NURSING LEADERSHIP: ITS IMPACT ON THE ROLE OF VILLAGE HEALTH COMMITTEES

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By
Winnie Gasefele Manyeneng

PROMOTER: Professor R. Troskie
CO-PROMOTER: Dr. O. Makhubela-Nkondo

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• Bokaa Village in the Kgatleng District.

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DEDICATION

Dedicated to my husband, Edward Moshupi; children: Gaorakwe, Gontle, Refilwe, Morati and Boitsheko; daughter-in-law Kgomotso and sons-in-law, Maele and Reuben.

W.G. Manyeheng
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I DECLARE THAT:

"Nursing Leadership: Its Impact on the Role of Village Health Committees in Botswana" is my own work, and that all sources that I have used or quoted have been indicated and acknowledged through a system of complete referencing.

W.G. Manyeneng

Date 22. 12. 99
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  • Hebron Village in the Barolong Sub-district;
  • Sesung and Mogoditshane Villages in the Kweneng District;
ensuring the flow of information, budgeting, accounting; personnel administration, training, developing, evaluating and coordinating. On the other hand, leadership is about guiding people, services and health systems toward the achievement of the health-for-all goal. When the nurse engages in sensitisation activities for behavioural change, motivation and organisation for health; and when the people he/she has sensitised take action and become actively involved and participate in positive health promoting behaviours then she has assumed a leadership role.

Results realised have indicated among others that:

- indeed the nurse does not only provide management but also leadership skills at the local level. Through village health committees, he/she creates leadership in people. This he/she either does directly himself/herself or indirectly through those that he/she supervises, such as the family welfare educator. According to results realised there is consensus among both the village health committee and nurse respondents on this, and

- Of the 53 village health committee members interviewed, 96.2 percent reported that they received monthly support from nurses. On the other hand, of the 17 nurses interviewed, 63.9 percent reported that they provided monthly support to village health committees. The nurse, therefore, has a very important role in the support of village health committees. Thus, he/she provides leadership for health development, and for health-for-all into the 21st Century.

Despite the above, there is still room for improvement, since it surfaced that feedback to village health committees still needs strengthening and, sensitisation activities such as community leaders health seminars. These seminars require to be revived and strengthened. Training in leadership skills would also provide nurses based within committees with the necessary skills.
CHAPTER ONE

ORIENTATION TO THE FIELD OF STUDY

Chapter One discusses background to the study, objectives of the study and the significance of the research.

1.1 INTRODUCTION

In 1976 the Botswana Ministry of Health, through its Health Education Programme, started to plan and run health seminars for community leaders throughout the country. All districts, major towns and villages were included. These seminars were later decentralised. They are now organised and implemented by local health workers down to the level of the smallest communities. Community members decided to promote their work through the use of small groups called village health committees.

The system of promoting public awareness, especially from the centre, is strong and utilises the Village Development Committees (VDC), Village Extension Teams (VET), Village Health Committees (VHC), among others (UNDP, Government of Botswana, & UNICEF 1993:50).

The intent of these seminars was to get community members' input in their health care delivery system by actively involving them. Groups with interest in health promotion and disease prevention were formed. These were called village or ward health committees in rural and urban areas respectively. Village health committees were formed as a result of continuous community
sensitisation, mobilisation and organisation activities for health. They are considered a viable instrument for community participation and for holding the key to true community mobilisation and involvement in the implementation of primary health care. This concept of community participation and involvement for health is one of the important variables in the health for all strategy. To support this view the UNDP, Government of Botswana & UNICEF (1993:47) defined community participation in health as the cutting edge of primary health care.

Village health committees are a form of community organisation for health that is in line with what has been identified as one of the key concepts of Health for All.

Their role is consistent with the Alma Ata conference declaration's definition of primary health care, namely

essential care based on practical, scientifically and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation in the spirit of self-reliance and self determination (Mahler 1988:16).

The major cities, towns and villages each have several village health committees, while other small villages have at least one committee each. Some committees are functioning very well, some fairly well whereas others are either barely functioning or not functioning at all. Health workers, especially nurses, find themselves having to assume health leadership roles.
They are expected to educate community members on health issues and to support them, as well as enable them to participate actively in their community’s health development. “They had the skills and qualities for primary health care, but not the authority and control over resources to fulfil their leadership potential” (Kasonde & Martin 1994:61).

Primary health care is said to refer to a voluntary health service created at the village level.

This normally involves at least two components - a local committee and a volunteer health worker. The committee accepts some responsibility for health. It may have been formed specifically to address village health, or the health responsibilities may have been added on to the duties of the village development committee (Carlaw & Ward 1994:xxxii).

The Ottawa Charter defines health promotion as a process which enables people to increase control over, and improve their health (Tenn 1995:354).

This view of primary health care emphasizes that individuals must be able to enter the continuous care system at various points and with the help of various health care workers.

1.2 DEVELOPMENT OF MEMBERS OF VILLAGE HEALTH COMMITTEES

The first step for village health committee members following selection to membership, is development in them of the ability to communicate effectively. They thus, in their endeavours, require regular and ongoing support in both communication skills and health knowledge. With the assistance of local health workers, village health committees are able to divide
their village or ward into manageable units. They then share responsibilities and define boundaries of operation under constant leadership and guidance of the local health worker, who in many instances is the local nurse, a member of the district health team. This district health team was formally known as the Regional Health Team (Botswana Government's Ministry of Finance and Development Planning 1985-1991:309).

There are three partners involved in regular and continuous provision of health care at the local level. These are the nurse who is the team leader and health professional; the family welfare educator who has received training in relevant health topics and interventions for six months and continues to receive local level in-service as well as on the job training from the nurse; and the village health committee member. The family welfare educator should be selected at the kgotla by the community; however, in urban centres she/he is now selected at the Council Offices. She/he must have attained at least Standard Seven to enable her/him to undergo formal training offered by the Ministry of Health at a selected central training centre. She/he is only employed, by the City/Town or District Council, if she/he succeeds and gets certificated.

The village health committee member criteria for selection included interest, commitment and dedication to the promotion of health and prevention of ill health. Educational level is not a criterion. Village health committee members were selected at the kgotla, with everyone involved, during one
meeting. They then received continuous on-the-job and informal training from their local family welfare educators and nurses.

The Family Welfare Educator (Community Health Worker), who is under the guidance of the local nurse, ensures that the village health committee in her area of operation remains motivated and, that it participates actively in health care development. The main goal of these community organisation activities for health is first of all to provide information to community members with the view to providing them with education. It is believed that once informed, they will internalise the education. This internalisation of education will then hopefully be followed by behavioural change and adoption of those behaviours that are conducive to health promotion.

The nurse is the member of the district health team who provides the family welfare educator with ongoing as well as on-the-job training, guidance and in-service training. The study intends to examine this function and to establish the role of the nurse in carrying out this function. Armed with this education, village health committee members should be able to accomplish the following:

- identify health problems that exist in their various communities, including identification of the real causes of problems;
- discuss local problems and their consequences with community members, either individually, in groups or as a community;
- work with fellow villagers, community members in the prioritisation of identified health problems that they wish to overcome;
• plan programmes that they wish to implement;

• identify problems that are caused by factors beyond health, such as those caused by socio-economic factors.

Africa's health problems are not confined to infectious diseases, though it is these that are characteristically given most attention because they reflect the pervasiveness and degree of ill-health. Insufficient nourishment afflicting hundreds of millions, reducing their energy and motivation and undermining their productivity, also makes them susceptible to the many parasitic and communicable diseases to which they are exposed. There is no agreement on the causes of undernutrition. Ignorance, declining food production, drought, political instability, absentee husbands and other social facts and conditions are often cited. What is clear is that there is some connection between certain ailments and poverty. Disease creates poverty; and poverty, continuing the cycle, maintains the condition that fester diseases (Macgregor 1991:146).

Economic development and death, especially among children, are thus related. This has also been demonstrated by the World Health Organisation as shown below in Figure 1.1:
Fig. 1.1  **Economic Development and Deaths Among Children, 1995**
Mortality rate per 1 000 live births

Causes of ill-health, being multi-faceted as well as being socio-economic can also be culture-related. They are thus most suitably addressed by focusing on their very causes. Some village health committees in Botswana engage in a number of activities in line with problems that exist in their communities. In
doing this, among other things they establish and set themselves targets for future evaluation. Examples of some of the targets are:

- at least one vegetable garden per family. This would increase vegetable gardens in the community and help towards the reduction of malnutrition;

- no tuberculosis defaulters in each member's area of responsibility, such as a ward or cluster of households. This is ensured by encouraging all tuberculosis patients to attend health facilities and by supervising each patient in the actual swallowing/taking of their treatment.

Tuberculosis continues to remain an important cause of death; it ranks third for women of child bearing age.

With the rise in AIDS cases, the incidence of tuberculosis is already going up (Maendeleo 1993:32).

- ensuring timely implementation of planned programmes, by actively involving all community members in their health care delivery system.

1.3 THE ROLE OF THE NURSE IN THE COMMUNITY

District Health Team members vary in the type and level of involvement, and in their approaches. Of all these members, nurses in Botswana, by virtue of their numbers, form the backbone of the health care delivery system. They are the most available group and most of the time they are on their own, except for those that they supervise.

As the largest group of health care providers, nurses combine promotive, curative and advocacy roles into clinical practice. The role of the nurse in community participation has been described in various ways. The nurse may be an encourager, a partner, a resource, a facilitator, a catalyst, an obstacle, or an obstacle remover (Sawyer 1995:20).
Nurses provide a comprehensive service which includes providing supervision, support and in-service training to both the family welfare educators and village health committee members in Botswana. In order to be able to do this, nurses in turn have to acquire skills and support from their supervisors and the health system. In addition to all this, nurses require the ability to communicate effectively:

... a critical element in nursing care is the act of communication. It requires greater skill than any of the highly involved technological procedures nurses are required to carry out ... Is there any time set aside for the nurse to study the significance of communication skills, and is there a constant and consistent strengthening of such skills throughout the training period? In a multi-cultural community with a wide diversity of language groups, true nursing collapses without this necessary skill and deteriorates into a technical service (Searle 1988:65-75).

The nurse is in the best position to provide whatever leadership is required in the area of health, including primary health care. In Botswana, most community members who visit a health facility leave it without having seen a doctor, while all patients at these facilities make contact with nurses. Likewise, community members are also in daily contact with the nurse. Other health team members such as the Senior District Medical Officer who oversees the district and visits only on scheduled days, the Health Education/Nutrition Officer and the Environmental Health Officer who also have responsibility for a wide area (district) only visit communities occasionally, only during scheduled trips. Nurses provide leadership in health care in their area of operation. They are also expected to help others to
develop leadership skills, in order to bring out the best in them. This leadership is the complex combination of personal characteristics such as knowledge, skills, values and attitudes that enable the leader to develop a leading process, to create a vision of the future, to take a clear position, communicate it, and convince others in order to create commitment and build organisations or groups to bring that vision into being. It is this leading process that should result in action, needed changes, adjustments to social needs, new environmental trends and anticipation for the future.

*Furthermore a social movement, such as primary health care, cannot be depended upon a single charismatic leader. It requires a collective leadership, encompassing all levels of society, creating a collective force towards the goal. It must be an enabling and empowering type of leadership which believes in the inherent strength and ability of the people, thereby building self-reliance* (Barrow 1988:26).

Since independence, the five yearly National Development Plans have taken primary health care as the priority in health care delivery. The sixth National Development Plan (NDP VI) of 1985 to 1991 had its priority in the health sector as health manpower development for primary health care. In this regard Botswana showed that she regarded her health workers as the instrument for translating her health goals and aspirations towards the realisation of a healthy nation into concrete health care activities (Botswana Government’s Ministry of Finance and Development Planning 1985-1991:313).

Empowering communities through active community participation and involvement for health should create in them ownership not only of the health care system but also of their own bodies. This way, community
members will also feel that they have control over their own lives and their health status. Furthermore, over-dependence on the health system as well as on curative health as opposed to promotive and preventive health, will be discouraged. The study will endeavour to find out if the nurse, who is the backbone of the health system, is adequately prepared and has acquired skills to organise the community and mobilise it for prevention of ill-health and promotion of their own health.

1.4 BACKGROUND TO THE STUDY

1.4.1 Initiating Village Health Committees

Throughout the world, during the years preceding the Alma Ata conference, mankind commonly considered health care delivery systems to be the sole responsibility of the government. The community had little input particularly in the planning, whereas the Ministries of Health, in virtually all the countries, in good faith, identified community needs and problems without consulting community members. In this regard, health personnel viewed health as their responsibility, with little or no regard for co-ordination of efforts with the community or with other sectors that are an integral part of, and relevant in the provision of social and economic services. In his sixty-page document prepared for the 1988 Riga Conference: Ten years after Alma Ata, Professor Bryant re-affirmed that:

Communities should be involved so as to promote self reliance.
The community's role must be more than that of responding to services planned and designed from outside. The community should be actively involved in the entire process of defining health problems and
Experience has proved that change will be long lasting if the decision for this comes from within the person himself/herself, or from within the community. Success is expected if it is neither imposed on the people nor on the community by any outside agent. It has also been proved that people do not change unless they are dissatisfied with behaviour or present way of doing things. For people to desire change, they should feel some need which is not satisfied by their present way of living. As early as 1966, during independence from the British System, it became necessary for the Botswana government’s health sector to raise the people’s level of understanding. One of the approaches involved enabling the people to relate their health status to their environment in general. People needed to recognise that they possess the ability to control their health status, and to know that their standard of living is greatly influenced by their health status (Botswana Government’s Ministry of Finance and Development Planning 1979-1985:274).

Around 1975, the Botswana Ministry of Health’s Health Education programme initiated community organisation activities that were geared to enable community members to appreciate problems in their communities that influenced health. The approach was to tap on existing structures. Working through the kgotla (traditional gathering place), the first village health committees were initiated around 1976. The Health Education programme has been instrumental in the initiation of community leaders’ health seminars. Like other health professionals, except nurses, professional health educators...
do not have representation in every village in the country. It would also not be cost-effective to have professional health educators based at every corner of the country (Manyeneng 1984:106).

These community leaders’ health seminars later gave rise to:

- responsible parenthood seminars for youths;
- teachers and health workers workshops;
- traditional doctors and modern health workers workshops, and

During community leaders’ health seminars, community members suggested that there was a need for them to organise themselves as a committee whose mandate is primarily health. The committee would ensure that the people actively participate in their health care delivery system, and would also report to the people. After their formation, village health committees became sub-committees of the village development committees. This is in line with the country’s management structure whereby the communication line is from the village development committee, to the district development committee, the rural extension co-ordinating committee, the rural development committee to the cabinet and finally to parliament (Gobotswang & Kobue 1997:9-10).

The next chapter on the country’s overview intends to further explain the relationship of the structures to the leadership role of the nurse in community organisation, specifically the village health committees.
1.4.2 The Role of VHC in the Community

Village health committees are not a formal part of, or members of the health care system. They are an independent, liberated, enabled and empowered group that actively participates in the prevention of ill-health and diseases. They also promote their own health status, and the health of all members of communities that they live with and serve. They can be equated to a pressure group that strives at bringing about optimum health through their full participation and active involvement. However, village health committees are dependent upon the health system for guidance in matters of health, motivation for action in bringing about an acceptable health status and in being empowered with health information. With this support they act positively for the promotion of health, prevention of ill-health and adherence to prescribed treatment protocols. It is only when the real causes of ill-health are understood and appreciated and when people have knowledge, that they are empowered and enabled to take action to change behaviours and adopt those that bring about optimum health (Gobotswang & Kobue 1997:62).

Through the village health committees' strategy, education policy makers at the village level, such as headmen, chiefs, village/ward development committee chairmen, councillors (political), and other community members are able to actively participate in health-related matters that affect them. This has now been going on in Botswana for 30 years. The result has been that these leaders have in turn been able to justify and advocate relevant health interventions as well as for related developments (Manyeneng 1984:75).
To form a village health committee, the chief or headman calls a kgotla meeting. “The kgotla, which is the traditional meeting place of the tribe --- is an important forum for consultation at community level” (UNDP, Government of Botswana & UNICEF 1993:41). With the support and participation of the family welfare educator and local nurses, the kgotla is guided in choosing persons from both sexes who have shown willingness to participate and who are interested in the health of the community in which they live. Committee membership normally rotates according to community needs and plans. Tapping of all existing expertise is encouraged. From inception to date, the functioning of village health committees has not been uniform. Understandably, they are engaged in different or in similar activities, using different approaches.

To this end, the aim is to instil in people a sense of active involvement in bringing about and maintaining optimum health, as opposed to complete reliance on health institutions and curative services provided by health workers alone, as “bringers of health”. This will hopefully empower people to attain good health through their own actions and initiatives. It was as a result of health seminars’ sensitisation that community members themselves decided to form village health committees.

1.4.3 Levels of Activeness of VHCs

Research conducted locally has identified reasons for the various levels of the village health committees’ activeness. Some of the reasons are that:
• as village health committees are not remunerated, there is a lack of willingness to volunteer;
• there are no established income generating activities for village health committee members that could allow them to continue to volunteer and at the same time earn a living;
• there is a lack of guidance and support from local health workers, particularly nurses;
• there are constant transfers of clinic staff, especially active nurses. These transfers are said to lead to the collapse of active committees in some areas and to the resuscitation of inactive committees in other areas. This situation does not allow village health committees to be firmly established. Their activeness and activities thus fluctuate;
• there is inadequate provision of guidance to, and training of committee members by health workers, especially local nurses. Office bearers are often unable to perform their expected roles properly because of lack of confidence and skills. Nurses, being deployed all over the country are best suited to impart information and skills and develop confidence in the people where health matters are concerned (Botswana Government’s Ministry of Health 1994:8-9).

1.5 STATEMENT/NATURE OF THE PROBLEM UNDER STUDY
While research conducted in Botswana has focused on several aspects of village health committees and their function and motivation factors, the nurse leadership role in providing guidance to these committees has not been
explored. Community health nurses who are to provide leadership in their primary health care services at the district, village and ward levels should be assisted to identify shortcomings and strengths in their leadership roles as well as their participation in community development. Social skills to enable nurses to give the necessary guidance in the community should likewise be developed.

It must be appreciated that the empowered individual has the ability to promote his own health status and to prevent ill-health. It is essential though that for the community to be empowered, nurse leaders should assist them to become knowledgeable in health matters. At the same time it is an undeniable fact that health services have to be made available, accessible and affordable to everybody. According to a number of researchers, nurses may provide the missing link in promoting collaboration between indigenous and cosmopolitan health care systems. Nurses are the largest group of health professionals and are a valuable resource as they are either in continuous contact with those seeking care or become teachers of others such as village health workers. Further, it is observed that the role of the rural health motivator in Swaziland, that is the equivalent of the village health committee member in Botswana, could be further developed under supervision of clinic nurses (Upvall 1992:35).

1.6 SIGNIFICANCE OF THE RESEARCH/PROBLEM
Assuming that village and ward health committees in Botswana have grown from the experience of participating in primary health care in the last two
decades, the study will help to assess the leadership strengths, gaps and needs, if any, of nurses deployed in the area of community health services provision. Results from the research could among other things lead to the:

- development of programmes geared towards revitalising community education, sensitisation, mobilisation and motivation for health;
- redirection, strengthening and provision of support to sustain the motivation of village health committees;
- reassessment and redirection of the preparation and in-service in community health nursing courses, for nurses, where necessary;
- inclusion and integration of a strong leadership training component into the nursing curriculum;
- review of the constant staff movements or transfer patterns of nurses;
- generation of information on the need for, and needs of, village and ward health committees;
- generation of information on the type of leadership qualities and style that the local nurse needs to be able to motivate village health committee members to function.

1.7 PURPOSE OF THE STUDY

Not much research has been done in the area of community involvement and participation for health in developing countries, including in Botswana. From this study, it is hoped that information related to the knowledge and skills required by nurses in order for them to promote and plan for sensitisation activities will be gained. Furthermore, it is envisaged that communities will,
as a result, be mobilised for active participation and involvement for health. The Institute of Health Sciences' nurse training programme will also be reassessed for producing community-focused health workers. It will, where necessary, be redirected to strengthen communities' active involvement. The intent is that whatever information is imparted to the people, would be internalised and will contribute towards a change in behaviours, or strengthening of positive behaviours where necessary, as well as adoption of acceptable health promoting behaviours.

The research could lead to the improvement and revitalisation of community sensitisation, mobilisation, organisation, involvement, participation and motivation for health strategies, as well as towards the improvement and development of primary health care services. The research should also lead to the determination of Community Health Nursing Education programmes that are likely to produce nurses with effective leadership skills.

The attainment of health for all by the year 2000 was the central issue of the International Conference on Primary Health Care, held in Alma Ata in September 1978. This conference came up with an explicit declaration on primary health care as the key to the attainment of health for all by the year 2000. The declaration, among other things, states clearly that people have the right and duty to participate individually and collectively in the planning and implementation of their health care (Carlaw & Ward 1994:1-11).

*People's participation is explicit in the national principles of democracy, and development is enshrined both as a national principle and national development*
objective. The Government of Botswana has long recognised the importance of popular participation, and has attempted to structure programmes in such a way that people may participate in the development planning process (UNDP, Government of Botswana & UNICEF 1993:60-61).

This means that voluntary participation is both part of the culture and also explicitly stated and encouraged in the national development plans.

1.8 BASIC ASSUMPTIONS

Community sensitisation, mobilisation, organisation, involvement, participation and motivation are as old as the existence of mankind; they form an integral part of primary health care. From time immemorial, mankind has always worked together to achieve common goals. With the collaboration efforts of both the consumers and providers of health care, the goal of health for all could be a reality. This is because

primary health care implies much more than concern for clinical treatment of the ill, though adequate treatment, referral and follow-up on the return of patients to their homes and places of work cannot be ignored (Maganu 1996:293).

Based on the fact that the Government of Botswana adopted and embraced the primary health care concept as her number one strategy towards the provision of health care services and the attainment of optimum health for her people from as far back as the sixties and the early 70’s (Joint GOB/UNICEF 1989:105), the following assumptions, that still require to be verified, can be made:
• nurses in Botswana are strongly primary health care oriented. They thus are adequately prepared for community mobilisation and support for health;

• community members in most parts of the country are actively involved in the promotion of their own health and that of their communities;

• nurses in Botswana play a leading role in the development of village health committees;

• the research results should be used to strengthen the existing primary health care programmes and for developing successful and sustainable community involvement and participation strategies in Botswana.

1.9 OBJECTIVES OF THE RESEARCH

1. Nursing leadership:

Regarding nursing leadership the objectives are to:

• determine the role of the nurse in the establishment of village health committees;

• find out if nurses are actively involved in community organisation for health activities;

• examine nurses’ supervisory roles in work related to community organisation for health;
• assess the extent to which nurses take the lead in ensuring that village health committees in their areas of operation are functioning optimally;
• determine the role of nurses in educating the family welfare educators, and
• identify the different leadership styles of nurses' community organisation approaches.

2. Community organisation role and style:
Regarding community organisation role and style the objectives are to:
• determine how much of nurses' time is spent on community education and mobilisation activities;
• determine nurses' perception of their responsibility in the community organisation for health strategy;
• find out if community members are actively involved in the promotion of health care;
• identify activities undertaken by village health committees for health;
• examine to what extent existing village health committees are functioning.

3. Training for community organisation
Regarding training for community organisation the objectives are to:
• determine if village health committees where nurses are actively involved in in-service training of family welfare educators are functioning optimally;
• identify changes to the nursing curriculum that will prepare nurses to give the necessary support to village health committees.

1.10 DEFINITION OF CONCEPTS

Chief/Kgosi
This is a traditional leader who in some instances is regarded as royalty. He is almost invariably a male. Chiefs are found in large villages and towns. They are in most instances descendants of former chiefs. By virtue of their position chiefs have political authority over the people and are respected by their communities. They have a great influence on decisions made by communities. The chief is, therefore, the first person to be approached in matters that will need community participation. Failure to go through the chief may result in poor attendance or lack of community participation (Botswana Government's Ministry of Health 1979:42).

Community
A community has been defined as a group of people living in the same area and sharing the same basic values and organisation, with common basic interests, targeted for interventions (UNDP, Government of Botswana & UNICEF 1993:47).
Community Involvement

Involvement has been explained as making a thing necessary and, as sharing in something. It has also been defined as having a part in something (Hawkins 1994:307). It can be seen as a dynamic process which includes community participation in a variety of activities. Community involvement in health development has been defined as

*a process by which partnership is established between government and local communities in the planning, implementation and utilisation of health activities in order to benefit from increased local self-reliance and social control over infrastructure and technology of primary health care* (Oakley 1989:13).

It means that people, who have both the right and duty to participate in the defining of health needs and solutions of their own health problems, have greater responsibilities in the assessing of health needs (at individual, family, local and national levels), mobilisation of local resources, in the suggestion of new solutions or refocusing where necessary, as well as in the creation and maintenance of local organisations that have a bearing on health. Community involvement for health development, therefore, does not only involve health policy and health resources, but also the responsibilities and capabilities of the community.

Community Participation

Community participation for health is whereby the community “takes part or people have a share ...” in their own health care and development system (Hawkins 1994:411). Participation implies joint decision making (and equal
power) with decision making structures supported by the principle of equality and the integration of non-health needs. Community participation in health is the cutting edge of primary health care” (UNDP, Government of Botswana, & UNICEF 1993:47).

**Family Welfare Educator**

The Family Welfare Educator is called the Community Health Worker by the World Health Organisation; she/he is called by different names in different countries. This is a community member who is trained in relevant health topics and interventions for a specified length of time, after being selected by her community with the local health worker's guidance and participation. There is very little academic emphasis. The main focus in addressing the problems is on prevention of ill-health, promotion of health, rehabilitation and some curative interventions.

The Family Welfare Educator spends very little of her/his time in a health facility. She/he is mainly community-based, where she/he conducts community needs assessments and identifies health problems. She delivers basic health services. These include educating people on nutrition to address malnutrition, treating minor ailments such as cough and diarrhoea, weighing children and pregnant mothers, taking of blood pressure and giving the first cycle of contraceptives, and providing condoms while awaiting nurses' visit. She refers patients to health facilities for cases that she cannot handle.
Headman/Kgosana

The headman is a traditional leader in a smaller village or at ward level. He is normally elected with the involvement of the chief and is accountable to the chief.

Instrument

An instrument is "... the tool by which the data are collected" (Hogstel & Sayer 1986:58)

Mobile Health Services

Mobile health services mainly provide clinical and educational health services through taking them to the people who usually live in the remote and rural areas (very far from urban centres). This is to ensure that they also get services. Vehicles are used to carry clinical and other health professionals, medicines and necessary equipment/instruments. Services rendered are usually basic such as diagnosis and treatment, referral, immunisations and a variety of reproductive health services such as family planning pills and loop insertions. Almost all mobile stops have structures that act as temporary clinics.

Kgotla

A kgotla is a gathering place, usually at the chief's place, where important issues that affect the community are discussed, plans for developments are made and important decisions are reached. The chieftainship system in Botswana exists throughout the country, including in the urban centres. It
runs side by side with the political structure and actively participates in
development activities.

Health Education Officer

A Health Education Officer is a health professional who is trained in
behavioural and social sciences in addition to health topics. His/her
responsibility is to impart information to the application of a combination of
educational and behavioural strategies, guided by available and prevailing
health statistics. A Health Educator has to focus on ill-health and disease
prevention, health promotion and rehabilitation where any disease or injury
exists through a process of enabling people to take action. His/her main goal
is to support and guide people until their actions are compatible with high

Nursing leadership

By virtue of their numbers, wide distribution and availability, nurses are best
suited to provide supervision, in-service training and support to the family
welfare educators and to village health committee members. Living among
the people, she/he is in the best position to provide them with health
information and education. The nurse is best suited to organise formal and
informal training activities to improve the knowledge and skills of those
she/he works with, such as the family welfare educator and the village health
committee member. She/he also undertakes home visits and follow-up cases
to support the family welfare educator and village health committee
members. She/he is able to establish rapport among those she/he lives with.
Leadership is multidimensional and complex. It encompasses the wise use of power, the ability to envision future goals and directions, visibility and a willingness to stick one's head above the crowd, paradigm and humanism. It must be concerned with goal attainment and task accomplishment, but not at the expense of the people involved. Indeed, leadership is effective only when it draws forth the best in people, is concerned with promoting the general welfare of human beings, and maintains group solidarity (Manfredi & Valiga 1990:4).

Management must be understood as a position, but leadership may or may not be tied in a position of authority in an organisation. Leadership is a relationship of influence, whereas management must be understood as a relationship of authority with the resultant manager - employee relationship.

*Leadership enjoys and wants ambiguity since it allows for change, but managers prefer predictability* (Manfredi & Valiga 1990:4).

**Primary Health Care**

This is a strategy that emphasises prevention of ill health, health promotion, rehabilitation to prevent further damage and curative services where disease has already occurred.

*Primary health care is not more medicine for the poor. Primary health care is essentially a call for a partnership in health, based on the concepts of equity and social justice, to enable communities, both rural and urban, to take intelligent responsibility for upgrading their health environment and health status* (Carlaw & Ward 1988:xxxii).

It is actually the health of the people, for the people, by the people and with the people themselves. In short, making informed choices to attain optimum
health, and active involvement and participation to acquire a high status of health are the key.

Village Health Committee

Is a group of villagers that is committed to the improvement of the health of the people, with support from health workers. Village health committee members are answerable to community members. Main activities include:

• doing a community assessment to identify prevailing health problems;

• educating community members on prevailing health problems, with information from nurses and family welfare educators;

• linking the health system and the people;

• doing home visits to educate, assess environment and general health status and supervise treatment taking where necessary;

• following-up long term and terminally ill patients as well as defaulters; and

• reporting any suspicious case of unreported illness to the local nurse.

Ward Health Committee

A ward health committee is synonymous to a village health committee. In urban centres, village health committees are called ward health committees.
1.11 SUMMARY

All villages in Botswana whether big or small have a village health committee comprising of community members. Bigger villages, towns and the city boast of several village health committees each. All village health committees in Botswana have been formed with active involvement of local nurses. It is the nurse at the local level who ends up having the ultimate responsibility for ensuring sustainability of the committees in her/his areas of supervision, since it is the nurse who is found at every corner of the country, including the remotest parts. For guidance and support in this area, nurses at the local level depend on the trained Health Educator, who mainly operates at the district level. Unfortunately, only a few districts enjoy the services of a professional health educator.

The national Health Education Unit, which is at the central level, has responsibility for supporting local authorities in their community sensitisation and mobilisation for action strategies for health, through the district health education officers. Health educators are not as close to the people as the nurses who actually reside in villages. The active functioning or inactivity of these committees, are greatly related to the support provided by local health workers at the peripheral level.

Chapter Two presents an overview of the country; that is, the country’s geography and environment including significant physical and climatic features as well as natural resources, communications and the country’s demographic features. A discussion of the country’s political and
administrative support is included. Of significance is the inter-sectoral co-
ordination, collaboration and consultation within and among programmes, as
well as between the different development committees and structures, such as
the rural hierarchy that facilitates and emphasises the bottom-up as opposed
to the top-down approach (Botswana Government's Ministry of Finance and
CHAPTER TWO

AN OVERVIEW OF THE COUNTRY

Chapter Two discusses an overview of the environment and structures that facilitate village health committees' work.

2.1 INTRODUCTION

In order for village health committees to be appreciated, there should be an understanding of the country and its people, its economy, resources and organisation system. The role of health workers (nurses) should also be clearly and adequately understood, not only in the context of provision of curative and rehabilitative health services but, also of preventive and promotive health. The focus would be community organisation and mobilisation strategies for health that are geared towards the promotion of the health of the people, by the people, for the people, and with their full and active participation. For this to take place, the environment must be supportive and conducive.

2.2 GEOGRAPHY AND ENVIRONMENT

2.2.1 Significant Physical and Climatic Features

Physical and climatic features are important in that they have an influence on the motivational levels of any voluntary organisation. An organisation that can be self sufficient in food production would, compared to the one that is not assured of food, do voluntary work. Likewise, vegetation types are

2.2.2 Physical Features
Botswana is a landlocked country whose total land area is approximately 582,000 square kilometres. It shares borders with Zimbabwe, Namibia, Zambia and the Republic of South Africa (Botswana Government’s Ministry of Finance and Development Planning 1985-1991:1). Botswana has no easy access to the sea. This does not facilitate trade, especially shipping. All sea food, that normally is high in protein is as a result not easily available. Since one of the duties of the village health committees is to educate community members in order to reduce malnutrition, they are faced with the difficulty of encouraging community members to produce food and to prevent malnutrition.

Most rivers in Botswana are ephemeral and, there are only a few perennial springs. This signifies an extremely dry country. None of the rivers are dammed. Without any water, not only are food production and pastoral farming compromised but, even getting water for cleanliness and hygienic purposes becomes difficult. The work of the village health committees is thus made very difficult. Their communities’ hygienic practices are negatively affected by water charges as well as the scarcity of this commodity.
In the north-west the Okavango River drains inland from Angola to form an extensive swamp. In the central north-west there is a large area of calcrete plains bordering Makgadikgadi Pans (Botswana Government's Ministry of Finance and Development Planning 1985-1991:6). This makes arable agriculture very difficult to engage in.

2.2.3 The Climate

The climate is not conducive to arable agriculture. The soil is mainly arid or semi-arid. This has negative implications on the nutritional status. Rainfall is mostly irregular and occurs in localised showers and thunderstorms. Its incidence is highly variable, both in time and space. The volume of rainfall is also a poor indicator of its value since there is rapid run-off and drainage during the short, intense storms that account for extreme soil erosion. This makes the country unsuitable for food production which is an obstacle to village health committees members, whose aim is to create a spirit of self reliance in the people. This would require water and fertile soils. High evaporation and transpiration rate accentuate the problem of water shortage.

