

LUSAKA URBAN HEALTH PROJECT:

A CASE STUDY OF NEIGHBOURHOOD HEALTH COMMITTEES

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I declare that this attachment report has not been submitted for a degree in
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Abbreviations

ANC	-	Africa National Congress
CIF	-	Community Initiative Fund
CSO	-	Central Statistics Office
DFID	-	Department for International Development
HC	-	Health Centre
HCSIC	-	Health Centre Sister-in-Charge
HR	-	Health Reform
HUZA	-	Human Settlement of Zambia
JICA	-	Japanese International Corporation Agency
DHMT	-	District Health Management Team
LUDHMB	-	Lusaka Urban District Health Management Board
LUD	-	Lusaka Urban District
MOH	-	Ministry of Health
NGO	-	Non-Governmental Organization
NHC	-	Neighbourhood Health Committee
NWC	-	Neighbourhood Watch Committee
RDC	-	Resident Development Committee
UNIP	-	United National Independence Party

Acknowledgement

I would like to thank Professor Francis P. Kasoma for the guidance provided in the preparation and writing of this report. I also thank the Department For International Development (DFID) for providing the logistical resources and facilities. I am particularly thankful to the DFID technical advisor, Mr Andy O'connel, for facilitating my attachment at District Health Management Team (DHMT).

I acknowledge the good reception and support given to me by the Director of DHMT, Dr Rosemary Kumwenda Phiri, and her management team. I thank all Neighbourhood Health Committee (NHC) members and Health Centre (HC) staff for their cooperation during my data collection.

The views expressed in this report do no reflect the official position of the organizations and individuals mentioned. I bear the sole responsibility.

To my wife Mwenya and children: Mbaliyi, Akambia and Mercy.

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Abstract

The Lusaka Urban Health Project (LUHP) is a five-year project funded by the Department For International Development (DFID) of the United Kingdom. It is a component of the Zambia Health and Population Sector Aid Programme. The programme began operating in 1994 and it will go on up to 1999.

The overall aim of the LUHP is to improve the urban poor's access to quality health services. This is to be done by improving services offered at the Health Centres (HCs) so that most minor health ailments could be dealt with at the HC level. One of the specific objectives of the project is to enhance active community involvement through Neighbourhood Health Committees (NHCs).

The LUHP evolves in the context of the on-going health sector reform which emphasizes on: decentralized management, autonomous functioning of hospitals, introduction of cost sharing and increased community involvement in health care management (LUHP Baseline Study, 1995).

The NHCs became operational in 1995. Three years down the road, reports of apathy towards the NHC were of great concern to health authorities. This student's attachment at the District Health Management Team (DHMT) was to identify the main cause(s) of the said apathy and provide recommendations to the higher authorities on the same.

CHAPTER 1

General Information about Zambia

Zambia is a landlocked country covering an area of 752,614 square kilometres. It shares borders with; the Democratic Republic of Congo and Tanzania in the north, Malawi and Mozambique in the east, Zimbabwe and Botswana in the south, Namibia in the south west and Angola in the west.

Administratively, the country is divided into nine provinces and sixty-one districts. The nine provinces are Central, Copperbelt, Eastern, Luapula, Northern, North-Western, Southern, Lusaka and Western.

Zambia has a tropical climate and vegetation. There are three distinct seasons: warm-wet season stretching from November through April, a cool dry winter season from May to August with a mean temperatures varying between 14 and 30 degrees centigrade and a hot dry season during September and October with mean day temperatures raising to between 29 to 32 degrees centigrade in the north and northwest and to 35 degrees centigrade over most of western Zambia.

The Copperbelt, North-Western, Northern and Luapula Provinces receive the highest precipitation, with the annual average ranging from 1,100 to over 1,400 mm. The tropical vegetation cover is woodlands, savanna with a mixture of various types of trees, tall grass, herbs and other woodlands which are mainly of the deciduous type usually found on the main plateau (Demographic and Health Survey, 1992:2)

Zambia became independent on 24th October 1964 and adopted a multiparty system with the United National Independence Party (UNIP) as a ruling party and African National Congress (ANC), led by Harry Mwaanga Nkumbula in the opposition.

In 1973 the country became a one party participatory democracy and President Kenneth Kaunda's UNIP continued ruling. The present government headed by President Frederick Chiluba came to power in November 1991 after winning both presidential and parliamentary elections in the reinstituted multi-party democracy.

