked

for both clarity and ease of delivery. The pre-test also helped to familiarise the enumerators with the field situation - with the interview schedules and also with field procedures. The results of the pre-test were used to construct the final schedule and served a particularly useful function in changing some of the upen-ended questions to those with fixed responses.

H - ENUMERATORS

Because of the short duration of the survey, it was decided by the survey co-ordinators that only experienced enumerators were to be used in the survey. It was intended that students from the University College of Swaziland with experience in statistics and/or sociology be hired, but because the survey ran into the beginning of the academic year this plan had to be changed. Instead the Department of Statistics was approached for a list of enumerators who had previously worked on the annual Swazi Nation Land Survey.

Seven males, all with GCE qualifications, were chosen to act as enumerators in the RHV evaluation survey. The enumerators were trained at the Public Health Unit, Mbabane, in survey techniques and were encouraged to familiarise themselves with two of the interview schedules: Homestead and RHV. After the five-days training programme, the survey team of nine (seven enumerators plus two survey co-ordinators) visited the pre-test area in order to familiarise themselves with the work of the RHVs.

During the field period all seven enumerators were assigned the task of interviewing homestead members in the areas without RHVs. In the areas with RHV coverage between five and six of the enumerators interviewed in the homesteads while the remainder interviewed all the RHVs assigned to that area. A rotation system was used in order that all enumerators received the chance to interview RHVs in at least one area.

After the field period was completed, the enumerators had the chance to fill out a short questionnaire in which they were asked to evaluate the impact of the Rural Health Visitors on their communities, as well as to evaluate the survey procedures themselves.

IV DATA PROCESSING AND ANALYSIS

A - CODING PROCEDURE

Data processing began during the field period and continued for one week after the survey team had returned to the Public Health Unit, Mbabane. At the end of the work day in the field the enumerators went over their completed schedules and entered the codes for the fixed alternative questions in the code boxes located on the right hand margin of the interview schedules. The survey co-ordinators would then spot check the schedules to make certain the correct code had been entered. About half way through the field period the survey co-ordinators took samples of the completed schedules and devised code sheets for the open-ended responses.

Once the field period was over intensive coding sessions were held at the Public Health Unit, Mbabane. Code manuals were then written for each of the sets of interview schedules.

B - HYPOTHESES ABOUT THE DATE

The data were then sent to an independent computer organization for key-punching on data cards. The data cards were then sent to the computer located in the Ministry of Finance building where programmes for two types of analysis were run. One programme supplied from existing pre-recorded programmes at the computer centre tabulated the column frequencies for the responses to each question per schedule. The second programme, also from a pre-recorded programme set, produced correlational analysis (Chi square statistic plus various tests of association) to test some hypotheses about the data. These hypotheses were as follows:

1) There is no difference between the level of health awareness in homesteads whether they are visited by RHVs or not;
2) There is no difference between the level of health awareness in homesteads in the different chiefs' areas visited by RHVs (in other words, a "within RHV area" test);
3) There is no difference in the manner that RHVs in the different clinic areas (i.e. "Nearest Health Unit") respond to questions concerning: a) personal information, b) RHV training programmes, c) daily activities, d) community relations, and e) job satisfaction;

4) There is no difference between the status of health worker and a) the amount of contact they have with the RHV, b) the awareness they have about the RHV training programme and duties of the RHVs and c) their knowledge of the community's acceptance of the RHVs.

V TIME FRAME

The original estimate for the duration of this survey was to have been six months total. Initial contact with the UNICEF sociologist began in the middle of March, however the actual starting date did not occur until the middle of May 1980. The survey was divided into three phases, each two months long. The first phase of field reconnaissance and schedule preparation lasted from 19 May to 28 July. The second phase, which encompassed the entire field period, lasted from 29 July to 30 September. The third phase, data analysis and report preparation, was to have lasted two months from 1 October to 30 November. Some delays in the keypunching operations pushed the end date back to the middle of December. The total period therefore lasted somewhat longer than the six months anticipated. If the period were calculated from the time of initial contact with the UNICEF sociologist, then the total time taken by this survey would be nearly eight months.

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