The climate is harsh and prone to extremes in temperatures, with drought being a recurring hazard. This type of climate, combined with poor soil, makes volunteerism difficult. When people are struggling to find food, they might not find time to volunteer. For one to be able to volunteer, one must be assured of where the next meal is going to come from. Village health committees try, as one of their strategies, to seek ways of producing food, and motivating community members to grow food in a very dry climate and
where soil is poor, in an endeavour to address the nutritional status of the people. As stated, "in some developing countries, drought is a life-threatening problem, especially as it affects food production" (Haglund, Finer, Tillgren & Petterson 1996:69).

The eastern margin of the country is adjacent to the Limpopo drainage system, at its confluence with the Shashe River. This eastern region, has a somewhat less harsh climate and more fertile soil than elsewhere. It is here that most Batswana live, since the land can be cultivated. Even this part of the country, though, is not able to produce much food because of the poor and unreliable rains (Botswana Government’s Ministry of Finance and Development Planning 1985-1991:1).

High temperatures, especially in the summer growing season, exacerbate the difficulties of agriculture by raising soil temperature and increasing the rate of moisture loss. Average summer daily maximum temperature recorded is about 33 degrees Celsius (33°C) in January and 22 degrees Celsius (22°C) in July, while extremes can reach 43 degrees Celsius (43°C) respectively. Average daily minimum temperatures are around 19 degrees Celsius (19°C) in January and five degrees Celsius (5°C) in July, with extremes of seven degrees (7°C) and below five degrees (5°C) respectively. The south-western parts of the country, have recorded temperatures below zero degrees Celsius (0°C) (Botswana Government’s Ministry of Finance and Development Planning 1985-1991:6).
One of the activities of village health committees is to grow vegetables as well as to encourage community members to cultivate vegetable gardens in their own homesteads to avoid especially malnutrition among the under-fives. Very often the harsh temperatures destroy these gardens. This often discourages and negates their efforts. The "drought situation has not been an encouragement" (Omondi, Atlholang & Diseko 1987:23).

2.3 COMMUNICATIONS

Botswana can be reached directly from outside by air, railway and road. The road network is important for the facilitation of quick referral of patients to higher health facilities. Drugs as well as all other supplies needed for curative health services are transported by rail, road and air. This facilitates the work of village health committees, who do not only refer patients from long distances to higher facilities but depend on both roads and telephones for supplies. The telephone is also useful for communicating with health facilities. The single-track railway links Botswana with South Africa in the south and Zimbabwe in the north-east, and hence with seaports. The railway system carries a substantial portion of the total freight traffic within the country. Regular air services connect the country with major international airports. The communication system is of vital importance to the country since most of its foodstuffs, medicines and clothing are imported from outside. As a result of communication systems not being very effective some village health committees produce food locally; this includes rearing chicken in order to feed underweight children. They strive to be self sufficient and
avoid imparting items that they can produce. Others are sewing clothes and use the proceeds from the sale of these for improving the health status of their villages. It must be borne in mind that until recently eggs have been among some of the imported products. All forms of communication are important in import and export, including drugs, food commodities. Referral of patients to secondary health facilities often include to facilities outside the country (Botswana Government's Ministry of Finance and Development Planning 1985-1991:8).

The road network is good in the urban, peri-urban and most of the rural areas. However, the very remote areas still have bad roads.

2.4 DEMOGRAPHY

Village health committees (VHCs) are bound to be engaged in activities related to the health of mothers and children, who form more than half of the country's population.

The activities of VHCs include promotion of family planning; personal hygiene, environmental sanitation and the construction of latrines; assisting Family Welfare Educators (FWEs: equivalent to Community Health Workers) with general work at health facilities; advising mothers on child care ... (Gobotswang & Kobue 1997:6).

Botswana has a total population of 1,327,000 (Botswana Government's Ministry of Finance and Development Planning 1991-1996:5) with an average of 2.3 persons per square kilometre. The current population growth rate is 3.5 per annum.
Most of Botswana’s citizens are members of the Setswana-speaking tribes or clans. There are other significant groups such as Basarwa, Bakalanga in the north-east, Baherero in the west and other semi-nomadic groups in the more remote areas. With the present population growth rates, issues such as family planning, including the need to educate community members in spacing of births and on the importance of family size cannot be over-emphasised. Equally important is the need to sensitise community members on other health related issues such as prevention of diseases and provision of care where necessary. Immunisation of children below five years of age and attendance of pre-natal care by pregnant mothers, post-natal care, supervised deliveries (by persons trained to deliver) especially in the case of Botswana who still has a very high maternal mortality rate estimated at 200 per 100,000 live births also needs attention (UNDP, Government of Botswana & UNICEF 1993:54). The infant mortality rate, at 45 per 1000 live births, is also comparatively high. These demographic indicators are important in the work of the village health committee, if it has to resolve real problems that are pertinent to people’s lives. Resolving them require active involvement beyond the health system.

According to the World Health Report (1996), in 1995 an estimated nine (8.9) million people developed tuberculosis, bringing the global total of sufferers to about 22 million and about three million of whom it is predicted will have died in a short space of time. The huge toll is the price the world is paying for
complacency. The magnitude of tuberculosis is such that in 1993 the World Health Organisation declared it an emergency. Tuberculosis has now found lethal partnership with HIV/AIDS and is the opportunistic infections that most frequently kill HIV positive people (World Health Organisation 1996(a):27-28).

Drug-resistant tuberculosis is also a growing threat world-wide. Incomplete or inappropriate treatment of the disease has also spawned the development of strains resistant to drugs that once destroyed the bacteria in one hundred percent (100%) of patients. If properly treated, tuberculosis is curable in virtually all cases. This is provided it is not caused by bacteria strains that are resistant to a range of drugs. If untreated, the disease is fatal in more than half the cases. Non-vaccinated babies are most vulnerable to developing diseases such as meningitis and disseminated or "miliary" tuberculosis (World Health Organisation 1996(b):28).

In the meantime growing numbers of poor, malnourished people live in unhygienic overcrowded conditions in which person-to-person transmission of diseases such as tuberculosis is most likely to occur. The answer is likely prevention of infection. This could be achievable only with combined efforts of both the health system and the people themselves. Hence, the importance of organised people's participation such as village health committees.

*To be successful primary health care needs individual and community self-reliance, maximum community involvement or participation, that is to say the active involvement of people living together in some form of*
social organisation and cohesion in planning, operation
... (Oakley 1989:8).

2.5 INTER-SECTORAL COLLABORATION AND CO-OPERATION

In their pursuit of improved health status, village health committees end up working on issues that require them to solicit assistance and guidance from a number of sectors such as Agriculture, Health and Water Affairs. It thus becomes easier where services can be co-ordinated. The country has since independence, adopted a planning strategy that facilitates co-ordination and consultation. The National Development Plan VII, like all the previous plans, emphasises the importance of inter-sectoral collaboration as a cornerstone of development policy.

The health sector alone cannot meet all the demands for health services in the country. Subsequently, the Ministry of Health

... has continued to mobilise and/or utilise intersectoral structures such as National Health Promotion Committee (NHPC) consisting of members from all Ministries (Ministry of Education, Ministry of Labour and Home Affairs, Ministry of Local Government, Lands and Housing, etc.) and other agencies ...
(Gobotswang & Kobue 1997:48).

The Rural Development Council at the highest level is responsible for reviewing all rural development plans, including advising on appropriate new initiatives, and making recommendations to Cabinet. It has several sub-committees, one of which is the Rural Extension Co-ordinating Committee (RECC). The National District Development Committee whose role is among others to feed into, and to liaise with, the Rural Extension Co-ordinating
Committee, culminates every two years into a National District Development Conference. Here progress and setbacks of every district are reviewed, and new and fresh strategies that are geared towards the solution of identified problems are developed. The Village Health Committee is a sub-committee of the Village Development Committee.

*At the village level the Village Development Committee (VDC) co-ordinates the overall village development activities. This functions through sub-committees; the village health committees ... (Gobotswang & Kobue 1997:10).*

The village-level cadres of extension workers, are organised into a village extension team. Members come from line ministries and district councils, with villages typically having a family welfare educator, a nurse, an assistant community development officer, an agricultural officer, a literacy officer, a teacher, and other available extension workers in the village. The mandate of village extension teams is to assist villages in meeting their developmental aspirations through the provision of concerted and comprehensively delivered technically sound services. Quite a number of extension workers are involved in the pre-service and in-service training of the family welfare educator, co-ordinated by the community based nurse. The family welfare educator, as coming from the same community, is instrumental in community mobilisation for health, and for other health-related programmes, such as agriculture for nutritional purposes. He/she participates in the formation and work of the village health committee, under the guidance of the locally based nurse. This underscores the team approach. While local authorities are charged with the management of rural and urban development at the district
and town levels, central government ministries play a complementary role including inter-ministerial committees such as the Land Development Committee, District Plans Committee, Urban Development Committee, the Primary Health Care Co-ordinating Committee, the Rural Extension Co-ordinating Council (RECC), the Resource Technical Committee, the Inter-Ministerial Co-ordinating Committee and the Food Strategy Working Committee. "The Ministry of Health is represented in all these structures" (Gobotswang & Kobue 1997:9).

Since 1972, and in successive Development Plans, the government has maintained a policy that engenders decentralisation in its broad meaning. That is deconcentration, delegation and devolution. This called for a bottom-up people-centred development approach, and for communication and planning of a decentralisation structure involving the people. See Figure 2.1 for an organogram indicating health focus bottom up planning and communication structure.
FIGURE 2.1  ORGANOGRAM INDICATING HEALTH-FOCUSED BOTTOM-UP PLANNING AND COMMUNICATION STRUCTURE
2.6 SUMMARY

The intent is to highlight and examine the role that the individual, the family and the community could play to relieve the already overburdened health system, and to elucidate the responsibility of the community health nurse especially in his/her capacity as a leader in initiating, nurturing, supporting and empowering village health committees in her area of operation. These are working with him/her in health promotion, and in ill-health prevention.

It is hoped that findings of the research will enable the system to critically examine the contribution of nurses, that are geared towards enabling community members to fully and actively participate in ill-health prevention and health promotion. It has been important to provide the background of the country for a better understanding of the particular system of community involvement and participation in health matters.

Chapter Three will present the role of the nurse in community organisation for health. The intention here is to highlight the unique role of the community based nurse as the most available and multi-purpose health worker in the community, representing the health care delivery system. The decision to highlight this role outside the literature review chapter is for purposes of comparing it against the findings of the study.
CHAPTER THREE

PEOPLE LEADING PEOPLE TO BENEFIT PEOPLE

Situation regarding the role of the nurse in community sensitisation, mobilisation and organisation for health.

AN OVERVIEW

3.1 BACKGROUND

Since 1974 local authorities have been assisted in their primary health care functions by Regional Health Teams. From the early 70's, local authorities in Botswana started to have their own health facilities and to run health services throughout the country. This meant that they recruited their own health personnel. At the same time, the Ministry of Health that has portfolio responsibility for the country's health continued to provide local authorities with support, guidance, professional and supervisory services. From 1984, Regional health teams were renamed District Health Teams, with each district as well as sub-districts having a district health team. This was an attempt at making health services accessible, available and affordable to all people in the country (Pedersen & Modisenyane 1986:2). District health team members include the senior district medical officer, known in Botswana as the public health specialist II; the council (senior) matron, environmental health officer (previously known as health inspector), health education/nutrition officer, rehabilitation officer, and where possible a community health nurse responsible for HIV/AIDS/STD and Tuberculosis as well as other health
workers such as a physiotherapist where they are available. The nurse has always been and remains, an integral part and, an important member of the district health team.

For many countries, a visit from the public health nurse to explain community-based primary health care and the selection of a volunteer for health training may be a first step in primary health care (Carlaw & Ward 1994:xxxvii).

Nurses throughout the country are in a better position to provide promotive, preventive, curative and rehabilitative care, as compared to other members of the district health team. In Botswana they are required to participate in the education of community members, families and individuals on healthy lifestyles, primary prevention of ill-health, protective and supportive measures, in addition to their normal and traditional roles of clinical nursing.

The health-for-all goals require that nurses not only provide highly specialised care at the secondary and tertiary levels but also function at the primary level, with roles including those of facilitator and manager of health care (Aksayan 1994:150).

Nurses are expected to encourage people to become involved in their own health care. They are thus to seek and obtain co-operation of other sectors of society who are involved with health or health-related matters.

Nurses engaged in primary care have to supervise other health workers, and participate in the planning, organisation and running of community health services. They have to assess health needs, consider the views of communities on these matters, communicate with them, and serve as their advocate (Aksayan 1994:150).

The community nurse in Botswana, is expected to be in the forefront with regard to the organisation of community members for health, and, therefore,
in the support and motivation of village health committees. This is in addition to her normal curative, rehabilitative, promotive and other preventive roles. The nurse is also required to support community health workers and traditional birth practitioners as well as to identify sources of health problems and the prevention of major diseases. This, if successful, would reduce the number of persons reporting to higher health facilities in search of curative health services.

3.2 THE CHALLENGE

Some of the challenges related to community involvement for health are that:

- communities do not possess limitless resources, rights, autonomy and freedom to enable them to identify their needs and work in partnership with health professionals to improve their own health status;

- community participation is in fact not a luxury but a necessity, especially in developing countries where resources are scarce;

- care must be taken to ensure that this participation is people-perceived and, not coerced or imposed on them by health professionals or leaders (Sawyer 1995:18);

- community involvement calls for a relationship with the people in which power is shared and communities are active subjects; and

- community involvement may threaten professionals because it requires the sharing of their sources of power, knowledge and skills to avoid tokenism.
3.3 THE ROLE OF THE NURSE

In Botswana, "... clinics and health posts are run by local authorities and the bulk of the health care at these facilities lies in the hands of nurses" (Botswana Government's Ministry of Finance and Development Planning 1985-1991:98). Referrals to the upper levels of the health care facilities are done only for cases that a nurse cannot cope with. The nurse in the rural area is expected to be trained to carry out most of the procedures and to refer only as a last resort.

- **Administrative Duties**

Within this role the nurse may be in charge of a clinic, ward or hospital whereby she/he is responsible to supervise nursing and other staff working there such as the family welfare educator. The nurse in Botswana has also assumed administrative positions at higher levels such as being in charge of a national programme or a health training institute.

- **Supervisory Duties**

The senior nurse of an area assists the nurse who guides and supervises those working under her/him in order to improve the quality of services provided. In this regard the nurse, who has direct supervision for the family welfare educator, has responsibility for ensuring that the community is given correct health information, sensitised, and motivated enough to be organised to form groups that work towards prevention of ill-health and promotion of healthful living standards.
• **Role in Service Provided at Health Facilities**

Presently the health care delivery system provides comprehensive health care services as follows:

*Curative Services Role*

During mobile health services’ visits it is the nurse who does consultations and screens patients. She/he also prescribes medicines and treatment for patients. In addition, the nurse during those visits collects whatever laboratory specimens are necessary for diagnostic and preventive purposes. Mobile services ensure provision of outreach work to areas without permanent staff or facilities. In most instances these services are provided to people at least once a month.

_The clinic staff in consultation with the village health committee, shall determine the mobile stop day and time, and this must be communicated to the community in good time (Government of Botswana 1987:7)._

However, in view of rough and/or impassable roads, transport shortage and vehicles that are constantly being damaged by remote areas’ bad roads or that require repair, visits become irregular.

At both the health post and clinic levels, especially with the existing shortage of medical doctors it is again the nurse, who is based in the rural and remote areas and who performs all of the above duties and only refers cases that she/he cannot handle.
District Health Teams or the clinic staff which must include a Registered Nurse/Midwife shall visit each mobile stop at least once a month and provide MCH/FP services to eligible clients (Government of Botswana 1987:7).

During the mobile health services and at the health post and clinic levels, the nurse also provides safe motherhood services such as ante-natal care, assessment and referrals where necessary, deliveries, breast feeding promotion activities and post-natal care. The nurse in Botswana has been trained to be able to provide assessments and family planning services such as prescription of the pill, insertion of intrauterine devices (IUD’s) and Injectable Progestin contraceptives such as Depo-Provera. Maternal and Child Health and Family Planning services “in Botswana shall mainly be provided through the integrated approach in which all components of these services are offered on a daily basis to a mother and her family at a single visit” (Botswana Government 1987:6).

When visiting a health post or providing MCH/FP services at the clinic, health centres or hospitals, the Registered Nurse/Midwife (RN/MW) or Community Health Nurse (CHN) shall in her assessment include a pelvic examination and provide both medical and non-medical methods including IUD and Depo-Provera. Screening for STD, cancer of the cervix through pap smears, and for infertility shall be done. Information, education and counselling for methods - shall be provided. Referral shall be made to the Family Nurse Practitioner, Medical Officer or Gynaecologist depending on work station (Government of Botswana 1987:7).

Preventive Services Role

Preventive services such as information, education, communication and counselling are provided as an integral part of all health care services. About
60-70 per cent of preventive health services in 1979 were done by nurses at clinics and health service centres. In addition to ante-natal and post-natal as well as family planning and child welfare services provision mentioned above, programmes such as the expanded programme on immunisation and services of acute respiratory tract infections, control of diarrhoeal diseases and school health programme continued to be provided and supervised by nurses.

*By the late 1970's, the Basic Health Services approach was replaced by the Primary Health Care approach. The difference between the two approaches was that the later went beyond the provision of physical and manpower infrastructure and the provision of specific curative and preventive health care services, but sought to utilise concepts like equity, community involvement and intersectoral collaboration to develop a more complete health system. The technology used had to be appropriate for the circumstances; the socio-cultural and economic background of the community were important factors. In other words, the communities became partners in their health care development rather than recipients of health care (Maganu 1996:10).*

The nurse also became responsible for the planning for, implementation of, and in-built ongoing evaluation of community educational programmes. These included seminars on health for community leaders and traditional healers, as well as on responsible parenthood for youths, and workshops for modern health workers and teachers, as well as initiation of strengthening and follow-up of village health committees. Other activities that the nurse became responsible for included prevention of diseases such as tuberculosis, malaria, sexually transmitted diseases, and non-communicable diseases such as hypertension. Success in these depended on collaboration with the people and communities.
Nurses also have a responsibility to use their professional power as client advocates for the benefit of the community. Nurses need to know the culture determine the culture of participation that already exists in the community: how the communities are organized, what means exist for participating, and what skills and resources are available in the community (Sawyer 1995:20).

The passport to success in preventive health is not to attempt to do it for the people but to enable people to do things for themselves. This, however, should not be interpreted to mean that the responsibility for the attainment of optimum health is to be shifted to the people alone.

Promotive Services Role

Health talks are part of health promotion activities. The nurses at the clinics cover a wide range of educative health subjects; in addition, they collect statistics, carry out immunisation and other preventive health services, take care of up to 10 beds for curative and maternity care services. Other activities include cooking demonstrations, condom distribution and regular medical check-ups. Healthy lifestyle activities such as acceptable eating habits and eating of a balanced diet as well as regular exercises, regular pap smear check-ups and examinations are other components of promotive health (Omondi, Balosang, Mokganedi, Mbongwe & Segokotlo 1994:3).

The nurse in Botswana, as the health worker of first contact has responsibility for ensuring that all the activities mentioned above are actually undertaken. In short, she/he finds herself/himself in the forefront for the undertaking of needs assessments, setting and implementation of goals and objectives in her
area of operation. She/he also plans for the acquisition of resources and their proper use. In her/his management of resources, be they monetary, human or any other such as infrastructure; the nurse's day-to-day activities involve an exercise of weighing alternatives to ensure optimal use of available resources. The nurse thus, has to do the best with what is available. For example, the she/he in the provision of health services at the most peripheral levels (clinics, health posts and mobile stop health services) is faced with a number of constraints.

Major constraints have been lack of transport for outreach programmes. Staff shortage has resulted in cancellation of planned mobile stops among others (Gobotswang & Kobue 1997:46).

3.4 NURSE'S ROLE IN COMMUNITY ORGANISATION FOR HEALTH

The importance of village health committees as a community organisation for health strategy that promotes community involvement, participation and mobilisation for health cannot be over-emphasised. This as earlier said can best be done by nurses.

Many nurses have discovered that they were providing primary health care without knowing that they were doing so, but what nurses have to better learn and be aware of is how to help the population to really participate in the organisation and development of primary health care, how to help people to be responsible for their health. That, is the biggest challenge (Dechanoz 1990:158).

Following community leaders' health seminars, the majority of the people and districts decided to form groups in their communities. These groups' role was to assess their communities' health status and needs and to come up with
strategies aimed at improving the health of their communities. A few of the communities decided to strengthen the relationship between the traditional healers and the modern health workers.

The potential political strength of the nursing profession comes from its numbers, its many central roles in health care, .... Consumers and governments both need to have health goals, and nurses are in a good position to help them develop these goals and achieve them (Fagin 1990:186).

The chief, following sensitisation in health and after appreciating the importance of community involvement and participation for health usually works with the nurse to facilitate the process of selecting village health committees. The nurses' role in this case is to provide guidance to the chief, to facilitate the selection of the right people. The nurse also provides newly elected village health committee members with orientation in health matters. This gives the village health committee members confidence in their addressing of health issues, and builds trust between the people and village health committee members. The nurse's approach in imparting health information to village health committee members is of importance.

The didactic, authoritarian model in which learners are lectured by teachers cannot meet the needs of people intending to work in health systems where equity, self-reliance, community participation and inter-sectoral collaboration are the watchwords (Ritchie 1994:147).

Nurses in the primary health care context are expected to be the statisticians, planners, economists, epidemiologists, organisers and public relations experts, among others. The big question is whether their preparation and in-service training adequately prepare them for the role that is expected of them
in the field. They are the pillars of the health care delivery system and as such must work with other health team members and different non-health professionals to ensure success.

Nurse managers are responsible for many of the health services provided in communities and hospitals, yet there is comparatively little information about their preparation and work. Management has been “considered to cover the determination of organisational structures and policy, the planning of resources and programmes, the setting of standards, supervising, delegating, ensuring the flow of information, budgeting, accounting, personnel administration, training, developing, evaluating and co-ordinating; the leadership was taken to involve guiding people, services and health systems toward the achievement of the health-for-all goals (Henry, Loresen & Hirschfeld 1994:153).

3.5 SUMMARY

In this chapter the situation regarding the role of the nurse in community sensitisation, mobilisation and organisation was discussed. Chapter Four will discuss the conceptual framework and the qualitative design and method.
CHAPTER FOUR

CONCEPTUAL FRAMEWORK AND QUALITATIVE RESEARCH DESIGN AND METHOD

This chapter discusses the conceptual framework and qualitative research design and method.

4.1 INTRODUCTION

The research aimed at examining the extent to which nursing leadership influences or affects the functioning of village health committees. To answer this question, a number of sequential steps were developed to reflect the research process (Hogstel & Sayer 1986:40). By virtue of its nature and the scientific quantification of data, both qualitative and quantitative research methods were employed.

4.2 THE RESEARCH DESIGN

The choice of the research design was guided by an objective review of the literature and the establishment of a theoretical framework. The word design according to Lobiondo-Wood and Harber (1995:193) "implies the organisation of elements into a masterful work of art". Research design on the other hand refers to a detailed plan for implementing the research and encompasses the specifics of the research process (Hogstel & Sayer 1986:56). It is therefore, "the overall plan for collecting and analysing data, including specifications for enhancing the internal and external validity of the study" (Polit & Hungler 1991:653). As indicated in the introduction, both qualitative and quantitative
research methods were employed, to aid in the solution of research questions and testing the assumptions as well as to maintain control. Control as defined by Lobiondo-Wood & Harber (1995:193) refers to measures implemented to ensure that the conditions of the investigation remain uniform. By maintaining control, possible impingement of bias on the dependent variable that may affect the outcome was avoided.

In this study a contextual, exploratory and descriptive design was used to reach the overall purpose of the research.

**Contextual:**

The context within which the study was conducted was focused on the role of village health committees in Botswana and the leadership role nurses have to play in establishing and sustaining these committees.

**Exploratory:**

The research implies the exploring/scrutinising of unknown regions to gain new insight into the phenomena of village health committees (Woods & Catanzaro 1988:50). This suggests that the researcher will not allow pre-conceived ideas to influence her research into the role of the nurse in establishing village health committees, or on the involvement of village health committees in the promotion of health care.
Descriptive:

The descriptive design was based on conversations and observations during interviews with village health committee members. The leadership role of the nurses in establishing village health committees are described as well as the involvement of village health committees in the promotion of health care.

4.3 CONCEPTUAL FRAMEWORK

The conceptual framework explains the main aspects to be studied, the key factors, constructs or variables - and presumed variables among them (Miles & Huberman 1994:18). It derives its boundaries and parameters from the problem, purpose, and variables of the research area. This research was on the village health committees in Botswana, and the role of nursing leadership in these village health committees which are a form of community participation, involvement and organisation for health development.

Objectives

The research intended to determine and assess:

• the role played by the nurse in establishing, promoting and facilitating the community's active involvement and participation as well as organisation for health

• innovative activities for community organisation, participation and involvement

• nurses' supervisory roles and what distinguishes leadership from management strategies
• motivational levels of nurses and their supervisees/subordinates (family welfare educators), and village health committee members, as a yardstick for health promotion and disease prevention.

Further explanations on the nurse's leadership role in village health committees' support is discussed in the conceptual framework under Figure 4.1 below.

Figure 4.1: Conceptual Framework for the Nurse's Leadership Role in Village Health Committees
The Nurses Action

As discussed in Chapter One, the nurse has a challenge of being expected, in addition to provision of health preventive, promotive, rehabilitative and curative responsibilities, to possess other qualities so as to be effective and efficient. He/she is required by virtue of the role played to also be an administrator, a manager and most of all a leader.

Administration and

... Management must be understood as a position, but leadership may or may not be tied in a position of authority in an organisation; leadership is a relationship of influence, whereas management must be understood as a relationship of authority with its resultant manager-employee relationships; leaders create and managers regulate; and leaders enjoy and want ambiguity since it allows for change but managers prefer predictability" (Manfredi & Valiga 1990:4).

Managers adapt impersonal attitudes towards goals, accepting those espoused by the organisation. They work to perpetuate existing institutions. On the other hand, leaders are imaginative and are driven by ideas and possibilities, not assurances.

The problem with many organizations and especially the ones that are failing, is that they tend to be overmanaged and underled (Charlton 1992:unnumbered paper).

Again, according to Charlton

Managers have a distorted view of the people they manage. Fewer than twenty percent today manage as if
their workers are competent. Yet, realistically, very little that managers do would have any relevance at all if it were not for one basic fact: by and large: people are capable of doing what needs to be done.

The research intends to establish the nurses' leadership roles and qualities as separate from the nursing duties' management activities. For nurses to work in collaboration with the community and enable them to establish health promoting and disease preventing goals they would have to be creative and deal with change; they would have to put themselves in their place and work beyond just the espousing the nursing of patients which is the aim of their institution. To achieve their goals, nurses would have to provide community members with skills to enable them to do certain things for themselves and reduce reliance and dependence on health institutions. At the same time they will have to continue with their regular nursing role.

The Family Welfare Educator:

The family welfare educator is first and foremost a community motivator. To do this she/he must continuously engage in community assessment and have clear and full knowledge of the community. To do this she/he has to know the people well enough to observe adoption of health promoting behaviours.

The above can be achieved with positive interpersonal relationship building between both the people and the nurse. This would reduce and avoid resistance to change and rejection by those whose health the family welfare educator is challenged with health problems to bring about positive change in people's health status. The same applies for nurses. For this health motivator
to succeed, even in the provision of basic curative health services, a continuous pre- and in-service training programme from the immediate supervisor is necessary.

Both the nurse and the family welfare educator require training and supportive environments to nurture, strengthen and build their leadership qualities and skills. It is only when armed with confidence, skills, knowledge, facilitative and supportive environments that nurses can support the community that they serve. This way, they can also support the family welfare educator/motivator, and enable the community to acquire knowledge and to further adopt health promoting and disease preventing behaviours. Most often communities have knowledge but, have not been enabled to synchronise this knowledge, behaviour and action to acquire the best results.

The Village Health Committee Member

The village health committee members also require to possess leadership skills and be exemplary. That way, they will be able to educate those with whom they share health information. The community will be educated only if they are able to convert the information they have acquired into positive behavioural actions that prevent diseases and promote health. It is with correct health information, and after being completely convinced, and after denials and initial resistance that people mostly decide to undergo change and adopt certain healthful practices and behaviours for good. Often those who do not need persuasion and are easy to change also tend to be easy to
revert to their initial practices. Again, constant and continuous support from motivators contributes towards ultimate behavioural changes for best results. Village health committees' performance should reflect their support or lack of conditions and status. Often, unfortunately, nurses are expected to produce required positive results without having been introduced to any leadership skills building strategies themselves throughout their pre- and in-service training.

4.4 METHODOLOGICAL APPROACH

Methodological approaches refer to the broad areas of research that reflect the factual or doing activities inherent in the research process. The methodological approach provides the researcher the basic direction in answering the question: How can the research question be most appropriately answered or what path must be followed to obtain answers that are consistent with the question being asked? (Hogstel & Sayer 1986:56).

The purpose of the research was to gather information on the organisational skills, role, support activities, involvement, sensitisation activities, participation and motivation of the nurse in the development of village health committees. The intent was also to determine the motivation and effectiveness of village health committees. The research was conducted over the period of February 1995 to November, 1998.

4.4.1 Methodology

Qualitative measures were used in focus group discussions to get the attitude, personal experiences, interpretations and the understanding of existing
problems by village health committees. Data collected by the use of focus groups was used to verify and/or refute assumptions. The quantitative measures were used to test assumptions.

This was done by manipulation of numerical data through statistical procedures for the purpose of describing the role of the nurse in the functioning of village health committees (Polit & Hungler 1995:653).

The focus groups' participants described situations and actions of their committees in sequence, and facilitated extensive and rich descriptions of their experiences. The interviewer on the other hand continued to seek further clarification through probing, rather than coming up with ready-made categories and schemes of interpretation. The presupposition of the method implies an openness to new and unexpected phenomena (Kvale 1983:176). It is focused on certain themes.

The main problem of analysis is: how should extensive material be structured for systematic analysis? In practice, the strictly quantifying forms of analysis in the positivist science-oriented tradition proved difficult to apply meaningfully. The researcher had to resort to the individually developed analysis of completed interviews through repeated replaying of radio tapes and written interview materials put together through cut out and taped together matching information as explained by Kvale. This proved to be a stressful, tiring and time consuming system, as opposed to the already
structured quantitative method. Effort was required to ensure exclusion of biases or exaggerations.

4.5 TRIANGULATION

This research has used two methods to collect and interpret data about the impact of nursing leadership on the role of village health committees. Triangulation has been defined as

*The use of multiple methods or perspectives to collect and interpret data about some phenomena, in order to converge on an accurate representation of reality (Polit & Hungler 1991:656)*

hence the use of both qualitative and quantitative methods in this regard, in an attempt “to provide a basis for convergence on truth” (Polit & Hungler 1991:383). The hope is that the two methods will complement each other and thus, the weaknesses of the use of a single method would be diminished. Quantitative data that usually is valid and reliable has at times proved to be superficial, due to its failure to capture the full context of the situation because of its tight controls. These controls invariably reduce complex human experiences, behaviours and characteristics to numbers. Qualitative data on the other hand is weak on quantitative data strengths but, it has flexibility.

The qualitative method has strengths that yield insights into the true nature of complex phenomena, as it collects a wealth of information. Reliability in this method is, however, not always assured.
Triangulation was incorporated into the entire methodological process of the research. However, it has not been given the prominence it deserves, given the fact that the loopholes that can compromise the study, such as focus group discussions, have been used in the addressing of the limitations of the study.

4.6 FOCUS GROUPS

The first step was to conduct qualitative research to assist in developing questions that are relevant for further investigating the role of village health committees and the support they receive from nurses. For focus group questions refer to Appendices 1A and 1B. The qualitative research method refers to research concerned with the collection, collations and analysis of data that is not amenable to quantification. It was decided to conduct focus group discussions to enrich and strengthen the development of questionnaires to be used for the quantification of data.

Focus group sessions are a qualitative research technique ... where it is considered essential to understand the psychological and behavioural underpinnings of consumer behaviour and to identify ways and means to influence this behaviour (Folch-Lyon & Trost 1981:443).

As opposed to the highly structured nature of the usual quantitative research techniques, the focus group discussion emphasizes the creation of an unstructured, although subtly directed, informal and permissive atmosphere in which a dynamic group interaction develops.
As a result of this dynamic interaction, focus group sessions offer a number of advantages. Given the proper environment, participants are less on guard against personal disclosures because the atmosphere is tolerant, friendly and permissive even when selfish, egocentric, aggressive, "daring", or questionable judgments are voiced. Personal revelations are facilitated by other group members who support, commend or disagree, as well as relative homogeneity of the group which acts as an encouragement for all to express strong opinions or ideas. The lively dialogue activates memories, feelings and experiences in a manner similar to the process of free association” (Folch-Lyon & Trost 1981:443).

As a result of intragroup stimulation, a group discussion with ten participants yields much more and richer information than ten individual interviews. A focus group discussion takes place in a comfortable venue under a relaxed atmosphere. After the introduction all participants are encouraged to express their points of view, experiences and feelings freely and spontaneously. Rapport and confidence have to be established between the moderators and the participants as well as between the informants/participants. Ideally the moderator/facilitator plays his/her role in such a way that participants do not even realise that they are guided from one subject to the other. The focus group discussions in this research were used to assess the attitude, personal experiences, interpretations and understanding of existing problems by village health committees.

Two health educators, Mr. F. Mokganedi and Mr. J. Moalosi participated in conducting of focus group discussions. Mr. D. Nchile, Statistician assisted as necessary. Despite the fact that one of the research assistants had participated in researches before, both assistants were trained by the researcher in
conducting focus group discussions, as well as in the analysis of focus group discussions data. Their training emphasized the importance of climate setting, whereby no discussions started until all participants/discussants were relaxed and had trust in the moderators/research assistants. They also were trained to just probe but not pre-empt discussions or do the talking; that is, they were not to influence or direct answers. Moderators/research assistants were also trained in data analysis as follows: in the
- use of the same protocol for analysis, to avoid the use of different approaches;
- transcribing of the tape recorded information, plus checking and rechecking the transcripts;
- listening to the tapes and comparing the capture of each word in the transcripts with the information in the tapes;
- photocopying and coding of the tape;
- importance of
  - keeping the tapes in a safe place; and
  - reading the transcripts several times for purposes of getting an overview of the contents and identifying the main concepts as well as to identify sub-categories.

4.7 TARGET POPULATION

The target population for the qualitative research was members of the village health committees in Botswana. To date it is not known how many village health committees are in existence in Botswana. What is known is that every town and big village are reporting to have more than one village health
committee. All small villages are reporting to have at least one village health committee. At the end of 1979, according to Mobea (1984) in Omondi et al (1987:13) there were sixty seven village health committees in existence; these village health committees have been steadily increasing in number over a period of time. Some of these committees were active but a number are quite inactive.

4.8 SAMPLING

For focus group discussions two representative villages were selected from the peri-urban basket. These were Kweneng East, being Mogoditshane, and the South East District, being the Ramotswa Village using the listing method described under 6.3 on page 105. Mogoditshane happened to have only one village health committee. Ramotswa had several village health committees. These were listed. Then each village health committee's name was cut out, folded and put in a plate. Only one paper was picked out and opened. The Siga village health committee in the South Eastern part of the village, was picked and thus selected for focus group discussions.

To join the focus group discussions one had to have been an active member of a village health committee for over a year. Literacy was an added advantage but not mandatory.
Figure 4.2
The most difficult problem became establishing the size of the discussion group in advance. Predicting how many of the invited members of village health committees would actually show up for the sessions was also very difficult. This was more so because of the distance of the villages to be visited, planning from a distance, and the fact that quite a number are employed and could only be available after hours. The researcher thus had to over-recruit in case others do not show up.

A conceptual framework as well as a set of questions and some predesigned devices for collecting focus group discussions data had to be prepared before hand and be put in place.

Sampling was purposive. Here the researcher selected only persons who have actually served specifically in a village health committee (and not any village committee such as the Home-based Care Committee, that is specifically for terminally ill patients only). Secondly, a purposeful attempt was made to include both male and female village health committee members; males are not particularly active in voluntary and health activities in Botswana. Newly chosen village health committee members (those that have served for less than a year) were excluded since they would not have any information on the committee’s roles and activities. They also had no experience of actively and closely working with nurses in community organisation for health to have observed their supervisory and subsequently leadership skills.
With the focus group discussions all present village health committee members participated. In the pre-test ten (10) members had participated. In the first focus group 15 participated and in the second focus group 20 participated.

4.9 ETHICAL CONSIDERATIONS

Ethics refer to "a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to the research subjects" (Polit & Hungler 1995:641). People should have the freedom to participate or not to participate. The issue of ethics was accorded importance in this research more so as it was using humans. Great care was taken that the rights of the participants were protected.

It was ensured that no nurse will suffer because of information obtained from the research. Village health committee members were also not coerced to participate. All participants were accorded the respect and human dignity, that are their right. In the case of this research, the pretesting of the questionnaire also built in trust and took care of interviewees' participation as well as the questionnaires' clarity and acceptability.

The issue of control of extraneous variables' procedures is an important component of the research design. Some of the important variables included are discussed below:
Ethics

Establishment of Trust

It became vital that before any collection of data could be embarked upon, rapport be established between interviewer and interviewee(s). This way, the research credibility was enhanced. Respondents were more likely to provide honest information where they trusted that it was not going to be used for negative purposes or against them.

Involvement in a research study should not place subjects at a disadvantage or expose them to situations for which they have not been explicitly prepared (Polit & Hungler 1995:120).

Issues of ethics included ensuring that trust was built into the whole research process. Care was taken to ensure that the research neither resulted in the intimidation or exploitation of village health committees nor had any negative impact on nursing leadership or repercussions on the profession.

In this particular research, the pretesting of the questionnaires intended to, among other things, build in freedom as well as to take care of clarity and acceptability. Here data was consistently and accurately collected, with the intent to reduce errors of measurement such as lack of reliability and validity mentioned above. The correct storage of data and exclusion of own perceptions that were planned for, were for purposes of increasing the reliability and credibility of the measuring instrument and subsequently making the results more accurate.
Approval/Informed Consent

Firstly, subjects were given all the necessary information. Before any data collection was begun, specifically where it involved obtaining information from individuals, approval was solicited from several sources such as the interviewee, supervisors and the Office of the President. "The concept of informed consent is one that implies that all individuals have human worth and dignity, that they have control over their own bodies, and that they should not be subjected to any kind of research that could harm them" (Hogstel & Sayer 1986:91). As a form of informed consent, "tape recorded interviews may include verbal agreement by the subject at the beginning of the interview" (Hogstel & Sayer 1986:92).

Because of the literacy issues in some cases, and the fact that people did not feel necessarily obliged to respond to the questionnaire even where they are literate, the face-to-face focus groups' method was used to

... allow individuals to ask about the meaning of questions. These types of interviews can collect information from people who may have difficulty reading or seeing (Fink 1993:95).

As a way of safeguarding the rights of the participants the following were agreed upon with participants:

- Anonymity and confidentiality were ensured to the participants, as their names and the area from which they came would not be made known.
- Informed consent was obtained, by explaining the purpose of the research.
• Consent was also obtained to use a tape recorder and to transcribe the interview verbatim, after which the transcription would be used for coding.

• Results would be made known on request.

• Participants were allowed to withdraw from the discussions at any stage.

• Participants were given the assurance that they would suffer no physical or emotional harm.

4.10 DATA ANALYSIS OF THE FOCUS GROUP DISCUSSIONS

For the data analysis of the focus groups, Kerlinger's (1986:477-483) method for content analysis was used. The researcher and the moderators or research assistants analysed the data. The following steps were therefore followed:

• The researcher and moderators discussed and used the same protocol to analyse the data.

• The data from the tape recorder was transcribed and the moderators assisted the researcher in checking the transcriptions. The moderators were given the transcripts and the tape recordings to listen to and compare the capture of each word in the transcripts. A final check of the recorded words against the written/transcripts was done by the researcher before typing the transcripts.

• Photocopies of the transcripts were given to the moderators for coding. The tapes were kept in a safe place, for reference and auditing purposes.
• The transcripts were then read to get an overview of the contents and this was repeated several times. The main concepts were underlined and verified with the moderators to identify the main categories.

• Transcripts were re-read to identify sub-categories.

4.11 RELIABILITY AND VALIDITY

Woods and Catanzaro's (1988) criteria for reliability and validity was used as applicable to this study, to explain the measures used to ensure reliability and validity.

The data was decoded by the researcher, the two research assistants and the statistician, after listening to the radio recordings and after their being translated into English. They all confirmed the findings as stated.

4.11.1 Reliability Factors

*The status of the researcher:* The status of the researcher is known to the group as she has been working with them for years, and a trusting relationship has been built. The role of the researcher as a student doing her D litt et Phil studies were explained to the participants as well as the role of the moderators in the process.

*Criteria for participation:* The criteria for participation was spelled out.
Procedure for collecting data: The strategies for collecting data was clearly described and noted. Tape recordings were made to audit the data. Two monitors were used to decode the data.

Reliability of the data collected from the focus groups was also ensured by having three different people decoding the data obtained after listening to the tape recorded data and transcribing it. The categories obtained from the data was confirmed by all the people involved in the decoding.

4.11.2 Confirming the Findings of Focus Groups

The Credibility of the findings from the focus groups were ensured by spending enough time in the research setting and knowing the context in which the observations were made and interviews were conducted. The moderators who assisted in interviewing, made observations to differentiate the relevant from the irrelevant (Woods & Catanzaro 1988:453).

Triangulation increased the credibility as questionnaires and individual interviews were used as a follow-up of the focus groups. Making use of research assistants/moderators also provided the opportunity to work as a team that could discuss the evolving data. The informants/participants also had the opportunity to revise the transcribed data (Woods & Catanzaro 1988:453).

Transferability of the findings to another area where use is made of village health committees is possible if the social situation is similar.
Confirmability is ensured by having the raw data available on tape and transcriptions. This way information can always be verified. All the observations and findings are recorded (Woods & Catanzaro 1988:454).

4.12 PRE-TESTING
A pre-test was done in a village which was not included in the final focus group discussions. A group of ten (10) members of the village health committee was interviewed, using the same method as described below. Due to unforeseen problems the recordings were barely audible, despite the fact that the instruments had been tested prior to use. For the analysis notes were used and observations made during the discussions. It was, however, clear that the way in which the discussions were conducted would give the researcher the required information during the final discussions.

4.13 CONDUCTING FOCUS GROUPS DISCUSSIONS
The intent was not to use and treat the two research methods, qualitative and quantitative as equal. The focus groups had been used as the initial step to break the ground, moreso that since the formation of the first village health committee in 1976 a research had not been undertaken to focus specifically on the role of nursing leadership in their promotion and sustainability, despite the fact that the nurse happens to be playing a role in the functioning of the village health committee. This has been evidenced especially by changes that have been observed to be related to the functioning of some village health
committees in relation to transfers of nurse leaders from one area/district to another.

This research being a new ground to venture into, required that the two questionnaires' items or questions, one for the village health committees themselves, and one for the nurses, should be “the researchers' likely interpretation of the question” (Brodigan 1991:2). It was very important that from the onset the wording of the questionnaire was such that both the interviewer and respondents understood issues the same way. Furthermore, the focus group sessions provided a “familiarity audit” (Greenbaum 1988:29).

Having some information and idea at the outset about the kinds of perceptions village health committee members have about nursing leadership and support in their work would direct or assist the researcher to develop questionnaires containing items which would measure the extent of those perceptions (Brodigan 1991:2). As such, the research problem was studied using more than one technique in order also to establish confirmation of the researcher's findings. The research technique assisted and strengthened the researcher's reason to believe that the findings are reliable, and corroborate findings.

Contact was made with the members of the focus groups first by the researcher after which the moderators were introduced. It was ensured that the physical setting where the discussions took place was free of any
interruptions. It was comfortable and within reach of the participants. The following information was given to the participants:

- The purpose of the research and the role of the researcher and moderators were explained to them.

- They were informed that they could withdraw from the discussion at any stage.

- Discussions would continue until a point of saturation was achieved and no new information was given by the participants.

- Permission was obtained to use the tape recorder and the purpose was explained. It was also explained that if any of the participants felt at any stage that they would rather have the tape recorder switched off, it would be done.

Some time was spent on establishing rapport with the participants through making them feel at ease and comfortable. Once the climate was set and the participants were at ease and relaxed the following probing questions were posed:

"How did you become a member of the village health committee?"

"What are your roles as a member of the village health committee?"

"What problems do you experience as a member of a village health committee?"

"What support systems are available to you as a member of the village health committee?"
Discussions went on until focus group members were satisfied. On the average discussions took 40 minutes. There was however a lot of repetition.

4.14 ADVANTAGES AND DISADVANTAGES OF FOCUS GROUPS

The advantages of the focus group discussions were as follows:

- it was efficient in getting the required information
- the researcher obtained the viewpoints of many individuals in a short period of time
- it allowed for all information to be captured, including the actual mood, expressions, emotions and exclamations
- it was taped recorded, as such all information was optimally used and could be listened to over and over again
- information from focus group discussions was used for the refining of the structured data collection tool (questionnaire)

The disadvantages of the focus group discussions were as follows:

- some people were initially uncomfortable about expressing themselves as well as their viewpoints in front of a group
- the interviewer had to work very hard at setting a relaxed climate and eliminating irrelevance without exposing those who were irrelevant.
4.15 SUMMARY

In this chapter the qualitative research method used with focus group discussions was discussed. In Chapter Five, a discussion will be given of the analysis and findings of the focus group discussions.
CHAPTER FIVE

ANALYSIS AND FINDINGS OF THE FOCUS GROUP DISCUSSIONS

This Chapter presents the analysis and discussions of information obtained from Focus Group Discussions.

5.1 INTRODUCTION

Focus group discussions were conducted at Ramotswa Village with the Siga Village Health Committee, a very strong and committed village health committee, and with the Mogoditshane peri-urban village health committee. The focus group discussions pre-test was also conducted with the Otse Village Health Committee in Otse Village. "A pre-test is sometimes desirable as a check on proper implementation of a programme" (Fitz-Gibbon, Taylor & Morris 1987:38). Otse is a very fast developing village, about 25 kilometres north of Lobatse town and 50 kilometres south of Gaborone city.

5.1.1 Focus Groups Pre-test

Focus group questions were pre-tested at Otse, with the Otse Village Health Committee. Here only ten (10) members were present, although more than double the number had been recruited. Among problems cited for the low turn up were that quite a number of people are in employment, and most would be available around six o’clock in the evening. Developments taking place there include among others, construction of a big police college to cater for the whole country. This is where a number of village health committee
members were reported to be working. Others were reported to be working at the Moeding College. Perhaps because of reports that the newly formed Home-based Care Committees for the terminally ill had a likelihood of payment for services rendered, some village health committees concentrated more on them. What was gratifying was that despite these engagements it was reported that on knocking off duty, regardless of how late it was, these village health committee members still devoted some of their time to home visits including to some disease prevention and health promotion activities.

The Otse Village Health Committee members engaged in all activities undertaken by all other committees except for vegetable gardening. The very impressive Otse clinic vegetable garden was reported to be wholly the clinic staff programme. It was also well cared for, and fenced. The village health committee still had the advantage of using it for demonstration purposes and nutrition education.

5.1.2 Focus Group Sites

Two focus group discussions were held at two different villages namely:

- Ramotswa: which is 34 kilometres south-east of Gaborone City and under the South East District Council. Twenty (20) Siga area village health committee members participated; of these four were males and sixteen (16) female.

- The village health committee members who participated here were selected according to purposeful sampling as described in Chapter Four under 4.8.
A village health committee in Ramotswa, the Siga Village Health Committee was selected through the earlier described sampling method. Twenty (20) members, four (4) males and sixteen (16) females participated.

- Mogoditshane: which is a mainly high density peri-urban area nine (9) kilometres west of the Capital City, Gaborone, in the eastern part of the Kweneng East Health District was also selected. Again the researcher had recruited a number of village health committee members. Using the same purposeful sampling method fifteen (15) female members were selected for participation in the focus group discussions.

Focus group discussions were conducted for village health committees only. It was then decided that it was not necessary to continue with focus groups, as the information obtained was sufficient to assist in refining the questionnaires for the quantitative data collection.

On referring to Appendix 1A and 1B, one realises that village health committee members do not have a uniform way of answering the same question. At times an answer is provided before the question to be asked has been posed; answers, therefore, now and then precede questions. This leads to some questions not being asked but to answers being provided. One question posed could lead to covering of other areas.
5.2 ANALYSIS OF THE DATA

After the discussions were transcribed as indicated in Chapter Four page 75, coding was done by the researcher and the two moderators. Consensus discussions were held with the moderators to validate the analysis. The interview is added as Appendix IA and IB. Data overload was reduced through constant reference to the conceptual framework and the research/focus group questions.

The main categories that were identified were:

- membership
- monitoring the environment
- health promotion
- problems
- support

In table 5.1 the main categories with their respective sub-categories are displayed.
<table>
<thead>
<tr>
<th>Main Categories</th>
<th>Sub-Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership</td>
<td>Kgotla - chosen - volunteering</td>
</tr>
<tr>
<td>Health Promotion</td>
<td>Health education, disease prevention, prevalent health problems, vegetable gardening</td>
</tr>
<tr>
<td>Problems</td>
<td>Lack of any employment; too far from institutes</td>
</tr>
<tr>
<td>Support</td>
<td>Nurses, Family Welfare Educator</td>
</tr>
</tbody>
</table>

Table 5.1: **Categories with Sub-categories Extracted from the Focus Group Discussions**

Kerlinger's (1986:477-483) method for content analysis was used. The researcher and an independent researcher analysed the data. The following steps were followed:

- The researcher and the independent researcher discussed and used the same protocol to analyse the data;

- the data from the tape recorder was transcribed and the independent researcher assisted the researcher in checking the transcripts. The independent researcher was given the transcripts and the tape recordings to listen to and compare the capture of each word on the transcript; then a final check was done by the researcher before typing the transcript.

- photocopies of the transcripts were given to the independent researcher for coding. The tapes were kept in a safe place, for reference and auditing purposes.
• the transcripts were read to get an overview of the contents. This was repeated several times. Prior to re-reading the main concepts were underlined and verified with the independent researcher to identify the main categories. These categories were:
  - monitoring the environment;
  - health promotion,
  - problems, and
  - no remuneration nor allowances for village health committee members.

• transcripts were re-read to identify sub-categories. The following were found with the trial-run/pre-list:
<table>
<thead>
<tr>
<th>Categories</th>
<th>Sub-Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring environment</td>
<td>Health status, cleanliness, monitoring treatment taking, referring those who require assessing, home environment and reporting accordingly, nurses care.</td>
</tr>
<tr>
<td>Health Promotion</td>
<td>Health information, education and communication, follow-up of discharged patients, disease prevention, supervision of treatment taking and encouragement provision, prevalent health problems addressing, vegetable gardening, positive behavioural change promotion.</td>
</tr>
<tr>
<td>Problems</td>
<td>Home-based care handling, volunteering and having to find full time employment, inadequate supportive structures, constant transfers especially of supportive nurses, drought prone conditions and poor soils, significant drop out of members.</td>
</tr>
<tr>
<td>Status of Volunteerism</td>
<td>Chosen by community members at the traditional gathering place. Some volunteer.</td>
</tr>
<tr>
<td>Support Provided by</td>
<td>Nurse(s), Family Welfare Educator/Community</td>
</tr>
<tr>
<td>Commitment</td>
<td>Complete commitment to community work, need for continuous information on health issues.</td>
</tr>
</tbody>
</table>

Table 5.2: Role in Health Development - Mogoditshane Village Health Committee
<table>
<thead>
<tr>
<th>Categories</th>
<th>Sub-Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring environment</td>
<td>Health status, cleanliness, monitoring treatment taking, referral for treatment, home environment assessment and reporting, nurses care.</td>
</tr>
<tr>
<td>Health Promotion</td>
<td>Health information, education and communication, follow-up of discharged patients, disease prevention, supervision of treatment taking and encouragement provision, prevalent health problems addressing, vegetable gardening, positive behavioural change promotion, inter-district competitions.</td>
</tr>
<tr>
<td>Problems</td>
<td>Home-based care for terminally ill, inadequate supportive structures, lack of gainful employment, drought, some drop out of volunteers.</td>
</tr>
<tr>
<td>Status of Volunteerism</td>
<td>Chosen by community members at the traditional gathering place. A few volunteer.</td>
</tr>
<tr>
<td>Commitment</td>
<td>Complete commitment to community work, not very serious concern for gainful employment though the need for employment expressed.</td>
</tr>
</tbody>
</table>

Table 5.3: **Role in Health Development: Siga Village Health Committee**
5.2.1 Membership

The question that represents this category was: How did you become a member of the village health committee? The two sub-categories that emanated from this for both village health committees was being selected at a kgotla and volunteering to became a village health committee member.

Kgotla

Following a meeting at the kgotla organised by health workers following the sensitisation of the chief and the community regarding village health committees, elections of members are conducted whereby people are chosen by community members. However, a number of the selected people do not always take action.

Well I was myself never chosen at the kgotla; my friend who is an elected member told me about what they do and got me interested. First I accompanied her. Then I realised that this was something I would like to be actively involved in. I then joined. (Translated version of Member of the Mogoditshane Village Health Committee:1998 recording)

Voluntary Participation

Those who were motivated by the selected members, volunteered to become involved. These were among those who were retained. Quite a sizeable number of those who were chosen by popular vote are also still volunteering on a full-time basis. However, a number of them are now in employment, and only volunteer after hours, because of the need to earn a living by getting some form of payment and to survive.

Much as we are prepared to volunteer and to take active steps to motivate everyone to adopt behaviours
that are conducive to health, we need shelter and clothing, especially to bring up our children and to also remain healthy. That is, we appreciate the importance of individual participation in bringing about positive health. We spend our time helping others, but we do not even receive a token honorarium that could motivate us. We are left with no option but to seek full time employment elsewhere. This leaves us with very little time, if any, for our health motivational activities' role. (Focus: Mogoditshane Village Health Committee)

Africa's health problems are not confined to infectious diseases, although they reflect the pervasiveness and degree of ill health, according to Macgregor (1991:146), indeed what is clear is the connection between these ailments and poverty. "Disease creates poverty; and poverty is continuing to maintain the cycle, and the conditions that foster disease" (Macgregor 1991:146). In receiving no form of remuneration or even honorarium and forced with environments, that promote reliance on cashed economy, such as poor soils, unreliable rainfall and poor agricultural technological knowledge, it is only understandable that village health committee members would seek employment especially in an attempt to get out of the poverty trap and subsequently ill-health. Their call for some honorarium is thus justifiable.

Historically, the realisation that the health status and well-being of people are a product not only of health programmes but also of socio-economic development and active participation of the people, provided the main impetus for the development of Primary Health Care (Macgregor 1991:146)

A call for some form of income supplementation does therefore, make sense where necessary. This would actually not negate volunteerism, but motivate it and support sustainability.
5.2.2 Role of Village Health Committees

Two main categories were extracted from the question: What are your role as member of the village health committee? These were: monitoring the environment and health promotion.

*Monitoring the Environment*

Sub categories identified from monitoring the environment were health status, assessment, addressing, monitoring, evaluation and follow-up, cleanliness promotion and referring of patients who require services that village health committee members were not able to provide.

*Health Status*

Monitoring the health status of the community was mentioned by both focus groups. The community is encouraged to seek medical treatment for tuberculosis and other ailments. Patients with tuberculosis are monitored by encouraging them to take their prescribed treatment; and, the taking of the medicine is also monitored. Defaulters are reported to the health care facility. This is also done for other clients on treatment. Those not seeking medical intervention are referred so that the nurse can follow them up. Fulfilment of this role is, however, becoming very difficult as everyone is looking for work, trying to make a living, because the village health committee members are not remunerated for their services.

_We do house-to-house visits in our wards encouraging those that are ill to visit health facilities, ensuring that those on treatment at home do not default and that they_
take their treatment accordingly. We also alert family welfare educators and nurses of serious cases that have not sought medical attention; otherwise they are too busy to know about problems in the village that should have reached them. They always appreciate and take immediate action. It is saddening that unlike other committees that do not even do anything near this work, we receive absolutely nothing in appreciation. Our being in full time employment denies those who require our services care, especially these days when many people are nursed at home. We would appreciate to get some form of remuneration (Focus group discussant 1998:Mogoditshane Village Health Committee).

A good working partnership does not happen by chance. It requires deliberate and well planned actions to develop and sustain it. Time and other resources must be invested in setting up mechanisms for collaboration (International Council of Nurses 1998:3)

Cleanliness

The cleanliness of the living environment is also monitored by the members of the village health committee. They then give the community information on the role that cleanliness plays in having a healthy community, and encourage community members to monitor their environments, and to take action in the promotion of making their own environments healthy.

We live in a village where there are no reliable services yet for refuse disposal. We also rely heavily on pit latrines, and have no flush latrines. Part of our work involves encouraging communities to dig refuse pits that can be covered once full. This is to avoid dumping refuse everywhere. We also promote the building of pit latrines. However, ever since we heard of pit latrines contaminating underground water here in our area, we are very worried and even hesitant regarding encouraging people to continue to dig them. We wish to have a safe sewage system. If underground water is indeed already being contaminated by pit latrines the urgency for the provision of a sewage system cannot be over-emphasised (Focus group discussant 1998:Siga Village Health Committee).
Referring

Cases that need nursing or medical care are referred to the family welfare educator, the nurse or doctor for attention.

Health Promotion

Health promotion could be sub-divided into health information, communication and education, disease prevention, prevalent health problems and vegetable gardening promotion as a means of improving nutritional status.

Health Information, Education and Communication

Providing information on prevention of ill-health and promoting health were indicated by all of the participants as important. Participants considered the village health committee as a very important institution whose role is prevention of ill-health and promotion of health. This is done by giving health talks to the community. After assessment and community diagnosis the village health committee member usually provides health information.

Disease Prevention

Health education to promote health is giving information on how to prevent diseases for example AIDS. This was done on a continuous basis. Part of the village health committee members' orientation included providing them with skills to undertake a rough community evaluation, which is usually a small ward's assessment and diagnosis of prevalent problems that negatively affect health. These were said to vary from district to district, village to village and
ward to ward, up to the smallest community grouping. Problems addressed included services where possible and were informative in the following:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Sub-Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Health</td>
<td>Immunisation, Growth monitoring and nutritional status, Diarrhoea prevention and management, Referrals,</td>
</tr>
<tr>
<td>Adolescent Health</td>
<td>Teenage pregnancy, Services for teenagers</td>
</tr>
<tr>
<td>Maternal Health</td>
<td>Ante-natal care, Post-natal care, Prevention of pregnancy/family planning, Infertility treatment, Safe delivery i.e. under supervision, Referrals.</td>
</tr>
<tr>
<td>HIV/AIDS/STDs</td>
<td>Prevention, Treatment, Home-based Care</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Prevention, Treatment and care, Referrals, Care at home, Avoidance of resistant TB</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>Nutritional status, Planned pregnancies, Safer sex, Toilet use promotion, Hygienic practices, Refuse disposal, Water handling and storage, Prevention of violence especially to women e.g. rape, assault, alcoholism, Road accidents and other injuries.</td>
</tr>
</tbody>
</table>

Table 5.4: Health problems identified by both Siga and Mogoditshane Village Health Committees
The above are just examples as problems differ from community to community.

Our role is to educate communities on prevention of diseases and anything that could even make them disabled, as well as where to find health services that they require (Both Focus group discussants 1998)

This is in line with what has been stated by Manyeneng (1984:75-80). Information imparting knowledge and working towards the adoption of healthful living practices are vital components in the promotion of health.

Services should not only be curative, but should promote the health of populations. Understanding of health and a healthy way of life and reach out towards the root cause of disease with an emphasis on prevention (Macgregor 1991:146)

Health information, education and communication activities go beyond just health talk to themes for organised and on-going activities such as during:

- Community leaders' health seminars;
- Responsible parenthood seminars for youths;
- Traditional and spiritual healers, and modern health workers workshops as well as a special focus on any other organised groups not mentioned above, for example, the Police, Red Cross Society, Churches, Girl Guides and Boy Scouts. This sensitisation becomes an on-going process and aims at a situation whereby the organisation will own the programme and assume a leading role to organise and run the same programmes for those that still require more sensitisation to attain desirable behavioural change.
As caretakers of their own health, community members can be mobilised to participate in a wide range of basic health care and intersectoral activities for health, including needs identification, project design, and adaptation of project activities and technologies to local needs (World Bank 1994:122).

Prevalent Health Problems

The prevalent health problems in the area include teenage pregnancies, HIV/AIDS and sexually transmitted diseases, tuberculosis and other chest problems, refuse and sewage disposal.

The participants mentioned that they provide information to the community on these diseases and health problems, and give them guidelines on how to prevent them and what their symptoms are. The community is also made aware of when to seek medical advise and treatment.

Participants at the Technical Discussion on “Leadership Development for Health for All” made a personal commitment

To promote self-reliance and enable others, particularly within the home and at the community level, to take greater responsibility for their own health and the health of their communities, through informing and educating them and developing their leadership potential (WHO 1988:29)

Vegetable Gardens

Among the activities undertaken by the members of the village health committee was engaging in, and getting the community involved in vegetable gardening. In this way the community could provide vegetables which are
given to patients with tuberculosis as well as to undernourished children. The vegetables were also sold for revenue purposes and proceeds thereof distributed to needy patients. This gardening was done mainly within clinic premises, where water was always available.

Where the health committee’s garden is within a health facility’s grounds,

- apart from assurance of water there is a likelihood of protection from animals by fencing, which often is done using government resources;

Much as it is believed that within facilities gardens will be fenced against animals, for the Taung and Siga Village Health Committees it was not the case.

We contributed and bought seeds for beetroot, cabbage, carrots and other vegetables. We also tilled the garden/soil, used fertilisers and removed weeds. The Agricultural Officer worked with us to ensure a good harvest. During office hours our garden was well looked after as the clinic gardener was present all the time; he chased away all goats and sheep. During weekends animals ate all our plants. As you can see this fence is in disrepair. It has been needing repair for a long time. Even the clinic fence itself has holes. The request for fencing has been made months ago, but to date there has been no action (Focus Group Discussant: Siga Village Health Committee).

Not only problems but also solutions must be presented in order to help people to act. Enabling factors helping people follow health conducive behaviour include:

- creating resources for innovative solutions to different problems.

(Haglund, Finer, Tillgren & Petterson 1996:25)

- Vegetables realised are very likely to be used for undernourished children, and pregnant mothers who are assessed at the health facility.
More people stand a chance of learning vegetable gardening under guidance of knowledgeable officers.

5.2.3 Problems Experienced

Expressed problems were indicated earlier in sub-categories under Table 5.1. Since village health committees often organise their work in such a way that one oversees a ward within easy reach, lack of transport for home visits was not identified as a problem. Other problems included inadequate resources in general, especially for those nursed at home who used to earn a living and are no more able to fend for themselves.

Home Based Care

Devoting a sizeable part of their time to home based care visits of persons suffering from terminal illnesses such as AIDS, left very little time for any other activities.

We thank Government for the social security that we are accorded. Much as this is not enough for the whole family and is actually meant to maintain the elderly, it has really come in handy especially as a number of young people who used to be bread winners are now made dependant and very poor by AIDS related diseases. This has now become the only source of survival (Focus Group Respondent 1998:Siga)

The Cruelty of this disease is the stigma that goes with it. I know a client whose children, the very ones she supported and educated, do not even visit her anymore since she was diagnosed. She now lives in abject poverty; she used to live quite comfortably before (Focus Group Discussant 1998:Siga)
The Government of Botswana has re-employed retired nurses, social workers, family welfare educators and other relevant cadres for purposes of strengthening the home-based care programme. The role of the village health committee member in this area will remain important since proximity is not the problem. Strict duty times are not observed. Village health committee members are in a better position to understand the disease culture prevailing.

**Allowance**

Due to drought and poor soils, people cannot afford to volunteer without any form of remuneration. They are forced to seek employment in order to survive. Other committees, such as the mother committee, which is the village development committee, are getting a regular sitting allowance from government. There was even talk of a sitting allowance for Hospital Advisory Committees. Village health committees feel that their contributions are not valued. This is discouraging village health committee members, although some are still holding on.

*Would you by any chance be able to explain why we cannot receive something? We mean like village development committee members who are getting a sitting allowance. Does this mean that our contribution is not appreciated? We do a lot; some of those we visit don't even have anybody but ourselves to turn to; we change their linen and feed them (Focus Group Discussant: Mogoditsane).*

5.2.4 **Support Received by Village Health Committees**

The question asked was: "What support systems are available to you as a member of the village health committee?"
Nurses

Members of the one focus group related mostly to the nursing sister who used to be based at the clinic and was now transferred. They recalled her as someone who

- worked with them;
- encouraged and motivated them;
- actively supported them;
- had interest in community work;
- had time for people and for community organisation for health.

The nurse was a leader who unfortunately, after mobilising these community members for action would be transferred. Some felt that transfers could result in a situation whereby a more active new nurse would be appointed to the post. Some of the participants were reluctant to indicate whether they received any support and rather related their experiences.

Health Education Officer

The health education officer was mentioned by the one group as giving the village health committee support and guidance regarding health education. The other group did not mention the health education officer as an existing source of support. They are in short supply and not every district has one. One focus group discussion took place around the annual national health committees' competition, hence they displayed a high motivational level.
We are having a seamstress today measuring us for purposes of sewing our inter-district choir competition uniform (Focus Group Discussant 1998: Siga Village Health Committee).

**Family Welfare Officer**

The same group who indicated the health education officer also mentioned the family welfare officer as someone who supported them in fulfilling their role. However, they recognised the fact that one family welfare educator was responsible for a certain number of people, as opposed to the health educator who would serve a whole district. This was indicated during the Siga Village Health Committee discussions as indicated in Appendix 1(A).

5.3 **SUMMARY**

In this chapter the findings from the focus group discussions were discussed. This information was used to refine the questionnaires used for the quantitative data collection.

In the following chapter the quantitative research method will be discussed.
CHAPTER SIX

QUANTITATIVE RESEARCH METHOD

This Chapter presents the sampling method, data collection and data analysis from the village health committee questionnaire.

6.1 INTRODUCTION

As indicated in chapter four both the qualitative and quantitative research methods were used in this research project. The purpose of the quantitative research method was to gather information on the organisational skills, role, support activities, involvement, sensitisation activities, participation and motivation of the nurse in the development of village health committees. The research was conducted over the period February 1995 to November 1998.

Quantitative measurement refers to the assignment of numerical values to objects or events to represent the kind or amount of a characteristic of those objects or events (Woods & Catanzaro 1988:227). Quantitative research as defined by Hogstel & Sayer (1986:58) is concerned with the quantification of measurement of data.
6.2 TARGET POPULATION

The target population for the quantitative data collection were two categories. The first group was all registered nurses, deployed at the selected research areas, who provide community health services at the village or town level in Botswana, and are charged with the responsibility for public health services' provision. The second category was all village health committee members in Botswana, regardless of sex.

The method involved the use of two structured questionnaires, Appendix II and III, one for the nurses and one for selected village health committee members. They were first pre-tested and results thereof used to recast the questionnaires.

6.3 SAMPLING

According to Polit and Hungler (1991:654)

*Sampling refers to the process of selecting a portion of the population to represent the entire population.*

The first step in sampling a representative number for the questionnaires' implementation was to select a number of health districts from the 22 functioning district health teams. Figure 4.2 on page 69 is a map indicating the health districts in Botswana.
The 22 functioning health districts and their headquarters are as shown below:

<table>
<thead>
<tr>
<th>Health District</th>
<th>Headquarters</th>
<th>District Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Bobonong or Bobirwa</td>
<td>Bobonong Village</td>
<td>4</td>
</tr>
<tr>
<td>2. Boteti</td>
<td>Rakops Village</td>
<td>13</td>
</tr>
<tr>
<td>3. Central or Serowe/Palapye</td>
<td>Palapye Village</td>
<td>3</td>
</tr>
<tr>
<td>4. Chobe</td>
<td>Kasane Village</td>
<td>10</td>
</tr>
<tr>
<td>5. Francistown</td>
<td>Francistown City</td>
<td>16</td>
</tr>
<tr>
<td>6. Gaborone</td>
<td>Gaborone City</td>
<td>15</td>
</tr>
<tr>
<td>7. Ghanzi now spelt Gantsi</td>
<td>Gantsi Village</td>
<td>7</td>
</tr>
<tr>
<td>8. Gomare or Okavango</td>
<td>Gomare Village</td>
<td>14</td>
</tr>
<tr>
<td>9. Goodhope</td>
<td>Goodhope Village</td>
<td>23</td>
</tr>
<tr>
<td>10. Kgalagadi</td>
<td>Tsabong Village</td>
<td>11</td>
</tr>
<tr>
<td>11. Kgatleng</td>
<td>Mochudi Village</td>
<td>9</td>
</tr>
<tr>
<td>12. Kweneng East</td>
<td>Molepolole Village</td>
<td>5</td>
</tr>
<tr>
<td>13. Kweneng West</td>
<td>Letlhakeng Village</td>
<td>20</td>
</tr>
<tr>
<td>14. Lobatse</td>
<td>Lobatse Town</td>
<td>18</td>
</tr>
<tr>
<td>15. Mabutsane</td>
<td>Hukuntsi Village</td>
<td>21</td>
</tr>
<tr>
<td>16. Mahalapye</td>
<td>Mahalapye Village</td>
<td>8</td>
</tr>
<tr>
<td>17. Ngamiland</td>
<td>Maun Village</td>
<td>1</td>
</tr>
<tr>
<td>18. North East</td>
<td>Masunga Village</td>
<td>2</td>
</tr>
<tr>
<td>19. South East</td>
<td>Ramotswa Village</td>
<td>17</td>
</tr>
<tr>
<td>20. Southern</td>
<td>Kanye Village</td>
<td>6</td>
</tr>
<tr>
<td>21. Selebi Phikwe</td>
<td>Selebi Phikwe Town</td>
<td>19</td>
</tr>
<tr>
<td>22. Tutume</td>
<td>Tutume Village</td>
<td>12</td>
</tr>
</tbody>
</table>

The numbering of the health districts was neither done alphabetically nor according to when they were formed or when they started operating. It was done by the Surveys and Mapping Department according to its criteria of mapping.

It then became necessary to arrange the health districts as follows, based on developments such as industries, telephone services, electricity, piped water and tarred road network services, the number of health facilities and distance from the railway line:
The above exercise was quite difficult to accomplish, because the country at independence in 1966 was mainly rural and remote. It continues to enjoy rapid industrialisation and urbanisation. Some health districts, Central or Serowe/Palapye and Mahalapye qualified to be classified as peri-urban because of the availability of services there, despite their not being close to any urban centre. Ngamiland was classified as rural for reasons that it is very far from railway services and its headquarters, Maun, although urbanised is surrounded by villages that mostly qualify to be classified as remote. All the areas classified as remote would enjoy telephone lines, a tarred road passing through it, fewer health facilities, some electricity, and are all considerably far from the city centre and the railway line.

All the names of health districts were alphabetically listed on a piece of paper. Then the names were arranged according to whether the health district was in an urban, peri-urban, rural or remote area as shown above. This was to
ensure that the four categories would have a village health committee selected from each of the areas.

A town/city/village was selected from each of the areas. For example, each of the urban town/city names were written on a small piece of paper which was then folded. They were put in a basket and an independent blindfolded person was asked to pick one piece of paper. The exercise was repeated for the rural, peri-urban and urban areas. The names of places selected from each basket during the first round were Lobatse, Kweneng East, Goodhope and Kweneng West.

A similar selection exercise was undertaken for the selection of a village health committee in each of the places. That is, a list of names of all villages in each health district was made. Using the same system as for the selection of health districts, a village was selected from each of the five (towns and sub-districts) areas namely: Lobatse, Kweneng East, Kweneng West, Kgatleng East and Goodhope. In Lobatse Peleng township was chosen; from Kweneng East and Kgatleng the two peri-urban villages selected were Mogoditshane and Bokaa, whereas in Kweneng West and Goodhope the villages selected, still through the same process, were Sesung, and Hebron respectively. Peleng township happened to have two village health committees where the rest (Mogoditshane, Bokaa, Sesung and Hebron) had one village health committee each. A deliberate decision was taken to select two peri-urban village health committees, taking into consideration their high population concentrations. A purposeful attempt was made to include males.
Five villages were selected for implementation of the two questionnaires as indicated on page 108 under 6.3.

**Village Health Committees**

- **Remote Code D**
  
  Sesung a very remote and comparatively small village in the western side of the Kweneng District’s Letlhakeng Sub-district was selected using the method already described. This village borders the Kgalagadi (desert) district. Although not on the map, Figure 4.2, it is around (20) Kweneng West.

- **Rural Code C**
  
  Hebron village in the Barolong Sub-district of the Southern District Council. This represents a rural village. Refer to (6) on Figure 4.2.

- **Urban Code A**
  
  Two village health committees in Lobatse town (of five per VHC) were interviewed, representing an urban area sample. Refer to (18) on Figure 4.2.

- **Peri-urban Code B**
  
  In view of the fact that Botswana is rapidly being urbanised, and quite a sizeable part of it is peri-urban, data was collected from two peri-urban areas, namely:

  *B1: Bokaa Village*, which is 40 kilometres on the north-west of Gaborone City, in the Kgatleng District. This village shares borders with both Mochudi
village, which is one of the big villages in Botswana, and the capital city. Refer to (9) on Figure 4.2.

*B2: Mogoditshane Village,* which is nine (9) kilometres from the Gaborone City centre, has recently become the biggest village in Botswana. It is on the eastern side of Kweneng District’s Mogoditshane Sub-district. It is in fact like a suburb of Gaborone. Refer to (5), Kweneng East, on Figure 4.2.

**Nurses**

Three registered nurses from each of the four villages namely Sesung, Hebron, Mogoditshane, and Bokaa, and one township in Lobatse (Peleng) were selected as a sample as explained in Chapter Six. The registered nurses represented the nurses who were in leadership or management positions mainly by virtue of their being deployed to work in the selected areas at that point in time.

**Village Health Committee Members**

Village health committee members were selected as a sample as explained in Chapter Six, 6.3.

Selection of two homogeneous groups for the research provided the required degree of congruence. Built into this was the control for extraneous variability or bias. The sample delimitations increased precision of the research and contributed to accuracy and generalisability of the findings.
6.4 INSTRUMENTS

Structured data collection has been described as "an approach to collecting information from subjects, either through self-report or observations, wherein the researcher determines in advance the response categories of interest" (Polit & Hungler 1995:655). In this research use was made of a questionnaire using a Likert scale, which is "a type of composite measure of attitudes that involves summation of scores on a set of items (statements) to which respondents are asked to indicate their degree of agreement or disagreement" (Polit & Hungler 1995:645). Although the questionnaires were highly structured, everything possible was done to get as much information as possible from the respondents. In view of the different types of information required from both the nurses and the village health committees, and of their different backgrounds, separate questionnaires were developed and implemented for each group.

The planned questionnaire included a fixed set of questions generally in a specific sequence and with pre-designed response options using the Likert scale, such as below:

- 1 = always
- 2 = sometimes
- 3 = seldom
- 4 = never
- 5 = not applicable
Because of the participants, it became necessary and was more appropriate to impose some structure and at the same time provide them with opportunities to reveal relevant information in a naturalistic way. Some of the questions required respondents to provide answers without introducing guidance and biases. This way, influencing the respondents in answering the question was avoided.

6.4.1 Structure of Questionnaire to Nurses

The type of questions in the questionnaire to nurses included:

- if they considered community participation and involvement in health to be important;
- how often village health committee members get support;
- the role of the community in health care delivery system;
- whether nurses consider village health committees to be important and who should spearhead their formation;
- how often the nurse supervises, guides and supports village health committees.

See Appendix III for the questionnaire to nurses.

6.4.2 Structure of Questionnaire for Members of Village Health Committees

Type of questions asked from village health committee members were

- how one became a village health committee member;
• where elections to the village health committee took place and who elects the committee;
• what activities they have embarked upon;
• what guidance and support they require from the health system; who supports them; the nature of the support;
• whether the support is adequate;
• to whom do they refer patients.

The questionnaire is attached as Appendix II.

6.5 RELIABILITY OF THE INSTRUMENTS

A reliable measure is one that can produce the same results if the behaviour is measured again by the same scale. It then refers to the proportion of accuracy or inaccuracy in measurement, and is concerned with consistency, accuracy, precision, stability, equivalence and homogeneity. A reliable instrument should obtain consistent results.

*A reliable measure is one that maximises the true score and minimizes the error component* (Polit & Hungler 1992:367).

Care was taken to remove error as much as possible, and to apply the questionnaires with consistency. The instrument was also pre-tested and a pilot study was conducted.
6.6 **VALIDITY**

Validity is concerned with systematic error or constant error that is attributable to relatively stable characteristics of the research population which may bias their behaviour, and/or cause incorrect instrument calibration.

*Validity refers to the degree to which a measure assesses what it purports to measure* (Fink 1993:95)

Oyster, Hanten & Llorens (1987:53) describe this validity as a measure that pertains to the accuracy of the research. According to Hogstel & Sayer (1986:84) if the instrument did not measure what is intended, the results obtained from the data collected by the instrument would not answer the research question.

**Content Validity:** the contents were verified with experts in the field of primary health care and with the use of literature review, as well as the use of personal reflections (Woods & Catanzaro 1988:252).

Measures to ensure validity were thus built into the study from the planning phases.

- **Content validity.** This concerned the sampling adequacy of the village health committees' knowledge of the disease prevention, health promotion and community organisation. The role of the nurse in supporting members of the village health committees and their partnership in health care
development was also assessed. To this effect the questionnaires contained questions aimed at measuring these intended factors.

**Criterion Related Validity:** The use of supervisory ratings of nurses in relation to the enabling of village health committee members to perform is an example of criterion related rating. The instruments were further developed during the actual report. **The Concurrent Validity** was also represented by having focus group interviews from which the questionnaires were refined. Furthermore, **Construct Validity** was ensured using different sources measuring the construct (Woods & Catanzaro 1988:255).

There are a number of factors that have to be taken into consideration in order to eliminate biases. Validity is an instrument measure that is used to assess to what degree what is intended or supposed to be measured, has been measured (Woods & Catanzaro 1988:251). In this study questions that were measured were whether nursing leadership was built in throughout both questionnaires.

The reliability and validity of the instruments are not totally independent as

* A measuring device that is unreliable cannot possibly be valid. An instrument cannot validly be measuring the attribute of an interest if it is erratic, inconsistent and inaccurate (Polit & Hungler 1995:354)*
6.7 ETHICAL ASPECTS OF THE QUANTITATIVE DATA COLLECTION

Anonymity and confidentiality were ensured. The respondents were given the assurance that their names would not be on the questionnaires or mentioned at any stage. It would not be possible to link the findings to any person or specific village health committee or registered nurse. Codes were given to the questionnaires instead of names.

Informed consent were obtained by first explaining the purpose of the research to the participants before requesting voluntary participation. The participants were informed that they could withdraw from the research at any time. According to Lobiondo-Wood & Harber (1994:346) people should have the freedom to participate or not to participate in research. "The concept of informed consent is one that implies that all individuals have human worth and dignity, that they have control over their own bodies, and that they should not be subjected to any kind of research that could harm them" (Hogstel & Sayer 1986:91).

Approval to conduct the research was obtained from the Office of the President, through the Ministry of Health’s National Health Research Committee and the supervisors (See Appendix X), signed by the National Health Research Committee’s Secretary, Mr. Pilate Khulumani, on behalf of the Permanent Secretary for Health. Approval to conduct the research in the respective areas was also requested from responsible leaders/supervisors. Refer to Appendix IV, V, VI, VIII and IX. Almost all of the request was treated by the districts
and sub-districts as part of routine, useful and necessary public health intervention; as such response, which was 100 percent positive, was given by telephone.

The Local Government Service Management coordinates all Health Districts. Appendix XI represents approval for the research to be undertaken in all the four villages and the town where research was undertaken which were Bokaa, Hebron, Mogoditshane, Sesung and Lobatse. It is also for the pilot study villages, Ramotswa, (Siga village health committee) and Mogoditshane. Correspondence from the Establishment Secretary endorsed the importance of the research results.

The local nurse is the only person who has the ability and authority to call or invite village health committees in her/his area of operation to assemble. Without her/his cooperation and assistance, they would not have been available and the research would not have taken place.

In some cases, and where people did not feel necessarily obliged to respond to the questionnaire, the nurses were given the questionnaires during the time when the face to face village health committees' interviews were conducted. The face to face interview method was used with a structured questionnaire to

*Allow individuals to ask about the meaning of questions. These types of interviews can collect information from people who may have difficulty reading or seeing* (Fink 1993:95).
6.8 PRE-TEST AND PILOT STUDY

The questionnaires were reviewed by the promoter and co-promoter as well as a statistician and the computer science section, who analysed the data. The questionnaires were then also given to experts who work in the field, to review for comprehensiveness. After the necessary changes as indicated by the different reviewers were made a pilot study was conducted.

The respondents to the pilot study were not included in the final collection of the data.

6.9 PILOT STUDY

A pilot study has been defined by Polit & Hungler (1991:651) as a small scale version, or trial run, done in preparation for a major study; whereas a pre-test has been defined as both "the collection of data prior to the experimental intervention; sometimes referred to as baseline data; or the trial administration of a newly developed instrument to identify flaws or assess time requirements.

The pilot study questionnaires were pre-tested in Mogoditshane, with the Mogoditshane Village Health Committee members for purposes of standardizing the instrument. Three registered nurses and six village health committee members who were later excluded from participation from the main research participated, each group in their own questionnaire. Those who participated in the pilot study were excluded from participation in the
actual research. The rest of the members who had been recruited could not make it.

It was found very necessary to test out the two questionnaires before administering them. This was for purposes of finding out whether:

- the questions were going to be understood in the same way by the respondents (nurses and village health committee members), and in the same context as intended by the researcher.
- the researcher could proceed using the same questionnaire or whether there was need to recast the whole thing.
- the subject being researched was acceptable for discussion to the respondents; and if respondents would co-operate.
- there was a need for improvement of the project.
- the study was not over-ambitious, time consuming and too broad.
- the framework conceptualisation was both adequate, and not over-ambitious.

The main problem with the questionnaire intended for the village health committee members were mainly to do with translation of English to Setswana, which often would slightly change the meaning or be vague. The researcher, two research assistants, an independent researcher and the statistician had to work together in the re-translation and agreement of clear vernacular words to be used in order to convey the intended meaning.
The exercise proved fruitful to everyone involved during the actual research. Here, the need for elaboration of questions and follow-up were needed or requested for. Again, following the pre-test it was decided that village health committee members, unlike nurses, should not be given questionnaires to complete. They were interviewed by an interviewer; that is the researcher or a research assistant. The Statistician also started testing the statistical model to be used and the question codes used. Other revisions and refinements to the questionnaire, which were mainly related especially to sequencing of the questions were proposed by the researcher's promoter. The overall improvement of the project and assessment of the study's feasibility came about because of piloting of the questionnaires. There was no reason for a major second trial run of the questionnaires.

6.10 SAMPLING

As early as stated the quantitative research has two questionnaires, one for village health committees and one for the nurses.

The sample size, defined by Polit & Hungler (1991:265) as the number of subjects needed in a sample, was 53 for village health committee members and 18 for nurses.

The method used in the questionnaires required

*the use of the most conveniently available persons or objects for use as subjects in the study.*
In both the village health committees and the nurses cases the subjects could not be equally and readily available. Because of social and economic pressures a number of village health committee members are in paid employment and can only be available after hours or when they are off duty. Their sample depended more on their being available. The fortunate thing is that because of their high motivation and their organisation by the local nurse they turned up in numbers.

Remote and rural areas in addition to the smallness of the populations they usually run facilities that are comparatively small in size and in line with the population served. Therefore, they end up with fewer numbers of nurses. Regarding peri-urban and urban areas the opposite of the above is true. Furthermore, serving larger areas and having concentrations of populations to cover dictates for more nurses. Because of their availability, more nurses in the peri-urban and urban areas than in the rural and remote areas completed the questionnaires.

In cases in which the phenomena under investigation are fairly homogeneous within the population the risk of bias may be minimal. In the heterogeneous population, there is no other sampling approach in which the risk of bias is greater (Polit & Hungler 1991:257).

Both the nurses and village health committees were homogeneous groups. The nurses had the same basic level of education, and training in nursing. They were all involved in the village health committee formation, strengthening and sustainability promotion in the process of ensuring community organisation. The main aim of all these nurses in this endeavour
was to work towards prevention of ill-health, promotion of health, curative services provision and rehabilitation where necessary. The village health committees though differing in levels of education, had the same orientation and interest in preventing ill-health, promoting health and helping their communities to be healthier.

The quota sampling seemed the most relevant method. It was thus used. According to Polit & Hungler (1991:258),

*By using information about the composition of the population, the investigator can ensure that diverse segments are represented in the sample in the properties in which they occur in the population.*

The researcher through this attempted, through the quota sampling, as indicated by Polit and Hungler (1991:258) to “guide the selection of subjects such that the final sample will include the correct number of cases from each stratum”.

### 6.11 DATA COLLECTION

The data collection was time consuming and took several months. The process involved were as follows:

- Obtaining a research permit or permission to conduct the research from the authorities. (See Appendix X), letter signed by Mr. P. Khulumani, Secretary of the National Health Research Committee, that reports to the Office of the President.
• Writing and getting permission from the areas where the research were conducted, see Appendices IV, V, VI, VII, VIII, IX, X and XI for an example of the letter.

• The two research assistants/moderators had to be trained as to what the purpose of the research was, the research methods to be followed, and especially regarding interviewing the participants. This was specifically necessary for the focus group discussions but also for conducting the structured interviews according to the questionnaires.

• The questionnaires were duplicated.

• Conducting of Interviews:

  Interviews

Nurses: For nurses, questionnaires were distributed to them, on the days that the interviewers were conducting face to face interviews with village health committee members.

This allowed for clarification where necessary. The nurses had also been requested to set aside time for completion of the questionnaire on that day to ensure that they were actually completed and handed back. Each individual completed his/her own questionnaire. This was partly to reduce interview bias, which was possible.
6.12 DATA ANALYSIS

Data analysis refers to the systematic organisation and synthesis of research data, and testing of the research hypotheses, (Polit & Hungler 1995:639). A statistician was identified and employed to assist in analysing the data from the questionnaires. Using Epi Info 2 programme. This programme for IBM-compatible microcomputers was produced.

6.12 SUMMARY

Chapter Seven will present the analysis and discussions of data obtained from questionnaires that were responded to by both village health committee members and nurses working in their communities.
CHAPTER SEVEN

DATA COLLECTION AND ANALYSIS OF THE QUANTITATIVE DATA:
FOR BOTH THE VILLAGE HEALTH COMMITTEES AND THE
COMMUNITY BASED NURSES

This Chapter presents the analysis and discussions of the data obtained from questionnaires of both the village health committee members and nurses.

7.0 STATISTICAL ANALYSIS AND DISCUSSION: INTRODUCTION OF VILLAGE HEALTH COMMITTEES' AND NURSES QUESTIONNAIRE

Following the focus group discussions which were conducted from the week of June to the middle of August 1998, the quantitative structured interviews were conducted, from July 3 to December 14, 1998. In this Chapter, the analysis of the data collected from both the village health committee members and the nurses will be discussed. The total number of interviewees was 53 (N=53) for village health committee members, and 18 (N=18) for the nurses.

7.1 NURSES QUESTIONNAIRE

Section A

During the nurses' questionnaire pretest, the nurses expressed their questionnaires' biodata, Section A, as unnecessary and superfluous. According to them, their leadership role assignment is linked to their (health facility) management and administrative role. The management role was assigned based on their educational and professional attainments; and, there
is a set standard, General Certificate of Education/Matriculation plus accredited registered nurse training that would make all of them give the same information. During the pre-test of the nurses’ questionnaire those interviewed stated that once assigned the management role in line with their experience age did not matter. That is, organising communities and initiating and supporting village health committees were expected from all of them. Based on this, much as Section A which was catered for, was found not necessary to complete it. An agreement was to exclude it. Nurses were expected to build leadership in their communities, therefore, their leadership was assessed based their participation.

Sections B and C

The numbering of the nurses questionnaire items were found to be faulty, but all required was in. For that the researcher apologises.

7.1.1 Data Collection from Nurses

The nursing data collection was conducted as follows:

It was decided that in addition to the local level nurses at Sesung (remote); Hebron (rural), Bokaa and Mogoditshane (peri-urban) and Lobatse (urban), nurse supervisors belonging to district health teams should also be included in Letlhakeng, Goodhope, Mochudi, Mogoditshane and Lobatse.

Nurses' Questionnaire

Nurses' questionnaire was distributed and answered as shown below: For
(a) Sesung where there is only one clinic nurse,
   
(i) she completed the questionnaire;
(ii) two nurses who were her supervisors, namely the matron/nurse in charge and her deputy in the Lethakeng Clinic which is the headquarters of the Kweneng West District Health Team each completed the questionnaire. This made the total number of nurses who completed the questionnaire here to be three (3).

(b) Hebron had two clinic nurses, who each completed the questionnaire. Since they relieved each other they were both involved with their village health committee. The matron based at the Goodhope District Health Team also completed the questionnaire, bringing the total number of the nurses who completed the questionnaire to three (3).

(c) the Peleng Clinic in Lobatse two nurses, who also relieved each other, and the Lobatse District Health Team matron each completed the questionnaire. In total three (3) nurses each completed the questionnaire.

(d) Bokaa, whose population is significantly larger than that of Sesung and Hebron, and which had several nurses had three clinic nurses completing the questionnaire. The Kgatleng District Health Team matron also completed the questionnaire bringing the total number of nurses who completed the questionnaire to four (4).

The difference in the number of nurses who completed the questionnaire between the Peleng township in Lobatse Town and
Bokaa village could be explained. Bokaa village though smaller in population than the whole of Lobatse township was taken as a village; it had one village health committee. On the other hand in Lobatse, which had several townships and village health committees, only Peleng township participated.

(e) Mogoditshane peri-urban area/village, the clinic served the largest population in comparison to Sesung, Hebron, Peleng and Bokaa. It is the largest village in Botswana with a population of over 100,000 people. Unfortunately, there was only one fairly staffed clinic in Mogoditshane. Five nurses completed the questionnaire. Its village health committee covered a very wide area. The total number of nurses who completed the nurses’ questionnaires was therefore 18.

With the nurses, 100 percent, 18, responded.

**Village Health Committee’s Questionnaire**

In each of the three villages of Bokaa, Sesung and Hebron ten (10) village health committee members responded to the questionnaire. The total number of completed questionnaire from these villages was therefore 30. In Lobatse the total number of respondents to the questionnaire was eleven (11). Mogoditshane had twelve (12) respondents to the questionnaire. The total number of respondents to the village health committee was therefore 53 as shown in table 7.1 below.
7.1.2 Data Collection from Village Health Committees

A 100 percent of village health committee members, 53, responded.

<table>
<thead>
<tr>
<th>Area</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bokaa</td>
<td>10</td>
<td>18.9</td>
</tr>
<tr>
<td>Hebron</td>
<td>10</td>
<td>18.9</td>
</tr>
<tr>
<td>Lobatse</td>
<td>11</td>
<td>20.8</td>
</tr>
<tr>
<td>Mogoditshane</td>
<td>12</td>
<td>22.5</td>
</tr>
<tr>
<td>Sesung</td>
<td>10</td>
<td>18.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>53</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 7.1: Village Health Committees Involvement by Area (N=53)

7.2 VILLAGE HEALTH COMMITTEES' QUESTIONNAIRE EXPERIENCE

Section A

During the pre-test, village health committees were quite comfortable with answering section A of their questionnaire. This section was also found to be very necessary in assisting to find out what age brackets actively participated in these committees. Results showed that almost all community members who belong to the ages 20 years to 49 years age group tended to participate in community matters. These were people who were active and could move from house to house doing home visits. They could also engage in activities
as indicated in the results. According to findings, marital status and the number of living children did not directly affect the communities volunteerism.

The level of education was found to be important, moreso that certain procedures such as weighing children would require some level of literacy. Although the study did not intend to include this aspect, the 11.9 percent village health committee members that had never been to school did not express any discomfort with procedures nor show any disadvantages in their work performance. It could be that established illiteracy eradication strategies in the country are having some impact;

A National Literacy Programme was launched in 1980. Other organisations that took the initiative to help illiterate Botswana were the Botswana Christian Council, the Young Women's Christian Association, the Botswana Council of Women and the Lutheran Church of Botswana. (Kwape 1997:216).

Sections B and C were implemented exactly as they were.

Data Analysis

Data analysis is

the systematic organization and synthesis of research data, and the testing of research hypothesis using those data (Polit & Hungler 1991:643)

Following data cleaning, which according to Polit & Hungler (1991:643) was the preparation for analysis by performing checks to ensure that the data were meaningful and consistent, the data was coded and entered onto an
input medium with the assistance of the statistician, Mr. Nchiile, for computer analysis. This was after the data had been put in the form in which it could be meaningfully analysed to come up with tables and figures of required values.

ITEM 2

7.3 Village Health Committee Members Interviewed By Age N=53

<table>
<thead>
<tr>
<th>Age</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29</td>
<td>10</td>
<td>18.9</td>
</tr>
<tr>
<td>30-39</td>
<td>21</td>
<td>39.6</td>
</tr>
<tr>
<td>40-49</td>
<td>14</td>
<td>26.4</td>
</tr>
<tr>
<td>50-59</td>
<td>5</td>
<td>9.4</td>
</tr>
<tr>
<td>60+</td>
<td>3</td>
<td>5.7</td>
</tr>
<tr>
<td>Total</td>
<td>53</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 7.2: Village Health Committees Interviewed by Age (N=53)

As can be seen from table 7.2 above, the majority of village health committees interviewed were between 30 and 39 years of age, at 39.6 percent, followed by the 40 to 49 years bracket at 26.4 percent. The least numbers interviewed fell in the age groups of 50 to 59 year olds, 9.4 percent, and the over 60 years of age, 5.7 percent.
Only 5.7 percent were male, and 94.3 percent female as shown in figure 7.1 above.
As shown in figure 7.2 above, the highest percentage, (39.2%) had attained upper primary school level education, followed by lower primary school level (29.4%). This percentage is followed by the 17.6 percent that attained secondary school level education. Of the 53 interviewed village health committee members, 11.8 percent had never attended school, and only two percent (2%) had attained post secondary school level education. Only 51 responded to the level of education question out of 53.
ITEM 5

7.2.3 Village Health Committee Members Questionnaire Response by Marital Status: N=49

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>24</td>
<td>45.3</td>
</tr>
<tr>
<td>Married</td>
<td>25</td>
<td>47.2</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
<td>1.9</td>
</tr>
<tr>
<td>Widowed</td>
<td>3</td>
<td>5.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>53</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 7.3: Village Health Committee Members by Marital Status (N=53)

Only 49 of the 53 interviewees responded to this question. One person responded to the divorced, separated or widowed column. As shown in table 7.3, 45.3 percent were single and 47.2 percent married.
As indicated in figure 7.3 above, 73.6 percent, the majority of respondents had 6 to 8 children alive, followed by the 18.9 percent that had three to five children living. Only a small percentage (7.5%), had zero to two children living. Figure 7.3 reflects a high survival rate of children. It also reflects large family sizes among village health committee members. It is, however, these village health committee members who on the other hand promote family planning. To them family planning could be referring mainly to spacing of births.
<table>
<thead>
<tr>
<th>Area Covered</th>
<th>Lower Primary Level</th>
<th>Primary Level</th>
<th>Secondary Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bokaa</td>
<td>20.0</td>
<td>25.0</td>
<td>22.2</td>
</tr>
<tr>
<td>Hebron</td>
<td>26.7</td>
<td>25.0</td>
<td>11.1</td>
</tr>
<tr>
<td>Lobatse</td>
<td>26.7</td>
<td>15.0</td>
<td>33.3</td>
</tr>
<tr>
<td>Mogoditsane</td>
<td>26.7</td>
<td>15.0</td>
<td>33.3</td>
</tr>
<tr>
<td>Sesung</td>
<td>0</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>*100.1</td>
<td>100</td>
<td>*99.9</td>
</tr>
</tbody>
</table>

* Percentages as displayed in frequency distribution

Table 7.4: **Level of Education in Different Areas**

According to table 7.4 above, of those village health committee members who were interviewed: Bokaa village had a cumulative percentage of 67.4 (67.4%) of its village health committee members having achieved lower primary school to secondary school level education. It was second to both Mogoditshane village and Lobatse town that ranked first and had an equal cumulative percentage of 75.0 (75%) of its village health committee members with lower primary to secondary school level education. Ranking third was the Hebron village health committee with 62.8 percent (62.8%) of its village health committee members having lower primary to secondary level education.
Sesung village ranked lowest with only 20 percent (20%) of its village health committee members having achieved higher primary level education. The above shows the gross disparities in the level of education and literacy rates between the remote and rural areas and other parts of the country. Village health committee members in Botswana, it can be concluded, are generally literate. They therefore are trainable and can safely render the services that they provide. They therefore would not be expected to distort health messages, and could safely advise fellow villagers on their taking of prescribed treatment.

SECTION B:

Item 7. How one became a member of the village health committee (N=52.)

<table>
<thead>
<tr>
<th>Member Village Health Committee</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gets chosen</td>
<td>12</td>
<td>23.1</td>
</tr>
<tr>
<td>Is elected/nominated</td>
<td>22</td>
<td>42.3</td>
</tr>
<tr>
<td>Decided to join</td>
<td>18</td>
<td>34.6</td>
</tr>
<tr>
<td>Total</td>
<td>52</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 7.5: How to become a member of a village health committee (N=52)

One interviewee did not respond. As shown above in table 7.5, the majority of respondents, 42.3 percent stated that one was elected or nominated to the committee, 23.1 percent stated that one got chosen to join the committee. The
two terms (elected and chosen) basically mean the same thing. Therefore a cumulative percentage of 65.4 percent agreed that for one to be a member of the village health committee one had to be elected. About a third of the respondents, 34.6 percent reported that one decided to join the committee. This supported the findings of the focus group discussions in Chapter 5, page 87, including as stated by the translated version of a statement by a village health committee member. According to responses nobody applied for membership. The above is similar to 7.3 below.

**Nurses Items 20, 21 and 22: How to become a member of a village health committee.**

<table>
<thead>
<tr>
<th>To Become Member Village Health Committee one is</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chosen</td>
<td>6</td>
<td>35.3</td>
</tr>
<tr>
<td>Is selected</td>
<td>5</td>
<td>29.4</td>
</tr>
<tr>
<td>Just joins</td>
<td>6</td>
<td>35.3</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 7.6: How to become a member of a village health committee (N=17)

Table 7.6 which is response results by nurses is put in this section for purposes of comparing it with table 7.5 on page 137. According to the nurses response to item 21, 64.7 percent of the nurses indicated that to become a village health committee member; one was chosen. As earlier stated the two
mean the thing. Though this was not changed in the final questionnaire, it was part of the feedback of the pre-test exercise. Cumulative percentages of 76.5 (76.5%) of the nurses and 65.4 percent of village health committees as displayed in table 7.5 were in agreement that to be a village health committee member that one had to be chosen or elected. Again, 34.6 percent of village health committee members and 35.3 percent of nurses reported that one could just decide to join the committee. There was quite a strong agreement by almost the same percentage regarding joining the committee voluntarily.

There was an agreement between village health committee members and nurses that to become a member of this committee one often had to be elected. Where any villager showed dedication and constant participation at the clinic, other village health committee members recommended him/her to the nurse who would also formalise his/her status and have the chief or headman endorse it.

Item 8. If elected, where are members of the village health committees elected? Village health committee questionnaire.

Only 39 village health committee members out of the 53 responded to this question.
<table>
<thead>
<tr>
<th>Where Member of Village Health Committee Elected</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>At kgotla</td>
<td>27</td>
<td>69.2</td>
</tr>
<tr>
<td>At health facility</td>
<td>8</td>
<td>20.5</td>
</tr>
<tr>
<td>Other (recommended by other village health committee members)</td>
<td>4</td>
<td>10.3</td>
</tr>
<tr>
<td>Total</td>
<td>39</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 7.7: Where Members of Village Health Committees are Elected (N=39)

As shown in the table 7.7, 69.2 percent of the respondents, stated that selection of membership to village health committees took place at the kgotla (traditional gathering place). According to 20.5 percent of the respondents, some members were elected at a health facility level, whereas 10.3 percent stated that they were 'elected' at other places such as working hard and being recommended by other members to the nurse. These findings correspond with Omondi et al in his statement that

*A relatively large number - 84.7% (17) indicated that they were selected at the kgotla. It is significant to note that some VHCs coopted members. (Omondi et al 1994:4)*

This supports the earlier mentioned statement that some members volunteered to join the committee. The above is related to item 21 on the nurses' questionnaire: Item on where village health committees are elected.
Table 7.8: Where Village Health Committees are Elected (N=17)  
(According to the nurses questionnaire)

<table>
<thead>
<tr>
<th>Members of Village Health Committees are Elected by</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kgotla</td>
<td>14</td>
<td>82.4</td>
</tr>
<tr>
<td>Health facility</td>
<td>3</td>
<td>17.6</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>100</td>
</tr>
</tbody>
</table>

As shown in table 7.8, 82.4 percent of the nurses stated that village health committees are elected at the kgotla. This was in agreement with the 69.2 percent stated by village health committee members in table 7.7. A very close percentage to the 20.5 percent of village health committee members, 17.6 percent of nurses, reported that some village health committee members were elected at the health facility level. There was also an agreement that some just volunteered to join. None stated that they applied for membership.

**Item 9. How often are elections to choose or elect village health committee membership conducted?**

Response was made by 39 out of a total of 53 village health committee members. These were not necessarily those who responded to item 7.4.
<table>
<thead>
<tr>
<th>Frequency of Elections</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once in 3 months</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Once in 6 months</td>
<td>1</td>
<td>2.5</td>
</tr>
<tr>
<td>Once a year</td>
<td>17</td>
<td>42.5</td>
</tr>
<tr>
<td>Every 2 years</td>
<td>20</td>
<td>50</td>
</tr>
<tr>
<td>Other/Specify</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Total</td>
<td>39</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 7.9: **How often Election to Village Health Committees are Held (N=39)**

As shown in table 7.9, a large percentage of 42.5 percent, reported that elections took place yearly/once a year. A slightly higher percentage, 50.0 percent half of the respondents, stated that elections took place every two years. Quite a high cumulative percentage of 92.5 percent of village health committee members reported that elections to membership took place every one to two years. A sizeable number of those who perform very well got re-elected. This is a regular and established pattern. An insignificant cumulative percentage of 5.0 (5.0%) reported that elections were conducted once in six months.

The related question to item 9 above is item 22 in the questionnaire for nurses. Both nurses and village health committees were in agreement that elections took place either annually or every two years. A cumulative percentage of
70.6 percent (35.6% each) indicated that elections were conducted either annually or bi-annually. 29.4 percent reported that elections were conducted every two years.

**Item 10. Village health committees' questionnaire. Who elects members of village health committees?**

Out of the 53, 39 persons who were not necessarily those who responded to item 9 above responded.

![Graph showing the percentage of who elects members of Village Health Committee](image)

**Fig. 7.4: Who Elects Members of Village Health Committee (N=53)**

As shown in figure 7.4 a high percentage (84.6%) of village health committee respondents reported that the community members elect people to the village health committee. Quite a small percentage (15.4%), reported that the health
worker in this case the nurse as the leader, does the elections. None of the village health committee members reported that the chief ever elects them. This demonstrates active community involvement for health, as well as community empowerment as opposed to electing their own members; village health committee members are not imposed upon communities.

The response provided under item 10 above indicated nurses sensitisation, motivation and empowerment of communities for confidence; involvement and participation in health development.

Item 11: Village health committees' questionnaire. How long one is expected to serve on the committee? Five of the respondents did not respond to this item.

<table>
<thead>
<tr>
<th>Expected Service in Committee</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>One year</td>
<td>15</td>
<td>31.3</td>
</tr>
<tr>
<td>Two years</td>
<td>29</td>
<td>60.4</td>
</tr>
<tr>
<td>Other/Specify</td>
<td>4</td>
<td>8.3</td>
</tr>
<tr>
<td>Total</td>
<td>48</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 7.10: How Long Member of Village Health Committee is Expected to Serve (N=48)

A number of village health committee members who perform well or are popular get re-elected several times. This therefore has an impact on the length of time a member is expected to serve on the committee.
As shown in table 7.10, a high percentage of the respondents, 60.4 percent, stated that one was expected to serve in the committee for a period of two years, followed by 31.3 percent that reported that one was expected to serve for a period of one year. The aim is to give everyone a chance to serve and to face challenges. None reported that the length of service expected was six months. A cumulative percentage of 91.7 percent stated that one was expected to serve for one to two years in the committee. A percentage of 8.3 (8.3%) reported other. These are those members who continued to serve in their committees for long periods of time. Some focus group discussants also indicated that they had been committee members for sometime. This confirms that people could participate beyond two years depending on their motivational levels, acceptability by the community, ability and interest. There is no drafted constitution for guiding village health committees yet. All the above was related to item 23 in the questionnaire for nurses.

<table>
<thead>
<tr>
<th>How long one is expected to serve on this committee</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Six months</td>
<td>1</td>
<td>5.9</td>
</tr>
<tr>
<td>One year</td>
<td>5</td>
<td>29.4</td>
</tr>
<tr>
<td>Two years</td>
<td>8</td>
<td>47.1</td>
</tr>
<tr>
<td>Other/Specify</td>
<td>3</td>
<td>17.6</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 7.11: Length of Time Member of Village Health Committee is Expected to Serve (N=17)
According to 47.1 percent of the nurses committee members are reported to serve for two years. A cumulative percentage of 76.5 (76.5%) stated that committee members were expected to serve for one to two years. This was in agreement with the cumulative percentage of 91.7 percent, of the village health committee members in item 11. Also, like in item 11, others indicated that members could serve for as long as they were, interested, active or needed to reinforce the committee.

Item 27 Nurses: Length of time the nurse has been supporting members of village health committee, and thus had been its member.

To mobilise and motivate others one had to be seen to belong with them. The nurse had to join and lead from within. This item was related to item 11. A small percentage (5.9%) had joined their committee only during the last six months. Of the remaining, 11.8 percent have been members for the last two years and above. A high percentage (82.4%) of nurses stated that they had been members of their committees for two years.

The above demonstrated that nurses were committed to community sensitisation, motivation and mobilisation for health. They were also able to motivate community members to participate without any form of remuneration as expressed in Chapters 4 and 5. Job and self satisfaction had perhaps been motivators here.
The other 41.2 percent of nurses indicated to have been members of their village health committees either since they were formed, or for the past ten years. This demonstrated support and experience of these nurses as motivators. There was a small percentage of nurses, (5.9%) that reported that they had never been members of a village health committee. They stated that they expected only elected village health committee members to be members and not themselves. This percentage was not showing leadership qualities whereby one led from within and not from outside. Be it in politics, religion or any grouping leadership is related to belonging.

This indicates that there was a small percentage of nurses that itself still required information, education, sensitisation, motivation and mobilisation training. The rest of those in the community were accordingly involved. As stated by Gobotswang and Kobue (1997:55),

Results indicated that VHC's do not achieve all set objectives due to factors like lack of commitment on the part of committee members themselves, lack of community support, lack of support from health workers, lack of resources and poor leadership.

Item 12: Village health committee questionnaire. When was the village health committee that the respondent belonged was formed; 47 out of 53 respondents responded to this question.
<table>
<thead>
<tr>
<th>Year Formed</th>
<th>Percentage Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1978 - 1982</td>
<td>36.2%</td>
</tr>
<tr>
<td>1983 - 1987</td>
<td>19.1%</td>
</tr>
<tr>
<td>1988 - 1992</td>
<td>29.8%</td>
</tr>
<tr>
<td>1993 - 1997</td>
<td>14.9%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Table 7.12: When was the Village Health Committee Formed (N=47)

According to the responses and table 7.12, a sizeable percentage of village health committees, 36.2 percent, was formed between 1978 and 1982. Another cumulative percentage, of 48.9 percent, indicated that most of the village health committees were formed between 1983 and 1992. Overall, a cumulative percentage, of 85.1 percent, of village health committees were formed between 1978 and 1992, 14.9 percent of these committees were formed between 1993 and 1997.

Items 24 and 25 in the nurses questionnaire have some relationship to Item 12 above. When the village health committee to which nurses belong was formed, and for how long it has been operating actively.
Table 7.13 indicates that 64.7 percent of the nurses who are members of their village health committees, belonged to committees that were formed one to five years ago; this percentage was followed by that of those who belonged to those committees formed six to ten years ago. An equal percentage, (5.9%) of nurses belonged to village health committees that were formed during the past 11 to 15 years and 16 to 20 years ago respectively. On the whole respondents included a rich variety of members ranging from those belonging to newly formed village health committees to those formed 20 years and above ago.

It would be interesting in follow up research to have information that has not been covered such as that regarding the difference in activities undertaken,
commitment of members, and perhaps later, age range of nurses in these committees.

**Item 26: Nurse’s position in village health committee.**

<table>
<thead>
<tr>
<th>What is your position in the committee</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treasurer</td>
<td>1</td>
<td>5.9</td>
</tr>
<tr>
<td>Member</td>
<td>13</td>
<td>76.5</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>17.6</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 7.14: Position of Nurse in Village Health Committee (N=17)

Only one nurse, (5.9%) indicated that she/he was their committee’s treasurer. The majority, 76.5 percent, were ordinary members of their committee and not office bearers, having delegated power (chairmanship, treasurer and secretary positions) to the village health committee members. The positions may not be many in number, but in terms of directing proceedings, recording notes and keeping money, they represented power. The chairman was also always a village health committee member. Therefore, the nurse had, as a true leader, allowed others to take over but continued to serve in a “vital role as a follower ...”. This is true leadership whereby the nurse provided supervision as a follower. The rest, 17.6 percent, did not indicate their position or membership. This showed that nurses in these committees mainly
provided guidance, support and leadership, and left committee positions to community members themselves. Nurses facilitated and built leadership skills by giving challenges and positions to those who volunteered, and did not take over. This way they promoted self-reliance, independence and creativity at the local level. Leadership as defined is

the competencies and processes required to enable and empower ordinary people to do extraordinary things (Booyens, 1998:417).

Item 14: Village health committee members positions.

The above is similar to item 14 in the village health committee members questionnaire.

Figure 7.5: Village Health Committee Members Positions (N=52)
Only one person did not respond.

According to the figure 7.5 above, 73.1 percent of village health committee members reported that they were ordinary members of their committees. Four of those (7.7%) interviewed were chairpersons, 11.5 percent were secretaries, and 5.8 percent were treasurers. 1.9 percent were reported as others. These could have been elected executive members.

**Item 13:** On village health committees length of time actively carrying out activities such as health campaigns or meetings.

<table>
<thead>
<tr>
<th>Period of Time</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 5 years</td>
<td>30</td>
<td>56.6</td>
</tr>
<tr>
<td>6 - 10 years</td>
<td>10</td>
<td>18.9</td>
</tr>
<tr>
<td>11 - 15 years</td>
<td>7</td>
<td>13.2</td>
</tr>
<tr>
<td>16 - 20 years</td>
<td>6</td>
<td>11.3</td>
</tr>
<tr>
<td>Total</td>
<td>53</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 7.15: **Length of Time Member of Village Health Committee Actively Carrying Out Activities (N=53)**

Table 7.15 indicates that 56.6 percent of village health committee members had been actively carrying out activities such as health campaigns or meetings for the last one to five years. This percentage reduced as years
progress. An example is that only 11.3 percent had been actively sensitising as above for the last 16 to 20 years. For the last 11 to 15 years the percentage increased to 13.2 percent, and to 18.9 percent during the last six to ten years. This may be demonstrating that membership kept changing or rotating among community members, and that at the same time there were some village health committee members that had been retained for a long time.

Section B in the questionnaire (questions 7 to 19) are relevant to nurses only. Here nurses management support and leadership status are assessed. Item 7: On whether the nurse is in charge of a facility or district. All nurses responded (N=18.)

As stated on page 126, under 7.1.1 all nurses in charge, except for only one, responded to this item. According to their response 38.9 percent (38.9%) were based at their district health team level. All the remaining 61.1 percent (61.1%) were deployed at the health facility level. Out of this 61.1 percent of the nurses, 38.9 percent were in charge of their health facilities and 22.2 percent were not. They were mostly deputies of those in charge.

Item 8: What the nurse thinks is his/her participation in the village health committee.

As shown in figure 7.6 page 154, 88.9 percent (88.9%) of the nurses stated that participation in a village health committee was essential. Participation by nurses in village health committees was also seen as obligatory for the nurse by 11.1 percent. Nurses were in agreement with village health committees
regarding the election venue for village health committees, and how often they should be elected.

Obligatory = 11.1%

Essential = 88.9%

Figure 7.6: How participation of nurses in village health committees is viewed (N=18)

As earlier shown in table 7.8 on page 141, 82.4 percent of the nurses stated that elections for village health committees took place at the traditional gathering place or the kgotla, or in the ward in urban settings.

It is also reported, by 50 percent of the nurses, that elections take place every two years in page 142 table 7.9. These statements are in agreement with responses of the village health committee members to both the questionnaire and the focus group interviews.

Item 9. On who the nurses thought are the most appropriate health workers/persons to initiate the village health committee.
According to table 7.18, page 158 the main role of the nurses in forming village health committees is sensitization of community members as indicated by 83.3 percent. Of those nurses who responded according to figure 7.7 above, 27.8 percent stated that the nurse is the most appropriate person to initiate the formation of a village health committee. An equal percentage, of 27.8 percent, stated that it is the responsibility of the community to organise themselves and form committees. Again, an equal percentage (27.8 percent) stated that this is the role of the family welfare educator. This indicates that
the nurses, themselves, who are leaders in health development at the local level are not clear as to who should play the leading role in initiating the formation of village health committees.

They are neither clear nor united regarding their role in community organisation. Furthermore, they lack certainty regarding who should spearhead community health leadership. This should be revisited and discussed and compared with responses to relevant items in Section C of the village health committee’s questionnaire, such as items 18, 19 and 20.

As reported by Omondi et al (1994:5),

> According to the key informants supervision and coordination of the activities of the VHCs is supposed to be carried out mainly by either the nurses or family welfare educators (FWE), or jointly by the nurse and the FWE.

**Item 10. On the role of village health committees, as seen by the nurse.**

<table>
<thead>
<tr>
<th>Role</th>
<th>Yes</th>
<th>No</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational</td>
<td>94.4%</td>
<td>5.6%</td>
<td>100</td>
</tr>
<tr>
<td>Follow-up of Patients</td>
<td>68.7%</td>
<td>31.3%</td>
<td>100</td>
</tr>
<tr>
<td>Vegetable Gardening</td>
<td>66.7%</td>
<td>33.3%</td>
<td>100</td>
</tr>
<tr>
<td>Supervision of Patients/Treatment and Care</td>
<td>27.8%</td>
<td>72.2%</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 7.16: **Role of Village Health Committee As Noted By the Nurse (N=18)**
According to table 7.16, the majority (94.4%) of the nurses reported that the main role of the village health committee is to engage in, and participate in, educational activities.

Still another high percentage, 68.7 percent indicated that the role of the village health committee is to follow up patients; 66.7 percent indicated vegetable gardening, whereas 27.8 percent stated their role as that of supervising patient treatment and care.

Local structures such as Village Health Committees (VHCs), and non-governmental organizations (NGOs) are instrumental in promoting community participation and involvement. The structures undertake various projects and programmes for the improvement of the quality of life for members of their communities ... (Gobotswang & Kobue 1997:55).

According to Oakley (1989:22)

to understand the potential of the community contributions to health development will involve a process of assessment, in which the communities will play a part, in order to determine what local capabilities and resources are available and in what way they can be built into health programmes and projects. More specifically local people's knowledge of health care and health practices should be ascertained and utilized.
**Item 11. Assessment of Working with Communities in Health Development.**

<table>
<thead>
<tr>
<th>Working with Community members in Health Development</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential</td>
<td>14</td>
<td>77.8</td>
</tr>
<tr>
<td>Important</td>
<td>4</td>
<td>22.2</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 7.17: Assessment of Working with Communities (N=18)

A high percentage of nurse respondents, 77.8 percent, stated that working with community members in health development was essential, and 22.2 percent stated that it was important. All respondents, 100 percent, indicated the importance of working with communities. This demonstrates the respondents appreciation of, and support for, community involvement.

**Item 12: Some of the tasks normally performed by nurses in forming village health committees.**

<table>
<thead>
<tr>
<th>In forming Village health Committees do you</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitise Community Members</td>
<td>15</td>
<td>83.3</td>
</tr>
<tr>
<td>Involve Community Leaders</td>
<td>3</td>
<td>16.7</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 7.18: Some Tasks Performed by Nurses in Forming Village Health Committees (N=18)
The focus of tasks first of all aimed at assessing and emphasising community involvement and participation for health. The response demonstrates that indeed the nurses appreciate the importance of working with, and involving, community members in health development. This implies that there is a realisation that health promoting behaviours require action from the individual and, this message is recognised.

Item 13: How often the nurse has undertaken home visits in the last 12 months.

<table>
<thead>
<tr>
<th>How Often Home Visits Undertaken</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly</td>
<td>6</td>
<td>33.3</td>
</tr>
<tr>
<td>Bi-Monthly</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>Every Six Months</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td>Once a Year</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>38.9</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 7.19: How Often Nurse has Undertaken Home Visits (N=18)

As shown in table 7.19, 33.3 percent of the nurses undertook home visits at least once a week. They thus provide the leadership required. Disappointingly there is quite a significant percentage (38.9%) of nurses that
reported that they did not do any home visits, or only undertook home visits when it is possible. Understandably some indicated that they undertook home visits only when it is possible, since their workload does not allow them to. This demonstrates willingness to do home visits, and knowledge that home visits should be done. Unfortunately, there is a small fraction that stated that they did home visits only for a specific purpose; this group requires to be sensitised.

Home visits are a form of support to assess, reinforce, and support the work of village health committee members. Village health committee members would not be so ambitious as to hope to provide services to a whole village or to a very wide area as a group. Normal practice is for the group to divide themselves in such a way that each one of them is responsible for a ward or any small manageable number of households. Their role in their area of operation would among others include the following:

- undertaking of community assessment to
  - acquaint and know area of operation;
- do a thorough needs assessment in order to
- identify presence of any patients whether on health facility treatment or not;
  - refer patients who need referral to health facility;
  - report any illnesses in her/his area to the family welfare educator or nurse;
- identify tuberculosis patients and any that have defaulted and give a report on them to the nurse or family welfare educator;
• advise household members with a tuberculosis patient on how to avoid infection;
• identify and report presence of patients with other diseases to health facility;
• keep a record of patients and give the nurses and family welfare educator a daily report on them;
• provide information and advice to such patients and to their relatives on different health issues. For example:
  - the need for a tuberculosis patient to have food prior to taking treatment. She/he also can report lack of food of any household to the social workers so that they assess whether the household qualifies for destitute services. These would include free packages of food and other accessories such as soap.
  - ensure that patients on treatment who are not keen to take it actually swallow their tablets/medicines in his/her presence.
• in malarious places participates in the identification of warning signs of the disease and report promptly to the health facility;
• participates actively in the insecticide impregnation of bednets as a protective measure against malaria.

In short village health committee members identify and report to health facilities all problems that would compromise the health of the people in their areas of jurisdiction. They then follow up and supervise any treatment given. In addition to house to house information and education they at times join
efforts with nearby wards and provide information and education. Other activities such as vegetable gardening have been already earlier mentioned. They keep records such as for pregnant mothers, underweight children, the health of adolescents, births and deaths in their wards, and report to the nurse. In the event of any emergency in the area of operation of the nurse she would, because of the watchdog role of the village health committee members, be able to promptly attend to the situation. Because of this role, people are also not able to hide any patients from the health services. She/he first of all as one of the people in the area starts by winning their confidence in her. Therefore, she/he must be respected and credible.

Home visits are thus quite important especially for assessment of living conditions and the environment, which often impact on health such as poor sanitary conditions or abject poverty. They facilitate relevant advice and focus towards the addressing of real, identified and specific problems. Activities in item 12, table 7.9 are thus broad and not specific tasks, as these would differ from community to community and from home to home depending on prevailing circumstances. They outline broad community involvement strategies and focus such as the need for community sensitisation activities and involving them. As indicated by Oakley (1989:12)

... forms of participation can be distinguished on the basis of whether they seek cooperation or promote power-sharing. Both forms involve interaction between decision-makers and those affected by the decisions.
Consequently, it is impossible to have a full and complete list of village health committees’ tasks, moreso that they would differ from place to place depending on the socio-economic and political situation, and the level of motivation for participation. As Oakley (1989:12) puts it,

*very different forms of participation may emerge from the relationship between those who decide and those who are affected by the decision.*

In community organisation for health strategies, communities are encouraged to be innovative and focused on problems that directly affect them. They are thus bound to differ. An attempt is nonetheless made to list some of these activities on page 167 table 7.22.

**Item 14: Addressing of who, according to the nurse conducts home visits.**

<table>
<thead>
<tr>
<th>Who Conducts Home Visits</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>11</td>
<td>61.1</td>
</tr>
<tr>
<td>Family Welfare Educators</td>
<td>16</td>
<td>88.9</td>
</tr>
<tr>
<td>Village Health Committee Members</td>
<td>6</td>
<td>33.3</td>
</tr>
</tbody>
</table>

*Table 7.20: Who According to the Nurse Conducts Home Visits (N=18)*

As shown in table 7.20, 88.9 percent of the nurses interviewed cited the family welfare educator as the one who does home visits. This still supports the nurses’ leadership role, since they are the ones who support and supervise the family welfare educator. It is, however, of concern that there is a small percentage of family welfare educators (11.1%) that does not do any home
visits. This implies this 11.1 percent is utilised in assisting in clinical duties at health facilities, as opposed to going out to do community sensitisation, organisation and motivational activities, that they are trained for.

7.3 VILLAGE HEALTH COMMITTEES’ Section C and continuation of Nurses’ Section B below.

Item 15: Village health committees’ interpretation of the village health committee as shown by table 7.21:

<table>
<thead>
<tr>
<th>Statements</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>N=53</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community is given a chance to contribute to its health care services</td>
<td>77.4%</td>
<td>22.6%</td>
<td>0%</td>
<td>0%</td>
<td>53</td>
</tr>
<tr>
<td>People are enabled to work as a team.</td>
<td>69.8%</td>
<td>30.2%</td>
<td>0%</td>
<td>0%</td>
<td>53</td>
</tr>
<tr>
<td>People organise themselves to address health problems</td>
<td>62.2%</td>
<td>35.8%</td>
<td>0%</td>
<td>1.9%</td>
<td>53</td>
</tr>
<tr>
<td>People do voluntary work</td>
<td>90.6%</td>
<td>9.4%</td>
<td>0%</td>
<td>0%</td>
<td>53</td>
</tr>
<tr>
<td>Health is given prominence in village development</td>
<td>56.6%</td>
<td>37.7%</td>
<td>5.7%</td>
<td>0%</td>
<td>53</td>
</tr>
</tbody>
</table>

Table 7.21: Interpretation of the Village Health Committee (N=53)

Table 7.21 interprets the members of the village health committees’ perceptions of the committees.
The aim here was to assess the village health committee members' perception of what they themselves think the village health committee is, and to find out how much they value it. All village health committee members (100%) responded to these questions. To rule out bias, the questions were not directly posed to the nurses. Nurses as motivators, it was assumed, knew the objectives for organisation of community members into groups for health development.

The percentage of village health committee respondents agreed that by these committees:

- the community was given a chance to contribute to its health care. The largest percentage, 77.4 percent, strongly agreed to this statement. This indicated nurses support for communities' involvement in their health care delivery system. No respondent disagreed to this.
- People were enabled to work as a team is 100 percent; of these, a high percentage of 69.8 percent strongly agrees.
- People organised themselves to address health problems. A high percentage, 62.3 percent, strongly agreed with this statement. Only a very small percentage (1.9%) strongly disagreed with the statement that village health committees enabled people to organise themselves to address health problems.
- People did voluntary work: an overwhelmingly large percentage (90.6%) strongly agreed to this, and 9.4 percent just agrees. There were no disagreement on that.
- Health is given prominence in village health development. 56.6 percent strongly agreed with this statement and 37.7 percent only agreed. Therefore a cumulative percentage of 94.3 (94.3%) was in agreement. Only 5.7 percent disagreed.

According to the above, village health committee members have a positive attitude about village health committees, and regard their contribution as valuable. They also see this as a way to organise themselves. Furthermore, they are aware that they are voluntary. According to Omondi et al (1994:8),

*When VHCs cry out for incentives it is clear that they are not only comparing themselves to the VDCs in terms of the sitting allowances that the VDCs get but they are also looking at non-tangible things like recognition and appreciation*

hence the fact that they continue to volunteer and have motivation towards active participation involvement.
Item 21: Activities undertaken by village health committees according to the 53 village health committee members who responded.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Understand</th>
<th>Daily</th>
<th>Weekly</th>
<th>Bi-Monthly</th>
<th>Monthly</th>
<th>Rarely</th>
<th>N=</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home visits</td>
<td>100%</td>
<td>0</td>
<td>34.0%</td>
<td>34.0%</td>
<td>9.4%</td>
<td>18.9%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Identification of health problems in area of operation</td>
<td>96.2%</td>
<td>3.8%</td>
<td>37.3%</td>
<td>23.7%</td>
<td>11.8%</td>
<td>23.5%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Disease prevention interventions</td>
<td>94.3%</td>
<td>5.7%</td>
<td>40.0%</td>
<td>28.0%</td>
<td>8.0%</td>
<td>24.0%</td>
<td>-</td>
</tr>
<tr>
<td>Vegetable gardening</td>
<td>54.9%</td>
<td>45.1%</td>
<td>65.5%</td>
<td>6.9%</td>
<td>3.4%</td>
<td>6.9%</td>
<td>17.2%</td>
</tr>
<tr>
<td>Follow-up of TB patients</td>
<td>92.5%</td>
<td>7.5%</td>
<td>51.0%</td>
<td>18.4%</td>
<td>4.1%</td>
<td>22.4%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Treatment supervision</td>
<td>86.8%</td>
<td>13.2%</td>
<td>60.9%</td>
<td>15.2%</td>
<td>2.2%</td>
<td>19.6%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Vaccination campaign</td>
<td>86.8%</td>
<td>13.2%</td>
<td>26.1%</td>
<td>8.7%</td>
<td>2.2%</td>
<td>23.9%</td>
<td>39.1%</td>
</tr>
<tr>
<td>Reproductive Health/FP</td>
<td>94.3%</td>
<td>5.7%</td>
<td>44.0%</td>
<td>28.0%</td>
<td>2.0%</td>
<td>4.0%</td>
<td>-</td>
</tr>
<tr>
<td>Child health promotion</td>
<td>92.5%</td>
<td>7.5%</td>
<td>40.8%</td>
<td>30.6%</td>
<td>2.0%</td>
<td>22.4%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Chicken rearing</td>
<td>32.7%</td>
<td>67.3%</td>
<td>5.9%</td>
<td>11.8%</td>
<td>17.6%</td>
<td>23.5%</td>
<td>41.2%</td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 7.22: Activities Undertaken by Village Health Committees (N=53)

Table 7.22 clearly displays the percentages on undertaking of activities and how often. From this, it was very clear that all village health committee members, 100%, undertook home visits. This way, they all did community diagnosis and appreciated problems that exist. Furthermore, they would appreciate the environment where the people they supported lived.

Identification of health problems was the next exercise undertaken, by 96.2 percent of respondents, followed by disease prevention interventions and family planning promotion/reproductive health by equal percentages of 94.3 respectively.
Follow-up of tuberculosis patients and child health promotion were next in popularity according to 92.5 percent of respondents.

Treatment supervision and vaccination were reported to be the next implemented activities by 86.8 percent of the respondents. Vegetable gardening was reported to be undertaken by slightly over half of the respondents 54.9 percent, with 45.1 percent responding that it was not engaged in the activity. The least undertaken activity was chicken rearing by about a third, only 32.7 percent, of the respondents. A large percentage (67.3%) of the respondents reported not to be engaged in any chicken rearing.

**Item 16 and Item 15: On nurses’ questionnaire. How often village health committee members view their involvement in selected activities as shown in table 7.23 below. VHC = Village health committees' response; one nurse did not respond.**

<table>
<thead>
<tr>
<th>No.</th>
<th>Role</th>
<th>Daily</th>
<th>Weekly</th>
<th>Monthly</th>
<th>Bi-monthly</th>
<th>Never</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Conducting home visits.</td>
<td>VHC 22.6%</td>
<td>34.0%</td>
<td>28.3%</td>
<td>15.1%</td>
<td>17.6%</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>Nurse 5.9%</td>
<td>52.9%</td>
<td>5.9%</td>
<td>17.6%</td>
<td></td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>2.</td>
<td>Identification of health problems in area of operations</td>
<td>VHC 22.6%</td>
<td>37.7%</td>
<td>20.8%</td>
<td>15.1%</td>
<td>3.8%</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>Nurse 17.6%</td>
<td>17.6%</td>
<td>41.2%</td>
<td>11.1%</td>
<td>11.1%</td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>3.</td>
<td>Disease prevention interventions</td>
<td>VHC 30.2%</td>
<td>32.1%</td>
<td>26.4%</td>
<td>5.7%</td>
<td>29.4%</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>Nurse 5.9%</td>
<td>52.9%</td>
<td>5.9%</td>
<td>5.7%</td>
<td>5.7%</td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>4.</td>
<td>Vegetable gardening</td>
<td>VHC 30.2%</td>
<td>7.5%</td>
<td>7.5%</td>
<td>5.7%</td>
<td>49.1%</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>Nurse 11.8%</td>
<td>17.6%</td>
<td>23.5%</td>
<td>47.1%</td>
<td></td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>5. (a)</td>
<td>Follow up of TB patients</td>
<td>VHC 0%</td>
<td>41.2%</td>
<td>0%</td>
<td>17.6%</td>
<td>41.2%</td>
<td>17</td>
</tr>
<tr>
<td>5. (b)</td>
<td>Case identification and case holding e.g. TB</td>
<td>Nurse 37.7%</td>
<td>17.7%</td>
<td>32.1%</td>
<td>5.7%</td>
<td>7.5%</td>
<td>53</td>
</tr>
<tr>
<td>6.</td>
<td>Treatment and Supervision</td>
<td>VHC 50.9%</td>
<td>13.2%</td>
<td>0%</td>
<td>18.9%</td>
<td>17.0%</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>Nurse 0%</td>
<td>23.5%</td>
<td>23.5%</td>
<td>11.8%</td>
<td>41.2%</td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>7.</td>
<td>Vaccination campaigns</td>
<td>VHC 34.0%</td>
<td>7.5%</td>
<td>22.6%</td>
<td>17.0%</td>
<td>18.9%</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>Nurse 11.8%</td>
<td>41.2%</td>
<td>0%</td>
<td>23.5%</td>
<td>23.5%</td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>8.</td>
<td>Reproductive Health promotion activities</td>
<td>VHC 47.2%</td>
<td>22.6%</td>
<td>22.6%</td>
<td>3.8%</td>
<td>3.8%</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>Nurse 5.9%</td>
<td>22.6%</td>
<td>0%</td>
<td>29.4%</td>
<td>3.8%</td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>9.</td>
<td>Child Health promotion activities</td>
<td>VHC 43.4%</td>
<td>26.4%</td>
<td>24.5%</td>
<td>1.9%</td>
<td>3.8%</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>Nurse 17.6%</td>
<td>47.1%</td>
<td>0%</td>
<td>23.5%</td>
<td>11.5%</td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>10.</td>
<td>Referral of patients to Health Services</td>
<td>VHC 58.5%</td>
<td>13.2%</td>
<td>17.0%</td>
<td>5.7%</td>
<td>5.7%</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>Nurse 17.6%</td>
<td>23.5%</td>
<td>5.9%</td>
<td>23.5%</td>
<td></td>
<td></td>
<td>17</td>
</tr>
</tbody>
</table>

Table 7.23: Nurses’ responses in percentages on how often village health committee members view their involvement in selected areas (N=17)
Table 7.23 presents a comparison/situation of how often village health committees perceived themselves to be involved in activities as stated in the table, as well as how often the nurse, as a member of the village health committee perceived the village health committees’ involvement in the same activities. The nurses indicated the extent of their involvement in comparison to that of village health committees. All village health committee respondents (N=53) responded. For nurses N=17; that is, one nurse did not respond to this question.

*Involvement in Home Visits:* 22.6 percent of village health committee members compared to 5.9 percent of nurses were reported to be involved in conducting home visits on a daily basis. This indicates that even though the nurse is busy with clinic and other duties, she was able to get feedback on some health problems at the local level from committee members.

Home visits were undertaken at least once a week, according to more than half of the nurses (52.9%). The village health committee members’ reported that visits were more spread out, with the majority of them (34.0%) undertaking home visits at least once a week 28.3 percent undertook them on a monthly basis, as opposed to 5.9 percent by nurses. Almost equal percentages (15.1% of village health committee members and 17.6% of nurses) did home visits every two months. All village health committee members undertook home visits, as opposed to 17.6 percent of the nurses that never do home visits.
Identification of health problems in the village/ward or area of operation: the majority of nurses (41.2%) reported that they identified health problems in the village/ward monthly. With village health committee members this task is undertaken and almost equally spread out as shown on the table, with the majority (37.7%) doing problem identification mainly on a weekly basis. Some of the village health committee members and nurses (3.8% and 11.1% respectively) reported that they never engaged in identification of health problems in their areas of operation. For them to embark upon activities though, it must be in response to existing identified problems.

Disease prevention intervention: an almost equal number of both village health committees and nurses (5.7% and 5.9% respectively) reported that the village health committees are never involved in disease prevention identification exercise. The majority of nurses (52.9%) reported that they engage in this exercise weekly, as opposed to village health committee members whose activities are almost equally spread out mainly between daily and monthly services.

Vegetable gardening: is one exercise that has quite significant percentages (49.1% for village health committees and 47.1% for nurses) that never engage in it. A percentage of 30.2 percent of village health committee members as opposed to 17.6 percent of nurses report participation in this exercise on a daily basis.
Case identification and follow-up of tuberculosis patients: 41.2 percent of the nurses reported undertaking this task weekly; an equal percentage (41.2%) reported that this exercise is never undertaken, and 17.6 percent reported to be providing this service every two months. With the nurses, the task mainly involved provision of clinical services to patients, and support and educational services to committee members. About a third of village health committee members (32.1%) reported to follow-up TB patients monthly. Where no nurses reported that they follow up tuberculosis patients daily, 37.7 percent of village health committee members reported to be following up tuberculosis patients daily, 17.7 percent weekly and 5.7 percent every two months.

Treatment and Supervision: 50.9 percent of village health committee members, as against zero percent of nurses, reported to be involved in treatment and supervision in the committee. This implies that it is the village health committee members who visit and ensure that patients who are treated at home (on home-based care) do take their treatment on a daily basis. This, though, they do under the guidance and support of nurses who are more knowledgeable and trained for that. Nurses undertake this exercise mainly spread throughout, from weekly to every two months. Quite a high percentage of nurses (41.2%), as opposed to 17.0 percent of village health committee members reported that it never undertakes the exercise. This can be interpreted to mean that it is an area that requires to be strengthened. This
supports Omondi et al (1994:9) whereby it is said that the core problem is complex and related to a number of concerns:

Lack of a well defined support structure; lack of clear guidelines and managing the VHCs; lack of regular supportive supervision; lack of support from some health workers partly related to lack of familiarity with the concept of VHC's; low level of acceptance by the community most likely related to insufficient time being spent in preparing the communities; and lack of monitoring, evaluation and feedback system and hence no way of objectively assessing their achievements. Village health committees are also calling for systematic training and preparation for the tasks that they are expected to accomplish not only to help them regain their confidence and credibility of the community, but also to help them relate with other effective community organizations from a position of respect.

The above is assumed to account for the percentage (41.2%) of the nurses who are leaders and supervisors and thus expected to motivate village health committees, and for the committees 17.0 percent that reports not to be involved in this task. The task of training as well as the attributes are highlighted in the quotation above.

**Vaccination Campaigns:** Both the nurses and village health committees generally agree on the importance of involvement in vaccinations. As indicated, there are those that report that they are never involved, indicating the multifaceted and complex nature of problems facing the village health committees. It is of concern that even after running campaigns, village health committee members and especially nurses are not involved.
Reproductive Health Promotion and Activities: Being mainly motivators, it is understandable that a significant percentage (42.7%) of the village health committee members as opposed to 5.9 percent of nurses report the village health committee to be engaged in reproductive health promotion on a daily basis. Of interest is the 35.3 percent of nurses reporting non-involvement in the exercise versus only 3.8 percent of village health committee members. The message conveyed is that although the nurses do not find time for directly providing community sensitisation and motivation for health activities, they have been able to train village health committee members, and have given them confidence in their community motivation work.

Child Health Promotion Activities: The response pattern displayed in reproductive health promotion is also applicable here. Of interest is that on a daily, weekly and bi-monthly basis the nurse is active in providing child health activities.

Referral of Patients to Health Services: Over half of village health committee members (58.5%), refer patients that they identify in the community, to health facilities on a daily basis. Furthermore, the percentage of village health committee members that never refers patients from the community to health facilities is only 5.9 percent, as compared to 23.5 percent of nurses.

Item 17: Village health committees' questionnaire. Guidance received by village health committees with regard to what is expected of them in their
involvement in the community. One village health committee member did not respond.

<table>
<thead>
<tr>
<th>How Often Guidance Received</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>26</td>
<td>49.1</td>
</tr>
<tr>
<td>Sometimes</td>
<td>26</td>
<td>49.1</td>
</tr>
<tr>
<td>Never</td>
<td>1</td>
<td>1.9</td>
</tr>
<tr>
<td>Total</td>
<td>53</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 7.24: Guidance Received by Village Health Committees Regarding Frequency of Guidance They Expect to Get in Their Work (N=53)

As displayed in table 7.24 above, 49.1 percent of village health committee members as well as an equal percentage (49.1%) expected to be always guided, and to be sometimes guided. An insignificant percentage of 1.9 of committee members never expected guidance.

Item 18: Village health committee: What guidance village health committees received.

Only 52 out of 53 village health committee members responded.
Table 7.25: Guidance/Support Received for Activities (N=52)

<table>
<thead>
<tr>
<th>Guidance/Support</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>N=52</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Giving health information</td>
<td>61.5%</td>
<td>38.5%</td>
<td>-</td>
<td>-</td>
<td>52</td>
</tr>
<tr>
<td>2. Information imparting/ Communication Skills</td>
<td>48.1%</td>
<td>40.4%</td>
<td>7.7%</td>
<td>3.8%</td>
<td>52</td>
</tr>
<tr>
<td>3. Planning Skills</td>
<td>36.5%</td>
<td>21.2%</td>
<td>11.5%</td>
<td>30.8%</td>
<td>52</td>
</tr>
<tr>
<td>4. Treatment Taking and Monitoring</td>
<td>32.7%</td>
<td>42.3%</td>
<td>7.7%</td>
<td>17.3%</td>
<td>52</td>
</tr>
<tr>
<td>5. Simple health procedures e.g. blood pressure taking</td>
<td>7.8%</td>
<td>5.9%</td>
<td>2.0%</td>
<td>84.3%</td>
<td>51</td>
</tr>
<tr>
<td>6. Rehydration in Diarrhoeal Diseases</td>
<td>82.7%</td>
<td>11.5%</td>
<td>1.9%</td>
<td>3.7%</td>
<td>52</td>
</tr>
<tr>
<td>7. Oral Health</td>
<td>32.7%</td>
<td>44.2%</td>
<td>11.5%</td>
<td>11.5%</td>
<td>52</td>
</tr>
<tr>
<td>8. Baby Weighing</td>
<td>52.9%</td>
<td>17.6%</td>
<td>3.9%</td>
<td>25.5%</td>
<td>51</td>
</tr>
<tr>
<td>9. Vegetable Gardening</td>
<td>40.4%</td>
<td>5.8%</td>
<td>-</td>
<td>53.8%</td>
<td>52</td>
</tr>
<tr>
<td>10. Child Rearing</td>
<td>2.0%</td>
<td>8.0%</td>
<td>2.0%</td>
<td>88.0%</td>
<td>50</td>
</tr>
<tr>
<td>11. Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>50</td>
</tr>
</tbody>
</table>

Health Information Giving: As indicated in table 7.25, 100 percent of village health committee members reported that they received good to excellent guidance in providing health information to community members. A high percentage (61.5%) reported that the guidance received was excellent. This is a commendable statement for the nurse, as the team leader at the local facility level.

Planning Skills: It is also commendable to the leadership that 57.7 percent (57.7%), overleaf of the village health committee members reported to have received excellent to good planning skills guidance. This enabled them to plan all their activities, including health talks. There was also the 11.5 percent (11.5%) of respondents that stated that the planning skills’ imparting was fair. Quite a significant percentage, however, 30.8 percent reported to be receiving poor planning skills guidance. This is a challenge for nurse leaders to strengthen village health committees in their areas of operation with planning skills.
This would enhance the planning skills of members and subsequently positively impact on the health of the communities that they serve.

*Information Imparting/Communication Skills:* Armed with information, people develop confidence in sharing information on health.

> It is generally accepted, however, that education and training for community involvement for health (CIH) should be considered at three levels - professional staff, community health workers, community leaders - so that contact and methods can be related to the differing roles and responsibilities of professionals and members of the community at the national, regional and district levels. (Oakley 1989:42).

Data in table 7.25 indicate that the interviewed village health committees had received the excellent guidance that they required to be able to provide health information to their fellow community members.

On information imparting and communication skills' guidance, 88.4 percent (88.4%) of respondents reported that they received guidance ranging from excellent (48.1%), to good (40.4%) and fair (7.7%). An insignificant percentage (3.8%) reported that the guidance it received was poor. This, however, is an area that requires constant strengthening and nurturing. It should thus receive attention in the pre-service nursing training curriculum.

> Good communication is the cornerstone of any strategy of rural health care. Village health workers identify major health needs by observing, listening and talking with villagers; the relationship between patient and health worker is one of dialogue, with both parties listening and trying to understand what the other is saying; qualified staff in supervising others do not just tell them what to do, but adopt a problem-solving approach, discussing,
The need to strengthen village health committee members on information imparting and communication skills cannot be over-emphasized. This, is a challenge for the nurses, who are leaders at health facility levels.

When people plan their work, confusion between contribution and true involvement is eliminated. "In the environmental or development activities people may be asked to contribute in cash or kind (material or labour). This is different from involvement, and is not a matter of participation. Involvement is to do with deciding about goals and tasks and working together to achieve this" (Amonoo-Larson et al 1985:92).

*Treatment Taking and Monitoring:* A cumulative percentage (82.7%) reported to be receiving guidance in treatment taking and monitoring ranging from excellent to fair. This is attributable to the fact that part of the role of village health committee members is to motivate those on treatment in their areas of operation to take treatment as per prescription. To address the problems of tuberculosis and resistance associated with defaulting to adhere to treatment schedule, treatment monitoring had to be strengthened right up to the individual level. "Tuberculosis is already the opportunistic infection that most frequently kills HIV positive people" (WHO 1996(a):28).

*At the same time, drug-resistant tuberculosis is a growing threat world-wide. Incomplete or inappropriate treatment of the disease has spawned the development of strains that are resistant to drugs that once destroyed the bacteria in 100% of cases (WHO 1996(a):28).*
It is thus of serious concern that 17.3 percent of village health committee members’ rated the guidance they received in the area of treatment taking and monitoring as poor. This is an area that even focus groups discussants described as very important, since in their daily home visits to those on treatment they play an important role in providing support and ensuring the actual taking of treatment as per requirements.

*Simple Health Procedures Such as Blood Pressure Taking:* According to the data analysis, a cumulative percentage of 15.7 percent reported to have received guidance in simple health procedures such as blood pressure taking. A very high percentage (84.3%) had received poor guidance in this area. Village health committee members' participation in this activity has potential to assist in the screening and timely referral of persons to health facilities. However, it requires decisions regarding how far the country's health system is prepared to involve community members in their own health development, as well as on its ability to provide equipment (such as blood pressure machines) for use in the activity. Of certainty, however, is the increase of cardiovascular and other non-communicable diseases in the country, moreso that according to Maganu (1997:300)

*There has been a noticeable increase in non-communicable diseases such as cardiovascular diseases, diabetes, neoplasms and degenerative disorders.*

*Rehydration in Diarrhoeal Diseases:* According to the table 7.25, a significant cumulative percentage (96.1%) reported to be receiving guidance in
rehydration in diarrhoeal diseases. This is commendable, and shows the local nurses leadership commitment to prevention of deaths from diarrhoeal diseases. The 3.8 percent that rated the guidance they received as poor indicates the need for continuous information provision and strengthening.

Oral Health: At the local level health facilities, where there is mostly absence of dentists and dental therapists, there exists a system whereby some nurses have undergone training in oral health care including tooth extraction. Hence the cumulative percentage (88.4%) that stated that it received guidance in oral health care services provision. This normally involves orientation in prevention of oral health diseases. A cumulative percentage (76.9%) rated the guidance it received as excellent to good.

Baby Weighing: Most of the practical baby weighing involvement by village health committee members takes place at the health facilities in the presence of the family welfare educator or nurse. Quite a sizeable percentage of the involvement is related to the imparting of information, especially on child nutrition. It is interesting to note that a significant cumulative percentage of village health committee members (74.4%) received guidance in this area. Participation and involvement of the village health committee members in child health can be safely assumed to have contributed significantly to the reduction of undernutrition among under-five children.

There was a steep decrease in undernutrition percentages among the underfives between 1980 and 1985; from 26% to 19% respectively. Protein energy malnutrition further declined gradually between 1985 and 1991. Since then
undernutrition remained stagnant at around 15% before decreasing to 13% (Gobotswang & Kobue 1997:23).

Vegetable Gardening: According to Chapter 2, especially under 2.2, geography and environment, it is quite clear that Botswana is not self sufficient in food production

Rather than seeing poverty as resulting from drought, destitution and other "exceptional" circumstances, it is more accurate to see poverty as a result of highly adverse climatic and soil conditions, which means that agriculture, in general, does not have the potential to provide adequate (non-poverty) incomes for large numbers of Batswana. Poverty is, therefore, a structural characteristic of Botswana's rural areas. This is one of the main factors that distinguishes Botswana from other countries, especially in Sub-Saharan Africa, where one of the most effective potential means of poverty alleviation is the "sort out" agriculture, by reforms to pricing policies, and the provision of extension services, so as to enable the underlying potential of agriculture to be realized (Jeffries 1997:37).

Most of the food in the country, including vegetables, is thus imported. Village health committees, in an attempt to ensure availability of fresh vegetables for the under-fives, pregnant and lactating mothers as well as patients such as those suffering from tuberculosis, decided to embark upon, and promote, vegetable gardening. This has not, however, been a successful venture as demonstrated by data in table 7.25. As indicated only a cumulative percentage of 46.2 percent stated that they received guidance in this area against 53.8 percent that rated the guidance given as poor. Motivational levels and training for productive arable agriculture in an environment as described in chapter two, is required not only by village
health committee members, but even by the very health professionals who should provide the guidance required.

*Chicken Rearing*: Is another agricultural activity that an insignificant number of village health committees has attempted to address nutritional status. The cumulative percentage of those involved in this activity is only 12 percent, with 88 percent reporting that guidance received is poor. Unlike with vegetable gardening, this is a possible project that committee and community members can embark upon with success, for their own economic upliftment. The nurse would not necessarily possess skills to guide committee members with this project; however, she/he is in a better position, in the spirit of intersectoral collaboration, to assist village health committee members to benefit from agricultural staff's expertise. This is an area that village health committee members will require financial and other resources to enable them to embark upon the project.

As indicated by Omondi et al (1994:22),

97.9% of the key informants interviewed indicated that they saw income generating activities (IGAs) as a viable incentive for village health committees (VHCs). They however cautioned that this could only be realized if certain conditions were fulfilled.

**Item 19: Village Health Committees' Questionnaire: Support to Village Health Committees.**
Figure 7.8 indicates no support from medical doctors. The majority of respondents, 58.5 percent, stated that they received support from the family welfare educator on a daily basis; the nurse was reported to give daily support by 39.6 percent of the respondents.

According to the key informants, supervision and coordination of the activities of the VHCs is supposed to be mainly carried out by either the nurses or Family Welfare Educators (FWEs), or jointly by the nurse and the FWE. There was however no consensus as to who holds the ultimate responsibility (Omondi et al 1994:5).

A cumulative percentage of 60.4 percent of the village health committee members reported to be receiving weekly support from nurses; this is against a cumulative percentage of 86.6 percent of the same group that reported to be receiving weekly support from family welfare educators. When it comes to
monthly visits, however, the cumulative percentage of nurses support rises to 96.2 percent as opposed to 82.5 percent for family welfare educators. This indicates that nurses as leaders at the local level undertake their supervisory visits and provide support on a monthly basis. This is also as opposed to monthly cumulated supervisory support provided by the environmental health officers and the chief, which were at 32.1 percent and 50.9 percent respectively. The above cumulative results clearly show the nurse as leading in providing support to village health committees.

The above is related to Item 16 in the questionnaire for nurses whose results are shown in table 7.26:

<table>
<thead>
<tr>
<th>Sources of Support How Often</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>4</td>
<td>23.5</td>
</tr>
<tr>
<td>Weekly</td>
<td>3</td>
<td>17.6</td>
</tr>
<tr>
<td>Monthly</td>
<td>2</td>
<td>11.8</td>
</tr>
<tr>
<td>Rarely</td>
<td>7</td>
<td>41.2</td>
</tr>
<tr>
<td>Never</td>
<td>1</td>
<td>5.9</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 7.26: How Often Support is Received (N=17)
The data displayed in figure 7.8 differs from the nurses’ responses as given in table 7.26 in that:

- In comparison with the 58.5 percent of village health committee respondents who indicated that they received daily support only 23.5 percent of nurses indicated that it supports village health committees daily. Only cumulative percentages (41.1% and 52.9%) of nurses indicated to be providing support to village health committees on a weekly and monthly basis respectively. This is as opposed to the 96.2 percent and 92.5 percent monthly support by nurses and family welfare educators respectively indicated by village health committees.

- Regarding support by family welfare educators, nurses responses reflect that they regard the family welfare educators’ support to village health committees on monthly basis to be exceeding the support provided by themselves (the nurses) at 65.7 percent weekly and 83.3 percent monthly.

In summary, 96.2 percent of village health committee respondents reported that it received monthly support from nurses; this is as opposed to only 63.9 percent of nurses that indicated to be providing that support to village health committees on a monthly basis. Regarding family welfare educators’ support, where 92.5 percent of village health committees reported to receive support from them on a monthly basis, the nurse respondents reported the percentage as 83.3 percent, which is less than the village health committees percentage rating by 8.2 percent.
According to village health committee members medical officers/doctors provided no (zero) support. Nurses on the other hand (11.8%), reported that doctors provided village health committees with support on a daily basis.

The above is understandable because in Botswana by virtue of their numbers in comparison with other health professionals

... clinics and health posts are being run by local authorities and the bulk of the health care at these facilities lies in the hands of the nurses (Botswana Government's Ministry of Finance and Development Planning 1985-1991:98).

Furthermore, as indicated by the UNDP, Government of Botswana & UNICEF (1993:51) nurses form the majority of health workers in Botswana. The number of medical doctors and health educators are both very insignificant.

To date training of doctors, pharmacists, dentists etc. Is still carried out abroad. The need to establish a medical school within the University of Botswana has been indicated. The MOH has instituted an accelerated programme to train doctors (Gobotswang & Kobue 1997:32).

The move to accelerate the training of medical doctors is quite recent and does not yet have visible results. The training of health educators is also not regarded as a priority as demonstrated by the discontinuation of the programme that was impending at the Gaborone National Health Institute. Information, Education and Communication for health are the cornerstones, as they are the answer to prevention of ill-health, promotion of health and rehabilitation where disability has set in. It is thus of great concern where the
cornerstone of primary health care, health education, becomes weak. As stated by Adeniyi (1988:xxx(ii) introduction),

... health education was destined, with time, to take on a meaning different from its original interpretation of "imparting or teaching of health information" to the application of a combination of educational and behavioural strategies to make people's action compatible with high standards of health.

This group of health workers is required for community sensitisation, mobilisation and organisation for health to succeed and to be sustained; it is when health education is active that other health workers, including nurses and family welfare educators, will be enabled to embark upon community-based activities. As stated by Gobotswang and Kobue (1997:61),

The Health Education Section (HES) made good progress in implementing its action plan with varying degrees of success. It played a major role in reactivating Village Health Committees (VHCs) which are vital in social mobilization and/or motivating community participation at local levels. Efforts at intersectoral network building have been made through technical support to NGOs engaged in health related activities.

Health is thus about team work; it is about intersectoral and multisectoral active involvement.
Item 20: How village health committee members rate the support they get.

<table>
<thead>
<tr>
<th>Cadre</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>N=</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>7.5%</td>
<td>7.5%</td>
<td>1.9%</td>
<td>83.0%</td>
<td>53</td>
</tr>
<tr>
<td>Nurse</td>
<td>45.3%</td>
<td>34.0%</td>
<td>17.0%</td>
<td>3.8%</td>
<td>53</td>
</tr>
<tr>
<td>Family Welfare Educator</td>
<td>73.6%</td>
<td>24.5%</td>
<td>1.9%</td>
<td>0</td>
<td>53</td>
</tr>
<tr>
<td>Environmental Health Officer</td>
<td>7.5%</td>
<td>7.5%</td>
<td>13.2%</td>
<td>71.7%</td>
<td>53</td>
</tr>
<tr>
<td>Local Chief</td>
<td>9.4%</td>
<td>24.5%</td>
<td>20.8%</td>
<td>45.3%</td>
<td>53</td>
</tr>
<tr>
<td>Businessman</td>
<td>5.7%</td>
<td>17.0%</td>
<td>28.3%</td>
<td>49.1%</td>
<td>53</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>75%</td>
<td>25%</td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>

Table 7.27: Rating of Support Received by Village Health Committees (N=53)

According to table 7.27, 73.6 percent of village health committee members report to be getting excellent support from family welfare educators. The cumulative percentage of excellent to fair support received from the family welfare educator is 100 percent. None of the village health committee respondents reported to be getting poor support from the family welfare educator. The next appreciable support was reported by nurses as follows: 45.3 percent excellent and 34.0 percent good. The cumulative percentage of excellent to fair support by nurses was reported to be 83.1 percent. An insignificant, but important, percentage (3.8%) reported that village health committees received poor support from nurses.
The local chief was reported by a cumulative percentage of 54.7 to be providing support, whereas 45.3 percent of the respondents rated the local chief's support as poor.

The cumulative percentages of 51.9 percent, 28.3 percent and 16.9 percent were recorded for support by the local businessman, the environmental health officer and the medical doctor (mainly Public Health Specialist) respectively.

Item 20 above is not similar, but related to Item 16 in the questionnaire for nurses which is on how often village health committees are supported by some health cadres as shown in table 7.28.

<table>
<thead>
<tr>
<th></th>
<th>Daily</th>
<th>Weekly</th>
<th>Monthly</th>
<th>Rarely</th>
<th>Never</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
<td>23.5%</td>
<td>17.6%</td>
<td>11.8%</td>
<td>41.2%</td>
<td>5.9%</td>
<td>100%</td>
</tr>
<tr>
<td>Doctor</td>
<td>11.8%</td>
<td>5.9%</td>
<td>11.8%</td>
<td>17.6%</td>
<td>52.9%</td>
<td>100%</td>
</tr>
<tr>
<td>Family Welfare</td>
<td>41.2%</td>
<td>23.5%</td>
<td>17.6%</td>
<td>11.8%</td>
<td>5.9%</td>
<td>100%</td>
</tr>
<tr>
<td>Educator</td>
<td>6.3%</td>
<td>12.5%</td>
<td>18.8%</td>
<td>43.8%</td>
<td>18.8%</td>
<td>100%</td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Table 7.28: **Support Received from Some Health Cadres According to Nurses**
As shown in table 7.28, a cumulative percentage of 64.7 percent of family welfare educators, according to the nurses, supported village health committee members on a daily to weekly basis. The cumulative monthly support percentage was 82.4 percent by family welfare educators. They also provided the highest daily support according to 41.2 percent of the nurses. The nurses supported village health committees on a daily to weekly basis. A percentage (11.8%) and quite a small percentage of family welfare educators (5.9%) rarely and never supported village health committees respectively.

A significant percentage (41.2%) of nurses rarely supported village health committees. The percentage of nurses that was reported to have never supported village health committees was the same as that for family welfare educators, (5.9%).

The cumulative support of daily to monthly support by doctors was 29.5 percent, while that for health educators was 37.6 percent. A cumulative percentage of 81.4 percent of the health educators weekly to rarely support village health committees as opposed to 47.1 percent of doctors. The two cadres, doctors and health educators, apart from being insignificant in numbers did not reside in any village or town but served at the district level.

*Shortage of skilled manpower, especially in the professional cadre of health educators, partly due to staff turnovers and vacancies of staff members on further studies. A Diploma Training programme which started at the Institute of Health Sciences will alleviate this problem. First graduates are expected in 1997.*
The diploma training programme mentioned above was started. However, plans are on to discontinue the programme again.

Guidance on a daily basis was mostly provided by the family welfare educator according to these findings. This she/he was able to do because of the support of the nurse who is motivated in community organisation for health.

**Item 36: The importance of the village health committee according to the nurse.**

All nurses agreed that village health committees could identify problems. This was supported by their earlier reported activities, including the ability to refer persons who require treatment.

Of the nurses 88.2 percent reported that village health committees were important for conducting home visits. This has been verified as indicated in item 21 and table 30, by village health committee members.

On village health committees as effective motivators of the community, 100 percent of the nurse respondents agreed. This is in agreement with item 21 from the village health committees' questionnaire. All nurse respondents agreed that village health committees were effective in educating the community on disease management and prevention. This, they could only achieve through continuous information imparting, education and
communication provided by the nurse, who continues to provide leadership in health at the local level.

On whether the village health committee can advise health workers on how to approach health issues and locate areas with problems in the community, it is interesting that a significant percentage of 76.5 of the nurses is in agreement. This does not only show maturity, but also true leadership qualities in the nurses. Leadership is defined by (Kaseje 1992:8) CONTACT, in Leadership for Health for All: The Painful Learning Experience of the Saradidi Rural Health Programme.

Willing to develop leadership qualities in others, delegating power, authority and responsibility appropriately and allowing others to take over from them; after a leadership transition, willing to continue serving the community in less prominent but vital roles as a good follower; less concerned about titles than tasks to be carried out.

An affirmative response of 64.7 percent to case identification and case holding e.g. TB, proves the leadership qualities as has been described above. The high percentage (82.4%) of the nurses who advocate for interests of the community members to be included in planning and development supports the leadership qualities, as well as partnership spirit. Of the nurses, 100 percent report that the village health committee serves as a link between the community and the health care delivery system, and that it is an avenue for community participation and health development. All this is confirmed by the definition of leadership as stated in Contact: Leadership and Community Participation for Health by Kaseje (1992:8-9).
According to table 7.22 on page 167, a cumulative percentage (68.0%) of village health committee members reported to be undertaking home visits on a daily to weekly basis. The rest of the home visits were done either twice in a month, monthly or rarely. For comparison purposes, items 36 on page 190 and 21 on page 167 were discussed together below.

As earlier stated by the same table on page 167, regarding identification of health problems in their area of operation, a cumulative percentage of 60.8 percent stated to undertake the activity on a daily to weekly basis. Again the next highest percentage was on a monthly basis by 23.5 percent of the respondents.

A cumulative percentage (68.0%) reported that they undertook disease prevention activities on a daily to weekly basis. Family planning/reproductive health promotion activities were done on a daily to weekly basis by 72.0 percent. This indicated that only a total of 28.0 percent of reproductive health activities as opposed to disease prevention activities (32.0%) were spread between bi-monthly and rare implementation.

Regarding follow-up of tuberculosis patients and child health promotion, the daily to weekly cumulative percentages were 69.4 percent and 71.4 percent respectively.
The daily to weekly cumulative percentage response of treatment supervision was 76.1 percent as against only 34.8 percent for the vaccination campaign. A significant percentage (39.1%) stated that it rarely engaged in vaccination campaigns. Indeed, campaigns were usually planned, not routine and therefore not always implemented.

A cumulative percentage (72.4%) reported daily to weekly gardening activities, with the daily percentage (65.5%) being the highest. This looks credible as gardening requires consistent and daily care. A significant percentage (17.2%) reported to have been rarely engaging in vegetable gardening.

Regarding chicken rearing, respondents were only 17 (N=17). A high percentage of this group (67.3%) reported that it did not engage in chicken rearing while 32.7 percent did engage in chicken farming. If these findings in forms of frequency are scrutinized it becomes clear that only one person actually participated in chicken rearing.

**Item 22 for village health committees on time devoted to community work.**

<table>
<thead>
<tr>
<th>Time Committed</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Half day daily</td>
<td>13</td>
<td>24.5</td>
</tr>
<tr>
<td>Daily</td>
<td>4</td>
<td>7.5</td>
</tr>
<tr>
<td>Two days per week</td>
<td>14</td>
<td>26.4</td>
</tr>
<tr>
<td>One day per week</td>
<td>19</td>
<td>35.8</td>
</tr>
<tr>
<td>One day a month</td>
<td>3</td>
<td>5.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>53</td>
<td><strong>99.8</strong></td>
</tr>
</tbody>
</table>

Table 7.29: Time Devoted by Village Health Committees to Community Work (N=53)
As table 7.29 indicates, only over a third (35.8%) of village health committee members, devoted time to community work at least once per week. A percentage of only 24.5 reported to be devoting half a day daily to community work. Only a very small percentage (7.5%) of village health committee members indicated devoting a full day in seven days (per week) to community work. This verifies earlier reports by focus group discussions that most of the village health committee members had to find work to make a living, and thus could only volunteer on a very limited part-time basis. A significant cumulative percentage (62.2%) could only devote their time to community work from once to twice per week. To demonstrate that motivation and determination were high, however, it was only a very small percentage (5.7%) that devoted time only once per month to community work. Despite shortage of time due to gainful employment, village health committee members continue to be committed to helping their fellow community members. This is verified by the saying that “Once a community health worker always a community health worker” (Omondi et al, 1994:15).

Item 23 in the village health committee questionnaire was found to be incorporated into Item 24 of the same questionnaire: How often health talks were discussed in various areas.
Table 7.30: How Often Health Talks Were Discussed in Various Areas

<table>
<thead>
<tr>
<th>Place</th>
<th>Weekly</th>
<th>Bi-weekly</th>
<th>Monthly</th>
<th>Rarely</th>
<th>Never</th>
<th>N =</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Kgotla</td>
<td>1.9%</td>
<td>3.8%</td>
<td>37.7%</td>
<td>49.1%</td>
<td>7.5%</td>
<td>100%</td>
</tr>
<tr>
<td>2. Health facility</td>
<td>79.2%</td>
<td>5.7%</td>
<td>11.3%</td>
<td>-</td>
<td>3.8%</td>
<td>100%</td>
</tr>
<tr>
<td>3. During Workshops/Seminars organised for the community</td>
<td>3.8%</td>
<td>9.4%</td>
<td>11.3%</td>
<td>49.1%</td>
<td>26.4%</td>
<td>100%</td>
</tr>
<tr>
<td>Other</td>
<td>100%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
</tbody>
</table>

Item 18 in the nurses’ questionnaire: How often nurses organise and address community members in some specified areas is similar to Item 24 in the village health committees questionnaire.

From table 7.30 it is clear that most of the health information, 79.2 percent, is provided at the health facility on a weekly basis. About half of the village health committee members (49.1%), reported that health talks rarely take place at the kgotla. A small percentage (7.5%) reported that health talks never take place at the kgotla.

Health seminars/workshops are also reported by 49.1 percent of the village health committee members to be rarely implemented, and 26.4 percent of village health committee members report that health seminars and workshops never take place.
That health talks at health facility levels are satisfactorily provided is very commendable. However, it can be deduced here that the only people who will gain from these health talks will be those who will visit a health facility, when services in primary health care have to be taken to where the people are; this is not satisfactory. It must be remembered that for health workshops/seminars to take place resources such as skilled/well-trained manpower and funds are necessary. According to Omondi et al (1994:5), some of the strong suggestions for strengthening village health committees are that

*regular seminars and workshops should be organised for the VHCs to provide them with an update and discuss issues pertaining to their roles in PHC and health care development.*

It is thus of serious concern that results demonstrate that village health committee members do not benefit from workshops and seminars.

**Item 24: How often nurses organise and address community members at various areas.**
<table>
<thead>
<tr>
<th>Setting</th>
<th>Regularly</th>
<th>Seldom</th>
<th>Never</th>
<th>N =</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kgotla</td>
<td>11.8%</td>
<td>76.4%</td>
<td>11.8%</td>
<td>100%</td>
</tr>
<tr>
<td>Health Facility</td>
<td>47.6%</td>
<td>52.4%</td>
<td>-</td>
<td>100%</td>
</tr>
<tr>
<td>Health Workshops/Seminars</td>
<td>7.6%</td>
<td>82.4%</td>
<td>10%</td>
<td>100%</td>
</tr>
<tr>
<td>Homes</td>
<td>43.8%</td>
<td>43.8%</td>
<td>12.5%</td>
<td>82.4%</td>
</tr>
<tr>
<td>Other</td>
<td>50%</td>
<td>50%</td>
<td>-</td>
<td>17.6%</td>
</tr>
</tbody>
</table>

Table 7.31: How Often Nurses Organise and Address Community Members

According to table 7.31 above nurses mainly regularly addressed community members at health facilities. This was when they had come to seek services.

It can therefore, be concluded that community leaders health seminars, responsible parenthood seminars for youths, traditional healers and modern health workers workshops and other community level health workshops are not regularly organised, and thus there is an urgent need to revive and strengthen them. This can successfully be implemented if the nurse leaders and staff are trained accordingly.

*It is argued that effective development of effective district health systems will require appropriately trained staff at the district level and planning and advisory support from the central health staff (Oakley 1989:34)*
hence the dire importance of all the National Primary Health Care Systems to continuously work with, and support district health services, and the need for continuous feedback both ways.

The addressing of people in their homes is impressive as 43.8 percent of nurses address people in their homes regularly. The family welfare educator as indicated in Items 13 and 14, is mainly the one who conducts home visits; the nurse does not usually have adequate time to undertake home visits more frequently.

**Item 37: How often the nurse participates in educational activities.**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Regularly</th>
<th>Seldom</th>
<th>Often</th>
<th>Never</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Community leaders health seminars</td>
<td>23.6%</td>
<td>29.4%</td>
<td>17.6%</td>
<td>29.4%</td>
<td>100%</td>
</tr>
<tr>
<td>2. Responsible parenthood seminars for youths</td>
<td>17.6%</td>
<td>58.8%</td>
<td>-</td>
<td>23.6%</td>
<td>100%</td>
</tr>
<tr>
<td>3. Traditional healers and modern health workers workshops</td>
<td>11.8%</td>
<td>41.2%</td>
<td>29.4%</td>
<td>17.6%</td>
<td>100%</td>
</tr>
<tr>
<td>4. Teachers and health workers workshops</td>
<td>5.9%</td>
<td>64.7%</td>
<td>11.8%</td>
<td>17.6%</td>
<td>100%</td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Table 7.32: Nurses Participation in Educational Activities (N=100%)

As table 7.32 indicates, a cumulative percentage of 58.8 of nurses stated that community leaders health seminars are either seldom or never implemented. A high percentage (82.3%) of the nurses report that responsible parenthood
seminars for youths are not implemented regularly. A significant percentage (58.8%) of the nurses also reported that traditional and modern health workers workshops are not held regularly. Furthermore, 82.4 percent of nurse respondents reported that teachers and health workers workshops do not take place regularly. The above supports the need to strengthen these activities as educational activities and information for planning for village health committees.

Item 25: Village health committees' questionnaire. Referral of patients by village health committee members.

![Fig. 7.9: Referrals by Village Health Committee Members (N=53)](image)
As figure 7.9 indicates, the majority of village health committee members, (57.5%) refer patients regularly to health facilities. The relatively high percentage (42.5%) who do not refer patients regularly could have been clarified if the reason for non-referral was asked. As the reason is not clear it is an aspect that needs to be investigated. Item 27 did give some options but was perhaps not phrased correctly.

**Item 26a: Village health committee members. Who usually attends to patients referred by village health committee members?**

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Seldom</th>
<th>Never</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1..</td>
<td>Doctor</td>
<td>77.4%</td>
<td>13.2%</td>
<td>9.4%</td>
</tr>
<tr>
<td>2.</td>
<td>Nurse</td>
<td>94.3%</td>
<td>3.8%</td>
<td>1.9%</td>
</tr>
<tr>
<td>3.</td>
<td>Family Welfare Educator</td>
<td>83.0%</td>
<td>11.3%</td>
<td>5.7%</td>
</tr>
<tr>
<td>4.</td>
<td>Other</td>
<td></td>
<td></td>
<td>-</td>
</tr>
</tbody>
</table>

Table 7.33: Who Attends Patients Referred by Village Health Committees (N=53)

Table 7.33 reflects a situation whereby the village health committee members refer cases that they cannot handle to higher levels. According to data 94.3 percent indicate that the patients they refer are always attended to by the nurse, followed by 83.0 percent whose referred patients are always seen by
the family welfare educator. Quite a sizeable percentage of 77.4 percent reported that the patients they refer end up being attended to by a medical doctor. The response to item 25 indicated that only 57.5 percent of the village health committee members refer patients; it is therefore advised that members of the village health committee be given guidance on screening of patients for referral.

Item 27: Where village health committee member does not refer, reasons for not referring could be that:

<table>
<thead>
<tr>
<th>Reason</th>
<th>Number of Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can handle all cases</td>
<td>1</td>
</tr>
<tr>
<td>Not my responsibility</td>
<td>1</td>
</tr>
<tr>
<td>Other village health committee members refer</td>
<td>2</td>
</tr>
<tr>
<td>Not allowed to</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
</tr>
</tbody>
</table>

Table 7.34: Reasons for non-referral by village health committee member

The response to this question is disappointing as this could have given an answer to the 42.5 percent who did not regularly refer patients; only five responses to the item were recorded which made the results insignificant. It would seem as though only those who never refer answered the question. Phrasing the question as an open ended question could have given more useful information.
Item 28 in the village health committees’ questionnaire. How often village health committee members got feedback on patients they refer.

<table>
<thead>
<tr>
<th>Regularly</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>50.0</td>
</tr>
<tr>
<td>Sometimes</td>
<td>38.0</td>
</tr>
<tr>
<td>Never</td>
<td>12.0</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 7.35: How Often Village Health Committee Members Get Feedback (N=50)

Only 50 out of the 53 village health committee members responded to the questionnaire. Results revealed that 88 percent of village health committees did receive feedback on patients that they referred, with 50 percent of them receiving this feedback regularly. There is however 12.0 percent that never received feedback.

It is of concern that only 50 percent of the village health committee members always received feedback. Giving feedback could serve as a motivator for future referrals. The 38 percent who sometimes received feedback, and 12 percent who never received feedback, could interpret not getting feedback as though their participation in health care delivery was not considered as important. Giving feedback to village health committee members who refer patients is to be strengthened, to facilitate partnership.
Community involvement for health (CIH) implies partnership between health services and their professionals and local community people. Only genuine partnership ensures a proper compromise between the views of government and local people (Oakley 1989:29).

Item 29: Whether the village health committees would like to receive feedback from health personnel on the patients that they refer.

Only 11 persons out 53 responded to this question. This supported Item 28, that it is only a small minority that never gets feedback, 81.8 percent of the respondents indicated that they would like to receive feedback on patients they refer. A very small percentage, (18.2%) would not like to get feedback.

Item 30: Who usually gives the village health committee members feedback?

<table>
<thead>
<tr>
<th>Persons</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>11.1%</td>
</tr>
<tr>
<td>Nurse</td>
<td>46.7%</td>
</tr>
<tr>
<td>Family Welfare Educator</td>
<td>26.7%</td>
</tr>
<tr>
<td>Other (3) (Environmental Health Officer)</td>
<td>6.7%</td>
</tr>
<tr>
<td>Other (4) (Health Educator)</td>
<td>8.8%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 7.36: Who Gives Village Health Committee Members Feedback (N=45)
Out of 53 respondents, only 45 responded. According to table 7.36, 46.7 percent of the respondents got feedback on patients that they referred from the nurse; this is followed by almost half of that percentage, (26.7%) that received feedback from the family welfare educator. There is 11.1 percent that reported to have received feedback from the doctor, indicating that the doctor does actually also communicate with the village health committees.

**Item 31: Kind of feedback given and received.**

According to results, only 25 out of 53 respondents responded to this question. The type of feedback provided included the following:

- Patients Treatment;
- Assistance provided and needed;
- Condition of the patient; and
- Family Welfare Educators' record

On the health status of the patients, of the respondents 36.0 percent reported receiving feedback. Other feedback included:

How the patient felt; nurses' reporting, patient’s coping, supervising of treatment, and treatment of the disease.

**Item 32: On whether feedback received was helpful. N=50**

A high percentage (92.0%) indicated that the feedback they received was helpful, as against only 8.0 percent that felt that the feedback they received was not helpful. Three people did not respond to this question. From this it
is clear that village health committee members do receive support in the form of feedback related to their work.

**Item 33** is an open-ended question that sought any information about the village health committee that the respondent belonged to. Comments on this included:

- the importance of attending village health committees regularly;
- a call on village health committee member, family welfare educators and nurses to continue to assist their communities;
- the need to engage more membership for efficiency;
- strengthening of the linking of the community with health personnel;
- strengthening of the linking of village health committees together;
- making health promotion a priority by village health committee members;
- addressing poor performance that results from village health committee members' other engagements (such as employment). This supports the findings and recommendations of Omondi et al (1994:5) that

  *The government should accord the VHCs the same status as VDCs by paying them an allowance just as they pay VDCs.*

This has become more justifiable especially because village health committee members, as reported during focus group discussions, find themselves having to be actively involved and in the forefront in the home-based care of the chronically and terminally ill.

Lastly, some village health committee members themselves are so committed that they have sent a message of encouragement to their colleagues.
Section C: Nurses Questionnaire.

**Item 28**: The extent to which nurses agree/disagree with statements are indicated in table 7.37.

The results of this question are important in that it will contribute to the assessment of the nurses' understanding of the role of village health committees.

<table>
<thead>
<tr>
<th>Item</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Community is given a chance to contribute to its own health care services.</td>
<td>58.8%</td>
<td>35.3%</td>
<td>-</td>
<td>5.9%</td>
<td>100%</td>
</tr>
<tr>
<td>2. People being able to work as a team.</td>
<td>58.8%</td>
<td>17.6%</td>
<td>6.0%</td>
<td>17.6%</td>
<td>100%</td>
</tr>
<tr>
<td>3. People do voluntary work.</td>
<td>47.0%</td>
<td>41.2%</td>
<td>5.9%</td>
<td>5.9%</td>
<td>100%</td>
</tr>
<tr>
<td>4. Health is given prominence in village development</td>
<td>35.3%</td>
<td>41.2%</td>
<td>5.9%</td>
<td>17.6%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 7.37: Extent to Which Nurses Agree/Disagree with Statements (N=17)

Table 7.37 reflects that according to a high cumulative percentage of 94.1 of nurse respondents, the village health committee system is a way of giving the community a chance to contribute to its own health care development. This is in line with the International Nurses Day's message (International Council of Nurses, 1998) that

*If given power, resources and trust, communities have the potential to influence their health and the health of their own families positively. It follows that communities must be involved at all stages of programme development.*
A significant percentage (76.4%) of nurses reported that village health committees promote team work.

*Placing greater decision making in the hands of community representatives tends to be associated with more rapid and comprehensive identification of health needs and expectations (World Bank, 1994:120).*

Furthermore, another significant percentage (76.5%) of nurses reports that through village health committees health is given prominence in village development.

It is interesting to note that the total percentages that disagree with the above are insignificant compared to those that strongly agree, as demonstrated by table 7.37.

**Items 38 and 39. On whether nurses involvement in educational activities is essential and to what extent if essential.**

<table>
<thead>
<tr>
<th>Involvement in Educational Activities</th>
<th>No.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential</td>
<td>15</td>
<td>93.8</td>
</tr>
<tr>
<td>Not Essential</td>
<td>1</td>
<td>6.3</td>
</tr>
<tr>
<td>To a great extent</td>
<td>14</td>
<td>87.5</td>
</tr>
<tr>
<td>Minimal extent</td>
<td>2</td>
<td>12.5</td>
</tr>
</tbody>
</table>

*Table 7.38: Are Nurses Involvement in Educational Activities Essential*
According to table 7.38, the majority of nurse respondents, (93.8%) reported that nurses involvement in educational activities was essential. It is through education and empowerment that leadership will be established in communities. Hence the importance of providing education and addressing real and existing problems. As Pradervand on Leadership in African in Contact (1992:25) puts it,

... When you create a context of real empowerments and authentic popular participation anywhere in the world, leaders emerge spontaneously. Knowledge gives access to power. The more you emphasize training in the broadest sense of the word, the more you have a context of authentic democratic popular participation, and the more you favour the emergence of leaders.

7.4 CONCEPTUAL FRAMEWORK

Results realised from both the qualitative and quantitative studies as reported by both the nurses and village health committees showed the nurse at the local level being central in health care delivery. In addition to her/his curative and management role she/he had preventive, rehabilitative and promotive health services and supervisory responsibilities. She/he also did not only have leadership roles but was the leader at the local level. The question is whether this nurse is trained or developed to perform all the roles that she/he is expected to assume. Among challenges that were identified by the Indiana Healthy Cities were the need for

a highly staff-intensive process for leadership development in the community (Flynn, Rider & Barley 1992:125).
Curricula, to be relevant must consider leadership development, which is empowering the nurse and manager as very important.

Fig 7.10: Conceptual Framework for the Nurse’s Leadership Role in Village Health Committees

The Conceptual Framework for the Nurses' Leadership Role in village health committees figure is confirmed by results as obtained from focus group discussions as well as the village health committees and nurses questionnaires. According to results obtained
• There is continuous interaction and communication between the family welfare educator, the nurse and the village health committee. This is ably demonstrated in figure 7.7 page 155 whereby 27.8 percent of nurses reported, that the nurse is the appropriate person to initiate the formation of a village health committee. Equal percentages of respondents (27.8%) stated both that the community is responsible for organising itself, and that organising community members is the role of the family welfare educator. This confirms the team spirit that is expected among the nurses, community members and family welfare educators. Another example is figure 7.8 page 199 in the text, that shows the involvement of nurses and family welfare educators, in support of village health committee members. Omondi et al confirms this in their quotation on page 172. Nurses as leaders show to be (in figure 7.8) providing support to village health committees in such a way that they are not doing everything themselves. They have trained family welfare educators, who they work with and supervise to ensure that village health committee members get the support that they need.

• The nurse is not only a manager, but also a leader at the local level. This is reaffirmed by Kaseje (1992), see italics quotation on page 191.

• Treatment and referral of patients also takes place between the village health committee member, the nurse and the family welfare educator. According to village health committee members (table 7.24, page 174) they receive guidance and support in their work/activities. These they receive
from both the nurses and family welfare educators, with the nurse providing both the managerial and leadership aspects.

• Information, Education and Communication (IEC) is provided as per table 7.24, page 174, according to obtained results. From the village health committees confidence in this area it can be safely concluded that the family welfare educators contributed to strengthening IEC in the village health committee members. On the other hand, the nurses in their training have provided the family welfare educator with grounding in IEC. They also continue to share information and communication strategies among themselves, leading to positive behavioural change, to adoption of health promoting behaviours, and thus to education.

• Table 7.26, page 183 demonstrates that the support cycle is between the family welfare educator, the village health committee member and the nurse. Data obtained here shows that poor support to village health committees according to their rating is rated at lowest levels for family welfare educators and nurses. The rest show quite high percentages of support.

• Nurses, village health committees and family welfare educators do home visits and share information as well as support each other. The village health committee member provides support to the health system through identification of problems and seeking assistance, the family welfare educator through supporting the village health committee member and
getting support from the nurse, and the nurse through providing both leadership and skills enhancing activities.

- The family welfare educator receives inservice training from the nurse and provides direct support to village health committee members. The results ultimately are positive interpersonal relationships, raised motivational and mobilisation levels and active participation and involvement for health development.

7.5 SUMMARY

Results show that the village health committee concept in Botswana, that started being implemented around 1976 is well established. The cumulative age of the majority of village health committee respondents (89.4%) ranged from 20 to 49 years. The percentages of the under 20 and over 50 were very insignificant. Results also show that the majority of village health committee members (94.3%) are female. On the level of education of village health committee members, most of the village health committee respondents (68.6%) had achieved lower and upper primary school level education only. Percentages for those that did not attend school and those that attained secondary school level education were low (11.8% and 17.6% respectively). Only a very insignificant percentage (2.0%) of the respondents had post-secondary school education. Interestingly this 2.0 percent was from the remote area, that also recorded the highest illiteracy rate at primary levels as indicated in the analysis of Item 7.
Section A of the nurses’ questionnaire on personal profile was omitted and not found to be necessary for this research.

Altogether there were 53 village health committee members' respondents and 18 nurses respondents as shown under 7.1. Results revealed a general agreement between the village health committee on the conducting of elections for the committees' membership; according to 69.8 percent of the village health committees and 82.4 percent of the nurses, people get elected to membership of the village health committee. Both parties are also in agreement regarding the fact that some just decide to join or become members through their interest and commitment. Both parties also agree that elections take place at the Kgotla (traditional gathering place), on a yearly to two yearly basis, with maximum community active involvement in choosing their own representatives, as against the nurses and chiefs imposing some people upon them. There is a small percentage (5.9%) of nurses that, however, reported that they had never had membership to any village health committee. They thus are not involved in this leadership in community sensitisation, motivation and organisation for health. Hence there is still need for training for this leadership for the benefit of ensuring community support.

Results also show that the nurses empower community members by providing guidance and leaving active village health committees’ position holding to community members themselves; they thus build leadership. Activities embarked upon by village health committee members include
among others home visits as stated above, that accord these volunteers to do community and home diagnosis and to address existing problems. Of significance are information, education, communication and exemplary behaviour. Other activities undertaken are as specified under Item 16, table 7.22 page 167.

The weakest of the activities undertaken are chicken rearing, vegetable gardening and simple health procedures, followed by imparting of planning skills. Chicken rearing is weak to an extent of not being done at all. This has also been verified by the focus group discussions results. The strongest of the activities are home visits, sensitisation and motivation for health, followed by other activities such as reproductive health and child health promotion, treatment monitoring and follow-up as well as referral of patients to higher services. Both the nurses and village health committee respondents are in agreement regarding activities. They only vary slightly on percentages and since they are not equal numbers (N=18 nurse and N=53 village health committees), their percentages are bound to be not quite comparable.

Regarding support to village health committees by nurses, a cumulative percentage (52.9%) of the nurses reported to be providing weekly support to these committees as opposed to a cumulative percentage (60.4%) of village health committee members that reported receiving weekly support from nurses. According to Item 20 (village health committees), of all other district health team members, the family welfare educator and the nurse provide most of the support. This is again verified by the nurses in Item 16.
Both nurses and village health committee members are not very clear as to who between the nurse and the family welfare educator has ultimate responsibility for village health committees' support. What is factual is that the nurse is the leader and also the direct supervisor of the family welfare educator. She/he therefore, does delegate duties to the family welfare educator.

Understandably a cumulative percentage of nurses (61.1%) as against that of family welfare educators (84.9%) stated that they undertook home visits monthly; the 61.1 percent by nurses is, however, very significant, showing that as leaders in health care development the nurse has not left everything completely to the village health committee members alone. Compared to the nurse, the family welfare educator was cited by 88.9 percent of the nurses as the one who undertook home visits. It is however, of concern that there is still a percentage (17.6%) of the nurses that according to results does not do home visits at all. This percentage is significant and needs to be addressed.

Research results (Item 15) also indicate that a cumulative percentage (100%) of village health committees (N=53) view their role as very important. This is as against the same view by 77.4 percent of the nurses (N=17) and supports Omondi et al (1994:23), that

98% of key informants interviewed indicated that VHCs are necessary.
Both the village health committee members (82.4%) and nurses (49.1%) are in agreement that the different community seminars/workshops are not implemented. They both agree that most of the health information and communication is provided at health facilities and in the homes. A significant percentage of village health committees (75.5%) refers patients to health facilities. Committee members, (50.0%) stated that they always received feedback from health facilities on patients that they refer, and 81.8 percent reported that they would like to receive this feedback regularly. The nurse was reported by a cumulative percentage (73.4%) of village health committees to be providing feedback on patients referred as opposed to all cadres. This is demonstrated in Item 30 table 7.36 page 203. Village health committees rated the feedback they received as valuable.

Nurses showed to value village health committees, with 100 percent of them agreeing that village health committees identify health problems in their area of operation, and 88.2 percent of the nurses showing appreciation for the committees' members ability to refer patients to them.
CHAPTER EIGHT

CONCLUSIONS, LIMITATIONS, SUMMARY AND RECOMMENDATIONS

This Chapter presents Conclusions, Limitations of the Research, Recommendations and a Summary.

8.1 INTRODUCTION

The research intended to examine nursing leadership, and its impact on the role of community involvement and participation for health, with a specific focus on village health committees. Use was made of two methods namely a qualitative method using focus group discussions, and a quantitative method whereby structured questionnaires were used.

8.2 RESEARCH OBJECTIVES

As stated in Chapter Four, the research intended to identify:

- The role played by the nurse in establishing, promoting and facilitating the community’s active involvement and participation, as well as organisation for health;
- Innovative activities for community organisation, participation and involvement;
- Nurses’ supervisory roles, and what distinguishes leadership from management strategies;
• Motivational levels of nurses and their supervisees/subordinates (family welfare educators) as a measuring stick for health promotion and disease prevention.

8.2.1 Age

The majority (84.9%) of village health committee members interviewed were between 20 and 49 years of age. These are people in both their productive and reproductive ages. There were no village health committee members below 20 years of age interviewed. Participation of persons who are 50 years and above was also quite a significant percentage (15.1%). The over 60 years old age group percentage was insignificant (5.7%).

8.2.2 Sex

Most of the village health committee members interviewed, (94.3%) were female.

8.2.3 Education

It is interesting to note that the majority of these village health committee members (88.2%) were literate, and only 11.8 percent had never been to school.

*Education has long been considered a basic human right (United Nations Declaration of Human Rights, 1948).*

*This is because it is seen as a means of enabling all persons to develop their capacities and skills, refine their sensibilities, and generally, enhance the quality of their lives. In this sense it is recognised as the right of the individual person. But it is also recognised as having a major social dimension because of society's direct interest*
in its potential for raising the capacity of individuals to contribute to social production and the quality of life generally (UNDP, Government of Botswana & UNICEF 1993:31)

Education could perhaps be one of the motivating factors for village health committee members to work towards the raising of the quality of their lives and that of their villages/wards. It is not surprising, however, that the majority of respondents had achieved primary education. By 1996, the national primary school enrolment was 83 percent. This national average did not take into account regional disparities.

The number of schools increased from 251 in 1969 to 670 in 1994. The government policy at this level is to achieve universal primary education for the whole country (Kupepe 1997:211).

There has been tremendous development also in the provision of basic education for different sectors of the Botswana population. However, according to the 1991 Census, about 17 percent of primary school age children (7-13 year age group) were not enrolled in formal education, contrary to earlier projections of only 10 percent.

8.2.4 Marital Status seems not to affect membership to the village health committees much, taking into account that 45.3 percent of respondents were single. Likewise the researcher, being more interested in the work of village health committees and the support that they receive from nurses, did not consider Section A in the nurses' questionnaire as important.
8.2.5  The Nurse

The nurses motivational level and level of support she/he provides to village health committees were of interest. Issues such as age and level of education, it was decided, were not to be of interest. The important thing was that this nurse was a qualified registered nurse. This she would not be, unless she had completed General Certificate of Education (equivalent of Matriculation), and received nurse training. It was also of importance that she/he be residing within the community and providing health services at the peripheral levels. That is, she/he would be providing public and community health services.

8.2.6  From the findings in Chapter Seven, the following conclusions were safely made:

- The nurse as the manager and supervisor at the clinic level plays a vital leadership role, especially in the initiation of village health committees. Both the village health committee members (65.4%) and nurses (76.5%) agreed that people get selected at the Kgotla into the committee. There is also a general agreement according to notable percentages (36.4% of village health committee members and 35.3% of nurses) that recognised that one can also just decide to join the committee. This has also been verified by focus group discussion participants.

The nurse plays a major role in community sensitisation, motivation and organisation for health. She/he has all the opportunity to work with community members from the health facility/clinic level and to even have them selected at the health facility level. As confirmed by focus group
discussants, the nurse is the one who initially sensitises the chief and villagers in health matters following that she/he requests the chief to call a meeting where village health committee members are selected. As the discussants report (Appendix I: Mogoditshane Village Health Committee),

once at the kgotla the chief encouraged community members to nominate from among themselves. This was after the nurse/health workers had sensitized ...

In this way she/he ensures that health services are provided in partnership with community members. As indicated under Item 18, 100 percent of nurses address and give talks to village health committee members, 47.1 percent provide these health talks regularly. To promote involvement and participation for health, the nurse does not only do sensitisation activities. She/he actually joins the committee and works with members under the chairmanship of a community member. That way guidance and supervision is provided from within. As stated under Item II

a high percentage (82.4%) of nurses stated that they had been members of their committees for two years.

It is also commendable that they are able to motivate community members mainly through ensuring their self satisfaction and continuous interest. Some of the nurses have been members of their committees for a long time, for ten years and above. There is, however, a percentage (5.9%) that stated that they had never assumed membership of any village health committee. This requires attention.
Much as the nurse plays a major role in the establishing, promoting and facilitating of community participation, involvement and organisation for health, she/he appreciates the role played by other health workers. According to Item 9 in the previous Chapter, equal percentages of nurse respondents (27.8%) reported that it is the nurse’s, the community’s and the family welfare educator’s responsibility to establish village health committees. This could also be interpreted as their lack of clarity regarding their role as managers and leaders. As earlier stated, according to Henry, Lorensen & Hirschfield (1994:53), Management for nurse managers includes responsibility for many of the health services provided in communities and hospitals. This covers determination of organisational structures and policy, the planning of resources and programmes, the setting of standards, supervising, delegating, ensuring the flow of information, budgeting, accounting, personnel administration, training, developing, evaluating and coordinating. On the other hand leadership was taken to involve guiding people, services and health systems toward the achievement of health for all goals. In other words

Managers focus on the present - administering and maintaining systems in the focus or getting the task done correctly. The instinct for survival leads to a reliance on proven tools of planning and budgeting and a tendency to conserve affairs. This stability orientation tends to rely upon routine rather than interpersonal involvement which may produce unpredictable change. This would lead to a tendency to rely on positional power and to operate from a premise of viewing people as incompetent, and therefore not to be trusted (Charlton 1992: handouts, unnumbered page)

On the other hand, according to Charlton
Effective leadership is not about position power in the organizational hierarchy but about personal power that enables us to create our own future as well as our own quality of life.

Leadership that does the right thing at the right time and enables ordinary people to accomplish things, according to Charlton, can no longer be the preserve of the "man at the top".

The nurse, as the research results reveal, is a manager by her/his training and assignment. It is indisputable that

Good management and leadership by nurses is essential for the achievement of health for all. Well prepared nurses are required locally and internationally who can identify problems and needs, work on interdisciplinary teams to formulate development plans for human resources, improve working conditions, and raise the quality of care at reasonable cost (Henry et al 1994:153).

through the village health committee strategy, the nurse has become a leader. As Flynn, Rider & Barley (1992:122) state,

although leaders exist in every community, they often do not realise their potential in promoting community health.

The above, thus highlights the nursing leadership skills and role, separate for the nurse’s routine management role. This is the kind of leadership that enables the nurse to create and promote leadership in others, as ordinary community members. This has been strongly supported by responses of both the village health committee members in Items 15 and 16 (Chapter 6) and the nurses’ response to their Item 15. What is noteworthy, however, is the fact that there is still room left for the strengthening and further development and
reinforcement of nurses' skills, as demonstrated by percentages whose responses showed their lack of involvement. Of importance is the existence of leadership potential to build on.

8.2.7 The research results and responses from both the nurses and village health committee members confirm that village health committee members are engaged in involvement and participation activities for community organisation for health. Of interest is the level of agreement of the results from the two questionnaires' responses. An example is table 7.23 page 168 of the village health committees' Item 16 and nurses Item 15 on how often village health committee members are involved in specified activities. Below are a few examples of agreements/disagreements:

- A cumulative percentage (100%) of village health committee members and another cumulative percentage (82.4%) of nurses are in agreement that village health committees undertake home visits monthly. According to nurses responses, 17.6 percent of them reported that village health committees never do home visits.

Even where there is general weakness there is agreement indicated:

- regarding vegetable gardening, 47.1 percent of nurses and 49.1 percent of village health committee members reported that the village health committee members never engage in this activity. Other activities are as indicated in Chapter Seven Items 15 and 16 for nurses and village health committees respectively.
Responses to the innovative activities for community participation, involvement and organisation for health are also in line with the conceptual framework for the nurses' role in village health committees as discussed in Chapter Three. According to this conceptual framework, the nurse as a manager provides treatment guidance and other related activities, as well as in-service training for family welfare educators, to enable them to initiate and continuously support village health committees. She ends up creating leadership in the village health committees (at village and ward level), through her imparting of communication skills to the family welfare educators, and sometimes directly to the village health committee members. In her supervision, motivational and mobilisation activities, she creates a ripple effect. In this regard the family welfare educators embarks upon sensitisation and mobilisation for action activities for village health committees. The village health committee also ends up implementing disease prevention and health promoting activities. Subsequently they influence their fellow villagers and motivate them to also embark upon health promoting activities. Activities to be embarked upon are not pre-prescribed, but emanate from community members undertaking community assessments of their environment and health status of their communities. The other ripple effect is demonstrated through the referral system, whereby village health committees refer all cases that they cannot handle (to family welfare educators or nurses), the family welfare educator refers to nurses and the nurse refers to the Public Health Specialist/Senior District Medical Officers who in turn is able to refer to other clinical specialists as per requirement. In line with the, UNDP, Government of Botswana, & UNICEF (1993:48)
Innovative strategies activities towards community sensitisation, involvement, participation, motivation and organisation for health include composing of health carrying messages; local, up to interdistrict and national music competitions; village/ward cleanliness competitions; role plays and dramas on specific and experienced health problems and achievements among others, with winners often getting a prize.

8.2.8 Motivational Levels of Nurses, Family Welfare Educators and Village Health Committees

From the results realized it is clear that the nurses, the family welfare educators and village health committee members, with the exception of quite small percentages are all motivated.

8.3 QUALITATIVE RESEARCH

Focus Group Discussions showed that there is quite a high motivational level among village health committee members of Siga and Mogoditshane villages as demonstrated by the following:

The high turn up of village health committee members on the day of the discussions. This included the fact that persons kept coming to the clinic or the interview venue directly from work. Despite the fact that a high percentage of them at all these villages have to be employed to survive, they continue to volunteer. As stated by some of them “we are now all over trying to make a living, for example some of us are working”. They actually
appreciate that some of their committees are not as strong as they used to be, because of the little time they now devote to volunteering, due to work commitments. At the Taung village for the Siga committee discussions had to wait for sometime for some of the members to come off duty and, unbelievably they came in large numbers straight from work without first going home. Despite their being employed, they still find time to carry on with their activities. The motivational levels and dedication are high. “Even when we commute to work during working hours, we continue to have very good intentions and plans”. According to reports of focus group discussants, the family welfare educators and nurses are the ones who support them on a daily basis. The health education officer at Ramotswa and other South East District villages was also reported to provide regular but not daily support, since she/he covers a wide area. Committee members stated that they deserve some allowance/remuneration for services that they render, especially for providing services for home based care for the terminally ill. The absence of even a small allowance, however, does not deter them from continuing with their volunteerism.

Following focus group discussions, the draft quantitative research questionnaires were recast. For example, some had indicated that much as the family welfare educator is very supportive of them, they still needed the nurses' participation as the officers in charge to work with them and that recognise them, hence questions 38 and 39 in the nurses' questionnaires. It was also after focus group discussions that the decision not to implement the nurses' Section A was again supported. Another example was whereby the
Mogoditshane discussants indicated that the transferred nursing sister who used to work with them had been actively supportive. They then indicated that from their experience it was more a matter of personality and perhaps experience and not age. The Siga village health committee had also had experience working with nurses of varying ages and had no experience of the nurses' ages affecting their work.

The refinement and reformulation of the quantitative research questionnaires was done with the qualitative research discussions influence. This, however, did not result in any drastic changes of the quantitative research questions.

8.4 QUANTITATIVE RESEARCH

As earlier stated, questionnaires were implemented in the four selected areas, namely: Mogoditshane (peri-urban village); Bokaa (rural village); Hebron (rural village); Sesung (remote village) and Lobatse (town). Sesung village is situated within the Kgalagadi (Kalahari) desert area and, is comparatively poor.

The interview schedules and questionnaires were designed, like with the qualitative research, to identify the degree of community sensitisation, involvement, participation, motivation and organisation for health. The whole aim was that of disease and ill-health prevention, and promotion of well-being.
It is clear from responses that communities are aware that health is a commodity that cannot be given. Individual, family, community and national action are a must for health promotion to take place. As Oakley (1989:4) states,

*Communities that begin to understand their health status objectively rather than fatalistically may be moved to take a series of preventive measures.*

The village health committee, thus, representing the community, supports, acts, enables and encourages individuals and families to objectively understand their health status, and to take action to attain prevention of ill-health and promotion of health.

The motivational level of the nurses is measured by the fact that much as they empower communities and do not hold positions in the village health committees, they continue to belong to these committees and provide guidance and leadership, to facilitate health promotion, disease prevention and active participation and involvement in health by ordinary people. Only a small percentage of nurses (5.9%) reported to be committee treasurer and, only a small percentage (7.7% and 5.8%) were either secretary or treasurer of village health committees.

A third of village health committee respondents (30.8%) reported the planning skills ‘training’ it received from nurses as poor. This implies that their achievements are compromised because of inability to plan appropriately. Planning is a very important tool that is required throughout
all the stages towards disease prevention and health promotion. For example, health messages have to be planned; their imparting and dissemination also require planning and evaluation. All other activities also require planning as opposed to haphazard implementation. Bad planning can off-set a very brilliant activity. As Amonoo-Lartson et al (1987:67) puts it

*with a plan, action is clearly defined with regard to specified problems and utilising specified resources, and can therefore be measured for its effectiveness in alleviating problems and its efficiency in terms of cost. Feedback can be obtained on how well specific aims can be put into practice.*

With proper planning of income generating activities for village health committee members, committee members could be liberated from selling their labour. Self-employment capability would also be improved and addressed. This could be done through involving the agriculture and other relevant sectors. Research results indicate that according to the members of village health committees chicken rearing is the task poorest implemented (32.7%), followed by vegetable gardening (54.9%). Income-generating potential activities for both the village health committees themselves, and communities that they aim to sensitise and motivate should be explored.

Motivational levels of nurses are demonstrated especially by their cumulative monthly visits support to committee members (of a cumulative 50.4 percent for village health committee members as against a cumulative 86.6 percent for nurses). In as far as organisation of activities at the community level to sensitise community members on health matters, and to provide them with a platform for dialogue with health workers (such as nurses, health educators
and family welfare educators) is concerned, results indicate that this is quite a weak area. Only 11.8 percent of nurses reported to utilise kgotla meeting for seminars and workshops. Village health committee members also reported that they do not benefit from organised workshops and seminars.

8.4.1 Whereas 88.7 percent of the village health committee members indicated that they refer patients on a regular basis to health facilities, and only 5.7 percent that they never refer patients, 23.5 percent of the nurses reported that patients are not referred by village health committee members.

This matter may require to be further investigated and to be appropriately addressed. The year 1988 marked 10 years since the Alma-Ata Conference had given birth to the Primary Health Concept. To mark this, the World Health Organization organised the Riga Conference, where the concepts of Alma-Ata were resoundingly re-affirmed. At this conference one of the priorities reaffirmed was that

*Services should be promotive, preventive, curative and rehabilitative. That is, services should not only be curative but should also promote the population's understanding of health and healthy styles of life, and reach toward the root cause of disease with preventive emphasis. Treatment of illness and rehabilitation are important as well (Bryant 1988:10).*

It is clear that village health committee members are not strong in clinical and curative services but, these were not initially part of their role. Referring cases for services is a must as part of the Primary Health Care strategy.
Therefore, village health committees have to be made strong in this area.

According to Bryant (1988:14):

Typically the medical education of the doctor, and often the nurses as well, is curative-oriented and hospital-based, provided in an institution where public health or community medicine are given little attention and less respect. Such health professionals are unlikely to be useful in leadership roles that require them to relate to communities, assess needs, and plan, manage and evaluate programmes, and oversee the inservice training of other personnel.

According to him often lacking such competencies but occupying leadership roles the person effectively obstructs the effective functioning of the rest of the health team.

Bryant states though that

it is probably fair to say nursing and nursing education are not as remote from these issues as are their medical counterparts.

In this he is very right, especially with regard to local and community based nurses. With education, information, communication, perseverance and persuasion, village health committee members can improve their referral system. For this, they need leadership and not only management.

Dame Barrow a renowned Barbados Nurse, who was General-Chair of the 41st World Health Assembly's Technical Discussion on Leadership Development for Health for All (1988:28-29), stated that

.... a social movement, such as primary health care, cannot be dependent upon a single charismatic leader. It requires collective leadership, encompassing all levels of society,
creating a collective force toward the goal. It must be an enabling and "empowering" type of leadership which believes in the inherent strength and ability of the people, thereby building self-reliance (Barrow 1988:28).

According to the author,

... leadership for health for all is an imaginative and courageous initiative which provides new opportunities to inform and communicate, to empower people to take new responsibilities for their health, the health of their families and their communities (Barrow 1988:29).

The researcher would like to differ on the imaginative aspect. The involvement of the community (such as village health committees, traditional doctors, adolescents, non-government organisations) would expand our partnership with them. We need to realise that health issues are no longer only for health professionals; they belong to the total communities.

Research results are proving Dame Barrow wrong in as far as the local community-based nurse is concerned. But, if we are to succeed in changing others, there is an urgent need for great change in us.

8.4.2 In contrast to 100 percent of village health committee members who indicated that they never received support from the doctors, 29.4 percent of the nurses reported that doctors do provide support to village health committees.
8.4.3 Although 94.1 percent of the nurses reported that they provide support to village health committees, only 28.3 percent of the village health committee respondents agreed to the statement.

8.4.4 The significant percentage (81.3%) of health educators that according to the nurses supports village health committees is much higher than the 58.5 percent that is stated by the village health committee members.

Apart from the above highlights the nurses and village health committees percentages were in support of each other, reflecting high motivational and support levels, as well as deliberate and tirelessly working towards ill-health prevention and health promotion. It has to be recorded here that the activities highlighted as undertaken are not the only ones. They perhaps stand a better chance, apart from role plays, dramas and educational songs composition, of being common to all committees. As stated, village health committees always undertake their own community assessment and diagnosis, at their local levels, with guidance of the nurse and family welfare educator. Some of their activities are area specific, depending on their locality. This is moreso with regard to differences between a remote village and an urban area (Lobatse), or even peri-urban areas. For example, gainful employment in Sesung is more uncommon. It is however, more common in peri-urban and urban areas.
8.5 LIMITATIONS OF THE RESEARCH

- The research included only one urban area and four other areas being two rural, one remote and one peri-urban area in questionnaires implementation.

- In focus group discussions the research in almost all the areas included, showed that urbanisation was eroding traditional ways of life, whereby village health committee members were only providing health voluntary services mainly on a part-time basis because they were forced by circumstances to find work for pay in order to survive.

- Much as the intent was to interview both sexes equally in the research, male respondents, in both the nurses and village health committees' questionnaires and during focus group discussions, composed a very small percentage of respondents.

- The questionnaires were pre-tested too close to their actual implementation.

- By the time the nurses questionnaires' numbering was found to be faulty (sections B and C) they had been duplicated. Redoing them was going to be costly.

- A few questions sounded repetitive when translated into Setswana.

- Because of the fact that village health committee members work on a completely voluntary basis, they tended to be mainly available after hours; this time was inconvenient and unsafe for the researcher to be driving out. Unfortunately, those in the peri-urban and urban areas have been forced by circumstances to seek employment and volunteer only after hours.
Conducting interviews quite late in the day, however, enabled the researcher to appreciate the motivational levels and complete dedication of these committee members, to an extent that they could be able to assist some patients on home-based care quite late in the day.

- The number of nurses interviewed (18), cannot be taken to be representative of the country.

- Generalisation of results from this research will require a larger research sample. The country has an estimated 300 or more village health committees. The number interviewed is thus not representative.

- Analysis results are not reflected by area. This would highlight urban, rural and peri-urban differences.

8.6 RECOMMENDATIONS

1. Nurses, to revive and strengthen community leaders health and other seminars, and actively involve village health committees, as this would strengthen them, provide them with up to date information as well as provide a forum for them to address issues pertaining to their roles and to health development.

2. Giving feedback to village health committee members who refer patients to higher levels (family welfare educator, nurse and doctor) should be strengthened. This would further motivate village health committee members, and increase their knowledge especially on how to approach the problem next time.
3. The differences in perception on support for village health committees (by the nurse, family welfare educator, doctor) should receive attention. This could be due to the fact that support is interpreted differently by different groups. For example, some could be thinking of support in monetary terms and some in terms of health information provision or others such as transport. Some support may be indirect.

4. Consideration should be given to providing some protection and status including remuneration to the village health committee members, considering their contribution at the household level especially in this era of home-based care for the terminally ill.

5. Nursing curricula to be strong in training for leadership for the Health For All vision realisation, and not just for management of health services delivery only.

6. Further research is required in the following areas:
   - Identification of who the 15 to 19 year olds who are members of the village health committees are; that is, whether this group has somehow missed school or whether they belong to some group, such as the Tirelo Sechaba (community service scheme) participants.
   - Investigation and strengthening of the feedback chain between family welfare educators, nurses and village health committees.
8.7 SUMMARY

Research results indicate that:

- Both the nurses and village health committee members regard the village health committee system, as a very important community organisation for health strategy, and an essential institution. It is interesting that the nurses and village health committee members mostly assessed each other the same way. Both the nurses, who supervise village health committees, and village health committee members are in agreement on several issues. These include that:

  - Village health committees are elected at the Kgotla (traditional gathering place).

  - Community involvement and participation for health is an empowerment strategy that allows community members to contribute in matters of their own health, the health of their families and their communities; and, that it empowers villagers. It enables them not only to identify health and related problems, but also to take active action to address them.

  - Team approach, as opposed to individualisation, is the best approach for tackling community problems.

- The nurse has a very important role in village health committees' initiation and support. She is charged with ensuring high motivational levels of village health committees in her area of operation.
Motivational levels are about sensitisation and motivation for action, behavioural change, willingness and commitment; they involve neither coercion nor control.

By virtue of her/his position and management role the nurse has to provide leadership for health development and for health for all into the 21st Century.

As Dame Barrow’s (1988:29) states,

*Ten years after Alma-Ata, it seemed as if we took too much for granted. It has also become evident that managerial or technocratic approaches alone will not get us to our goals. Primary health care, above all, must become a social movement - a movement in which people in all walks of life are involved as active partners and not just as recipients of the so called benefits. Such social movements demand leadership, therefore, at all levels, thereby sharing the vision of Health for All and reflecting certain essential qualities.*

From results obtained, the researcher is convinced that the community-based nurse at the local and community levels provides some leadership for community organisation for health. This leadership according to Charlton (1992: unnumbered paper)

*... is both an art and a descriptive that can be learnt, if people are willing to pay the price for change.*

The nurse only requires to be strengthened, trained and developed for leadership. Transformation is already here, and is a necessity. The nurse’s position itself determines her leadership role. As Sawyer (1995:19) puts it,
In the health planning approach the professional is the team leaders, consults with community leaders, and cooperates with communities to tap resources, define appropriate services, and improve utilization.

Nurses play a vital and significant role in the support and provision of leadership to village health committees, as demonstrated in the research results such as the following:

- item 26 and figure 7.5 page 151 on nurses position in the village health committee;
- figure 7.6 page 154 on who the most appropriate person to initiate the establishment of a village health committee is;
- table 7.17 page 158 on the nurses response to how essential the community members involvement in health development is;
- table 7.18 page 158 regarding tasks preferred by nurses in establishing village health committees;
- table 7.19 page 159 on how often nurses undertake home visits;
- table 7.20 page 163 regarding how often according to the nurse home visits are conducted;
- figure 7.8 page 182, tables 7.26 page 183, 7.27 page 187 and 7.28 page 188 on support from nurses and family welfare educators to village health committees;
- table 7.28 page 188 on the frequency of guidance by health cadres to village health committee members;
- table 7.32 page 198 regarding nurses participation in educational activities;
Nurses in Botswana form the target group of health workers. Unlike other health professionals nurses are well distributed in the country. They also provide mobile health services in areas they do not reside in. As such, in their provision of preventive, promotive, rehabilitative and curative services, nurses find themselves having to both provide and to build leadership in others to ensure continuity. They usually are the ones who initiate, support and promote the formation and functioning of village health committees. To ensure sustainability for community organisation for health, people must be sensitised, motivated and mobilised for active action; this, the nurse, especially at the local level, according to results of the research, has been able to do quite well. What is required is training and support for building of leadership skills.

According to results of the research, the nurse is the most suitable candidate (especially in the district health team), to provide leadership, and (as a team), together with

- other health professionals;
- different levels of workers in the health system;
• members of other sectors relevant to health such as Water Affairs, Agriculture, Women’s Affairs, Education, Transport and Communication, Local Government, Lands and Housing and Commerce and Industry

• the private sector;

• non-governmental organisations

• youth and the elderly; and

• community members, strive for the attainment of Health for All into the next millennium, the 21st Century, with the nurse facilitating.
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MOGODITSHANE VILLAGE HEALTH COMMITTEE

Translation of Radio Recording - RE: V.H.C. Focus Group Discussions

Question: How did you become members of the village health committee?

Answer: Following a meeting at the kgotla by health workers. The at the initiation of the village health committee, members were elected/chosen at the traditional gathering place, the kgotla. Later we realized that some of the persons who were elected at the kgotla did not necessarily have the aptitude nor love for village health committees; then we started to actively recruit those with interest to come and join. These were retained since they joined voluntarily.

Question: Who actually chooses members? Is it the chief, the nurse or the community?

Answer: Once at the kgotla the chief encouraged community members to nominate from among themselves. (This was after the nurse/health workers had sensitized the communities, including the chief, for action. We used to be many. As committee members we identify persons who are ill in the community; then we inform nurses so that they can follow-up the patient.

Question: Do you volunteer?

Answer: Yes, we have been volunteering.

Question: Are you told/encouraged regarding what you should do, that is, activities?

Who usually supports you?

Answer: The nursing sister who used to work here used to be actively supportive and interested in community work. Of all people, this nursing sister had time for us. She is now transferred.

Question: There are patients in the community, e.g. PTB patients, do you support them? What do you mostly do?

What is it that you actually do as village health committee members?
We're now all over trying to make a living, for example, some of us are working. This used to be a very strong village health committee. Part of what we do, however, is to encourage patients, such as those with PTB, to come to the clinic and to take their treatment regularly and accordingly. We monitor patients at home and report to the health facility. Some of our activities included vegetable gardening at the clinic level. These vegetables (we would give out to patients together with their treatment, such as those patients with tuberculosis). One thing that we have not been doing, however, is to encourage those TB patients to grow or have their own vegetable gardens at home.

Among other things, we would undertake home visits and also specifically visit patients who are on any treatment to be taken at home. We would supervise that treatment taking, and report any incidents where the treatment regime was not accordingly taking or followed to the clinic, as this would otherwise have a negative bearing on the success or effectiveness of the treatment.

The village health committee is a very important organ for health promotion and disease prevention. Ours has been weakened by the fact that with drought, that has not enabled us to grow food where we are, some of our village health committee members, since we are completely voluntary, have had to commute especially between here and Gaborone to find work there. Even when we commute to work during working hours, we have had very good intentions and plans, such as the intent to meet after hours after knocking off. This, however, has not always been possible. At times we meet but we kept dropping in at different times until we could not discuss anything as per our good intentions.
SIGA VILLAGE HEALTH COMMITTEE

Translation of Radio Recording - RE: V.H.C. Focus Group Discussions

**Question:** How did you become members of the village health committee?

**Answer:** Most of us were selected at the kgotla following sensitisation of the chief by health workers. We were chosen by community members. Very few of us decided to volunteer and join on our own out of interest.

**Question:** Who asked community members to nominate names of people and why did they not leave the selection to nurses alone? How did community members know that they would be allowed to select from among themselves?

**Answer:** The village health committee system in our area dates back to around 1978/1979. Choosing these members has not become routine. People therefore are aware of the type of people to choose for serving in these committees. They also are aware that this is part of their involvement in the health care delivery system and therefore, they are the ones to make decisions regarding how they wish to see the health of their village progress.

**Question:** Do you volunteer?

**Answer:** Yes, we volunteer. We are regarded as a sub-committee of the South East District’s Village Development Committee. Village Development Committee members get a sitting allowance but we get nothing, yet we have serious challenges, including exposure to infection especially during this serious HIV/AIDS era.

**Question:** Are you told what to do or encouraged to assess the health situation of your wards and then develop activities?

**Answer:** We regularly attend lectures, at least once a week. During these lectures we are taught about prevalent health problems in our area. We have also been trained on communication and on how to approach people; that is on how to make ourselves acceptable.

**Question:** Who trains you?
We have gone through different types of health workers. Because of transfers, we have had very supportive, fairly supportive to not so supportive nurses. Right now we are enjoying excellent support from our nurses.

Our family welfare educator is very supportive. Right now she is not available; she has to attend to some problems. We have present here another family welfare educator from the next village who has been sort of relieving her. She is also not new to us; we have been used to both of them.

We have a very helpful health education officer. He is newly qualified and helpful. The only problem is that she, unlike others, travels through and serves the whole sub-district.

Do you support patients in your community e.g. those with tuberculosis? What do you actually and mostly do as village health committee members?

Who usually supports you?

Allow us to start where we are today. You may be knowing that this month is the month when we usually have inter-district village health committee' music competitions and that the music we compose and sing should carry health messages. These inter-district competitions follow district competitions and village competitions. Well, we are going to compete at Mahalapye in the Central District and are travelling there in about two weeks time. The reason you found so many of us today and perhaps had to select and not interview all of us is because we have all come to be measured by the seamstress, who is sewing our music competition uniform. We are also rehearsing, you chose the right time to appoint for a visit/a focus group discussion.

This is commendable. How are you travelling and who is supporting your participation?

We are driving. The District Council is assisting us. We also have raised funds through holding of concerts and are paying for ourselves using some of these funds. It is really exciting.

Can we get back to the question on what you mostly do as village health committee members?
We do daily home visits. Our activities include:

- Follow-up of discharged patients.
- Visiting TB patients. Assessing their condition and reporting to the family welfare educator or the nurse.
- Encouraging TB patients on treatment to go to the clinic daily for swallowing of their tablets and stressing the need for them to have a meal before taking treatment to ensure that they retain the treatment and do not vomit it.
- Assessing the environment and encouraging cleanliness.
- Referring patients we cannot handle, such as those whose condition have changed to the health facility. We have problems of lack of transport for referring patients. Other community members always assist though.
- Vegetable gardening. Our fence has fallen and animals destroy our garden. We wish it could be repaired.
- Educating community members especially during home visits on:
  - Child health including child welfare clinics, nutrition and immunisation.
  - Spacing of births and having only the number of children we can afford.
  - Antenatal and postnatal clinics importance
  - Prevalent health problems in the village such as high blood pressure.
  - Visiting chronically ill patients e.g. those with cancer and AIDS. This village has no AIDS committees yet.

Our problems include

- Continuous droughts.
- Animals that destroy our vegetable garden and lack of fencing of the garden. Even the clinic fence has fallen.

We meet very regularly; at least once a week without fail.
Questionnaire No: 1
(Village Health Committee Members)

NURSING LEADERSHIP:
ITS IMPACT ON THE ROLE OF
VILLAGE HEALTH COMMITTEES

Undertaken for the fulfilment of a doctorate degree,
University of South Africa

* All answers will be treated with strictest confidentiality. Names of respondents will not be divulged.

* Nobody shall be forced to answer.

* Please elaborate/substantiate wherever your response is “Other”.
## SECTION A:

1. 

2. **Age:**
   - 15 - 19: 1
   - 20 - 29: 2
   - 30 - 39: 3
   - 40 - 49: 4
   - 50 - 59: 5
   - 60 - older: 6

3. **Sex:**
   - Male: 1
   - Female: 2

4. **Level of education:**
   - None: Did not attend school: 1
   - Lower primary: 2
   - Upper primary: 3
   - Secondary: 4
   - Post secondary (Indicate): 5

5. **Marital Status:**
   - Single: 1
   - Married: 2
   - Divorced: 3
   - Separated: 4
   - Widowed: 5

6. **Number of living children:**
   - 0 - 2
   - 3 - 5
   - 6 - 8
SECTION B:

7. How does one become a member of the Village Health Committee?

- Gets chosen
- Applies
- Is elected/nominated
- Decides to join
- Other (specify)

8. If elected, where are members of the VHC elected:

- At kgotla
- At health facility
- Other (specify)

9. How often are elections to membership conducted?

- Once in three months
- Once in six months
- Once a year
- Every two years
- Other (specify)

10. Who elects members of the VHC?

- The Chief
- The Health Worker
- Community Members

11. How long is one expected to serve on this committee?

- Six months
- One year
- Two years
- Other (specify)

12. When was the VHC to which you belong formed?

- 1978 - 1982
- 1983 - 1987
- 1988 - 1992
- 1993 - 1997
13. For how long have you been actively carrying out activities such as health campaigns or meetings?

<table>
<thead>
<tr>
<th>Years</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 5 years</td>
<td>(1)</td>
</tr>
<tr>
<td>6 - 10 years</td>
<td>(2)</td>
</tr>
<tr>
<td>11 - 15 years</td>
<td>(3)</td>
</tr>
<tr>
<td>16 - 20 years</td>
<td>(4)</td>
</tr>
</tbody>
</table>

14. What is your position on the committee?

- Chairperson 1
- Secretary 2
- Treasurer 3
- Member 4
- Other (specify) 5

SECTION C

15. The village health committee system means the following: (Put X in the appropriate column). Indicate to what degree you agree with the following statements:

<table>
<thead>
<tr>
<th>Statements</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Community is given a chance to contribute to its own health care services.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. People are enabled to work as a team.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. People organise themselves to address health problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. People do voluntary work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Health is given prominence in village development.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
16. How often are you as a member of the VHC involved in?

<table>
<thead>
<tr>
<th>Role</th>
<th>Daily</th>
<th>Weekly</th>
<th>Monthly</th>
<th>Bi-monthly</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Conducting home visits.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Identification of health problems in area of operation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Disease prevention interventions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Vegetable gardening.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Case identification and case holding, e.g. TB.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Treatment supervision.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Vaccination campaigns.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Reproductive Health Promotion</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. Child Health Promotion Activities</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. Referral of patients to Health Services.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. Other (specify)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

17. VHC members are guided in what is expected from them?

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
18. If involved in the following, what guidance do you get?

<table>
<thead>
<tr>
<th>Guidance/Support</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Giving health information.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Information imparting/Communication skills.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Planning skills.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Treatment taking monitoring skills.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Simple health procedures e.g. blood pressure taking</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Rehydration in diarrhoeal diseases.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. Oral health.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. Baby weighing.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. Vegetable gardening.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. Chicken rearing.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. Other (specify)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

19. How often do you get support from the following?

<table>
<thead>
<tr>
<th>Sources of support</th>
<th>Daily</th>
<th>Weekly</th>
<th>Bi-weekly</th>
<th>Monthly</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Doctor</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Nurse</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Family Welfare Educators</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Environmental Health Officer</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Local Chief</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Businessman</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Other (Specify)</td>
<td>1</td>
<td>2</td>
<td>3</td>
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</tr>
</tbody>
</table>
20. How do you rate the support you get from...?

<table>
<thead>
<tr>
<th>Cadre</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Doctor</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Nurse</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Family Welfare Educators</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Environmental Health Officer</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Local Chief</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Businessman</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. Other (Specify)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

21. Do any of your activities include the following? Yes, No.
If yes, how often?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
<th>1 Daily</th>
<th>2 Weekly</th>
<th>3 Bi-monthly</th>
<th>4 Monthly</th>
<th>5 Rarely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Home visits.</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Identification of health problems in area of operation</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Disease prevention interventions.</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Vegetable gardening.</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Follow-up of TB patients</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Treatment supervision.</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Vaccination campaign.</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Family Planning Promotion.</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Child’s health promotion activities</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Chicken rearing.</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Other (specify)</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
22. How much of your time is devoted to community work?

<table>
<thead>
<tr>
<th>Time Devoted</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Half a day daily</td>
<td>1</td>
</tr>
<tr>
<td>Full day 7 days</td>
<td>2</td>
</tr>
<tr>
<td>Twice per week</td>
<td>3</td>
</tr>
<tr>
<td>Once per week</td>
<td>4</td>
</tr>
<tr>
<td>Once in 2 weeks</td>
<td>5</td>
</tr>
<tr>
<td>Once a month</td>
<td>6</td>
</tr>
<tr>
<td>Other (Specify)</td>
<td>7</td>
</tr>
</tbody>
</table>

23. In the last 12 months, how many times has the nurse discussed health issues with the community?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>1</td>
</tr>
<tr>
<td>Weekly</td>
<td>2</td>
</tr>
<tr>
<td>Monthly</td>
<td>3</td>
</tr>
<tr>
<td>Never</td>
<td>4</td>
</tr>
</tbody>
</table>

24. How often are health talks discussed at the following?

<table>
<thead>
<tr>
<th>Place</th>
<th>Weekly</th>
<th>Bi-Monthly</th>
<th>Monthly</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Kgotla</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Health Facility</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. During workshops/ seminars organised for the community</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Other (Specify)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

25. How often do you refer patients to the health facility?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regularly</td>
<td>1</td>
</tr>
<tr>
<td>Seldom</td>
<td>2</td>
</tr>
<tr>
<td>Never</td>
<td>3</td>
</tr>
</tbody>
</table>
26. If yes, who usually attends to them?

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Seldom</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Doctor</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Nurse</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. FWE</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Other</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

26. If no, why?

<table>
<thead>
<tr>
<th>Reason</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can handle all cases</td>
<td>1</td>
</tr>
<tr>
<td>Not my responsibility</td>
<td>2</td>
</tr>
<tr>
<td>Other VHC member refer</td>
<td>3</td>
</tr>
<tr>
<td>Not allowed to</td>
<td>4</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>5</td>
</tr>
</tbody>
</table>

28. How often do you get feedback on patients that you refer?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>1</td>
</tr>
<tr>
<td>Sometimes</td>
<td>2</td>
</tr>
<tr>
<td>Never</td>
<td>3</td>
</tr>
</tbody>
</table>

29. If never, would you like to receive any feedback from the health personnel on the patients you refer?

<table>
<thead>
<tr>
<th>YES</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>2</td>
</tr>
</tbody>
</table>

30. If yes, who usually gives you the feedback?

<table>
<thead>
<tr>
<th></th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Doctor</td>
<td>1</td>
</tr>
<tr>
<td>The Nurse</td>
<td>2</td>
</tr>
<tr>
<td>The FWE</td>
<td>3</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>4</td>
</tr>
</tbody>
</table>

31. What kind of feedback do you get?
32. Do you think the feedback you receive is helpful?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
</tbody>
</table>

33. Is there anything you would like to say about the VHC to which you belong?
Questionnaire No: 2 (Health Workers/ Nurses)

NURSING LEADERSHIP:
ITS IMPACT ON THE ROLE OF
VILLAGE HEALTH COMMITTEES

Undertaken for the fulfilment of a doctorate degree,
University of South Africa

* All answers will be treated with strictest confidentiality.
  Names of respondents will not be divulged.

* Nobody shall be forced to answer.

* If your response is other, please elaborate or substantiate.
SECTION A:

1. 

2. Age:
   - 15 - 19: 1
   - 20 - 29: 2
   - 30 - 39: 3
   - 40 - 49: 4
   - 50 - 59: 5
   - 60 - older: 6

3. Sex:
   - Male: 1
   - Female: 2

4. Designation:
   - Doctor: 1
   - Family Nurse Practitioner: 2
   - Community Health Nurse: 3
   - Enrolled Nurse/Midwife: 4
   - Enrolled Nurse: 5
   - Registered Nurse: 6
   - Registered Nurse/Midwife: 7
   - Degree level: 8

5. Marital Status:
   - Single: 1
   - Married: 2
   - Divorced: 3
   - Separated: 4
   - Widowed: 5

6. Number of living children: 
   - 1 child: 1
   - 2 children: 2
   - 3 children: 3
   - 4 children: 4
   - 5 children: 5
   - 6 children: 6
   - 7 children: 7
   - 8 children: 8
SECTION B:

7. Are you in charge of: 

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>District</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

8. Do you think your participation in the VHC is...?

- essential: 1
- obligatory: 2
- not essential: 3
- other (specify): 4

9. Who are the most appropriate persons to initiate the VHC?

- Community: 1
- Nurse: 2
- Health educator/nurse officer: 3
- Environmental health officer: 4
- Other (specify): 5

10. The role of the VHC is to engage in:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>educational activities: 1</td>
<td>2</td>
</tr>
<tr>
<td>follow-up of patients: 1</td>
<td>2</td>
</tr>
<tr>
<td>vegetable gardening: 1</td>
<td>2</td>
</tr>
<tr>
<td>supervision of patients' treatment and care: 1</td>
<td>2</td>
</tr>
<tr>
<td>Other (specify): 1</td>
<td>2</td>
</tr>
</tbody>
</table>

11. Working with community members in health development is...

- essential: 1
- important: 2
- unnecessary: 3
- Other (specify): 4
12. In forming the VHC, do you normally perform the following tasks?

<table>
<thead>
<tr>
<th>Task</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitise community members</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Involve community leaders</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Tell them what to do</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Allow them to decide on activities</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

13. In the last 12 months, how often did you undertake home visits?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly</td>
<td>1</td>
</tr>
<tr>
<td>Monthly</td>
<td>2</td>
</tr>
<tr>
<td>Bi-monthly</td>
<td>3</td>
</tr>
<tr>
<td>Every six months</td>
<td>4</td>
</tr>
<tr>
<td>Once a year</td>
<td>5</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>6</td>
</tr>
</tbody>
</table>

14. Home visits in your area are conducted by...?

<table>
<thead>
<tr>
<th>Conductors</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Family Welfare Educators</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>VHC members</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
15. How often do Village health committees in your area engage in the following activities?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Daily</th>
<th>Weekly</th>
<th>Bi-Monthly</th>
<th>Monthly</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Home visits.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Identification of health problems in area of operation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Disease prevention interventions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Vegetable gardening.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Follow-up of TB patients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Treatment supervision.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Vaccination campaigns.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Reproductive Health Promotion Activities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. Child Health Promotion Activities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. Referral of patients of health services.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. Other (specify)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

16. Village health committees are supported in their work by:

<table>
<thead>
<tr>
<th>Sources of Support</th>
<th>Daily</th>
<th>Weekly</th>
<th>Monthly</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nurse</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Doctor</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Family Welfare Educators</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Health educator</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Other (Specify)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
17. How often do the following people guide village health committee members?

<table>
<thead>
<tr>
<th>Source of Guidance</th>
<th>Daily</th>
<th>Weekly</th>
<th>Monthly</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nurse</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Family Welfare Educators</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Health Educator</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Other (Specify)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

18. How often do you organise and address community members at the following settings?

<table>
<thead>
<tr>
<th>Settings</th>
<th>Regularly</th>
<th>Seldom</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Kgotla</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Health facility</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Health workshops/ seminars</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Homes</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Other (Specify)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

19. [How do you perceive their involvement?] Do you regard their involvement as:

- essential
- necessary
- not necessary
- other

20. To become a member of the village health committee, one

- is chosen
- is selected
- applies
- just joins
21. Members of the VHC committees are selected/elected at
- the kgotla 1
- the health facility 2
- Other (specify) 3

22. How often are elections for the village health committee conducted
- monthly 1
- annually 2
- bi-annually 3
- Other (specify) 4

23. How long is one supposed to serve on this committee?
- Six months 1
- One year 2
- Two years 3
- Other (specify) 4

24. When was the VHC to which you belong formed?
- 1 - 5 years ago 1
- 6 - 10 years ago 2
- 11 - 15 years ago 3
- 16 - 20 years ago 4
- other 5

25. How long has the VHC been operating actively?
- 1 - 5 years ago 1
- 6 - 10 years ago 2
- 11 - 15 years ago 3
- 16 - 20 years ago 4
- other 5
26. What is your position on the committee?

<table>
<thead>
<tr>
<th>Position</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chairperson</td>
<td>1</td>
</tr>
<tr>
<td>Secretary</td>
<td>2</td>
</tr>
<tr>
<td>Treasurer</td>
<td>3</td>
</tr>
<tr>
<td>Member</td>
<td>4</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>5</td>
</tr>
</tbody>
</table>

27. How long have you been a member of the VHC?

<table>
<thead>
<tr>
<th>Duration</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Six months</td>
<td>1</td>
</tr>
<tr>
<td>One year</td>
<td>2</td>
</tr>
<tr>
<td>Two years</td>
<td>3</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>4</td>
</tr>
</tbody>
</table>

SECTION C

28. Indicate to what extent you agree/disagree with the following statements?

<table>
<thead>
<tr>
<th>Item</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Community is given a chance to contribute to its own health care problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. People being able to work as a team</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. People do voluntary work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Health is given prominence in village development</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
29. How often do you undertake community work?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>1</td>
</tr>
<tr>
<td>Every other day</td>
<td>2</td>
</tr>
<tr>
<td>Weekly</td>
<td>3</td>
</tr>
<tr>
<td>Monthly</td>
<td>4</td>
</tr>
<tr>
<td>Rarely</td>
<td>5</td>
</tr>
<tr>
<td>Never</td>
<td>6</td>
</tr>
</tbody>
</table>

30. Do VHC members need any support from health workers?

<table>
<thead>
<tr>
<th>Support Needed</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
</tbody>
</table>

31. If yes, what kind of support do they need?

32. How often do the following health staff provide VHC members with support?

<table>
<thead>
<tr>
<th>Cadre</th>
<th>Always</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>FWE</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Other (Specify)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

33. Who gives VHCs indirect support?

34. Village health committees are ...

<table>
<thead>
<tr>
<th>Importance</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>important in the health system</td>
<td>1</td>
</tr>
<tr>
<td>essential in the health system</td>
<td>2</td>
</tr>
<tr>
<td>necessary in the health system</td>
<td>3</td>
</tr>
<tr>
<td>unnecessary in the health system</td>
<td>4</td>
</tr>
</tbody>
</table>
35. If your answer to question 34 was unnecessary give the reasons.

36. What is the importance of the VHC?

<table>
<thead>
<tr>
<th>Reason</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. They can identify health problems.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. Conducting home visits which health workers are unable to carry out on regular basis.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. Effective motivators of the community</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4. Educating the community on disease management and prevention.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5. Can advise health workers on how to approach health issues and locate areas with problems in the community.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6. Case identification and case holding, e.g. TB.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7. Advocate for the interests of community members to be included in health planning and development.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8. Serve as links between the community and the health care delivery system.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9. An avenue for community participation in health development.</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

37. How often do you participate in the following educational activities?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Regularly</th>
<th>Seldom</th>
<th>Often</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Community leaders' health seminars</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Responsible parenthood seminar for youths</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Traditional healers and modern health workers' workshops</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Teachers and health workers' workshops</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Other (specify)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
38. Is the nurses' involvement in educational activities essential?
   Yes 1
   No 2
   Do not know 3

39. If yes, how essential is it?
   To a great extent 1
   Minimal extent 2
   Other (Specify) 3
Council Secretary,
Southern District Council,

Att. Assistant Council Secretary,
Barolong Sub-district.

Dear Sir/Madam

REQUEST TO CONDUCT RESEARCH ON THE ROLE OF NURSING LEADERSHIP IN VILLAGE HEALTH COMMITTEES

I hereby request to be permitted to conduct the above-mentioned research among your district health nurses and one village health committee with not less than ten (10) members.

The research aims to assess the role that nursing leadership plays in the formation, support and motivation of village health committees.

It is hoped that the results of the research will help towards the strengthening, support and motivation of village health committees in the country as well as subsequent addressing of nursing leadership skills’ development through training where necessary.

The research is planned for two to three days during the last two weeks of July, 1998.

I thank you for your support.

Yours faithfully

W.G. Manyeneng

cc: Public Health Specialist/Senior District Medical Office
    Matron
Council Secretary,
Kweneng West District Council,

Att. Assistant Council Secretary,
Lethakeng Sub-district.

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I thank you for your support.

Yours faithfully

W.G. Manyeneng

cc: Public Health Specialist/Senior District Medical Office
Matron
Council Secretary,
Kweneng East District Council,

Att. Assistant Council Secretary,
Mogoditshane Sub-district.

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Yours faithfully

W.G Manyeneng

cc: Public Health Specialist/Senior District Medical Office
Matron
Council Secretary,  
Kgatleng District Council,  

Att. Assistant Council Secretary,  
Kgatleng West Sub-district.  

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The research is planned for two to three days during the last two weeks of October, 1998.  

I thank you for your support.  

Yours faithfully  

W. G. Manyeneng  

cc: Public Health Specialist/Senior District Medical Office  
    Matron
Town Clerk,  
Lobatse Town Council.

Dear Sir/Madam

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The research is planned for two to three days during the last two weeks of September, 1998.

I thank you for your support.

Yours faithfully

[Signature]

W.G. Manyeneng

cc: Public Health Specialist/Senior District Medical Office  
Matron
Council Secretary,
South East District Council,

Att. Assistant Council Secretary,
Ramotswa Sub-district.

Dear Sir/Madam

REQUEST TO CONDUCT RESEARCH ON THE ROLE OF NURSING LEADERSHIP IN VILLAGE HEALTH COMMITTEES

I hereby request to be permitted to conduct focus group discussions with the Siga village health committee (VHC), with not less than ten (10) of its members.

The aim will be to assess the role that nursing leadership plays in the formation, support and motivation that village health committees receive in the work that they have volunteered to do.

It is hoped that the results of the study will help toward the strengthening, support and motivation of VHC’s in the country as well as subsequent addressing of the nursing leadership skills development through training where necessary.

The focus group discussions are planned to take place during the last week of June or early July, 1998 depending on the time that will be most suitable. The intent is for the focus group discussions to take place during the committee’s normal meeting days.

I thank you for your support.

Yours faithfully

W.G Manyeneng

cc: Public Health Specialist/Senior District Medical Office
    Matron
Mrs W. G. Manyeneng
Ministry of Health
Private Bag 0038
Gaborone

Dear Manyeneng

Re: Application for a PhD. research permit on Nurses Involved in Community Mobilisation.

We are pleased to inform you that you have been granted permission to conduct research on "Nurses Involved in Community Mobilisation."

The permit does not give authority to enter any premises, private establishment or protected area without permission of concerned parties. Such permission should be negotiated with those concerned. You may also need to request permission from other relevant authorities, i.e. Chiefs, headmen, etc.

You are also requested to submit at least one copy of the findings of your study to the Ministry of Health, Health Research Unit.

Yours sincerely

Pilate Khulumani / For PS.
26 November 1999

Winnie G. Manyeneng
P/Bag 0038
GABORONE

Dear Madam,

RE: REQUEST FOR ASSISTANCE, DOCUMENTED CLEARANCE TO UNDERTAKE RESEARCH

Reference is made to your letter dated the 18 November 1999 on the above subject.

Please be informed that though your request came rather late, it is believed that if the research is successfully completed it would be of assistance in the drive for improved health service delivery.

On the basis of the above therefore this department has no objection to your undertaking the research using the council health facilities.

Thank you.

Yours faithfully

E. B. Moabi
FOR/ESTABLISHMENT SECRETARY