There are 73 officially recognized ethno-linguistic groups. The main ones are: Bemba, Nyanja, Tonga, Lozi, Luvale, Lunda and Kaonde. These are concentrated in different parts of the country. Bembas are primarily in the Northern and Luapula Provinces, the

Nyanja and Nsenga in the Eastern and Central Provinces, the Luvale, Lunda and Kaonde are in the North-Western Province whereas the Lozi are in the Western Province .

The years after independence saw a rapid growth in the country's urban population. This was because of the relaxation on controls on internal migration and new settlements. People moved from rural areas to urban centres to take advantage of urban opportunities and infrastructure and escape rural hardships.

Zambia is today one of the most highly urbanised countries in Africa south of the Sahara. The 1980 and 1990 censuses estimated the population to 5.7 and 7.4 million respectively. The population is now estimated at 9.2 million (World Bank, 1996 :188). It is particularly concentrated in Lusaka and the Copperbelt provinces (World Bank: Zambia Poverty Assessment Vol. 3 1994 :4)

Most of these never returned to rural areas. This scenario has created real and major constraints on the delivery of social services, housing, water and sanitation, employment, education, health care and other basic services particularly at the level of local government.

General Information About Lusaka Province

Lusaka Province is the smallest of the nine provinces of Zambia. It has an area of 21,896 square kilometres. The hills around Kafue, Chongwe, Rufunsa, Manenekela, Lwimba form part of the Muchinga Escarpment which is also found in the Central Province.

People found in Lusaka Province include: the Soli, Chikunda, Sala, Lenje, Nsenga, and the Goba. The Luano people are also found in Lusaka province although many of them live in the Central Province.

The Soli people live in a big area from near the City of Lusaka to eastwards up to the area around Rufunsa. The Nsenga, Chikunda and the Goba live in the Luangwa District of Lusaka Province

The province has three districts. These are Lusaka Urban, Kafue and Luangwa. The City of Lusaka is known as Lusaka Urban District (LUD).

Lusaka Province has good soils especially near and around the City of Lusaka. The soil is also good around Chongwe, Chalimbana and Lwimba.

Lusaka Province shares boarders with Mozambique to the East and Zimbabwe to the South. It has six rivers. These are Zambezi, Kafue, Luangwa, Chongwe and Lufunsa.

It also has a mine where sulphur and little copper ore are mined. The mine, Nampundwe, is 53 kilometres west of Lusaka City (Social Studies Reader Five, 1972).

General Information About Lusaka Urban District

The Lusaka Urban District (LUD) is located within the Lusaka Province at a latitude of 15 degrees south of the Equator. It occupies 360 square kilometres and has a population of more than 1,202,412 , Central Statistic Office, 1997 (CSO).

LUD is the capital city of the country. It is also the provincial headquarters of Lusaka Province. It has 93 residential areas out of which thirty are high cost and the rest are medium and low cost areas.

60 percent of Lusaka has piped water, but its flow is intermittent.

The situation worsens in the dry season. The unplanned urban areas do not have piped water hence they depend on shallow wells. There are more than 1500 wells in George, Chazanga, Garden and Chaisa. The water from these wells is highly contaminated. These contaminated wells often lead to out-breaks of water borne diseases such as cholera (LUDHMB Action Plan 1997: 2)

Data shows that 20 percent of the houses in Lusaka are on water borne sewerage whereas 40 percent are on septic tanks and another 40 percent on pit latrines. Due to old age, the sewage experiences many blockages and leakages. The pit latrines in peri-urban areas are poorly built and are unstable for these areas. These often flood and contaminate the wells during the rainy season (LUDHMT Action Plan, 1997 : 2).

General Information About the District Health Management Team

The District Health Management Team (DHMT) is situated at plot 5231 off Makishi Road between the Great East Road and Tuleteka Road. It is headed by a director, who

is supported by two managers. A technical advisor from the Department For International Development (DFID) of the United Kingdom provides the technical support.

Apart from being a supervisory body on health matters in the LUD, DHMT is the implementing organ of the Lusaka Urban Health Project (LUHP). The project is funded by the DFID. The aim of the project is to improve the access of the urban poor in Lusaka to upgraded health centres (HCs). One of its specific objective is to promote community involvement in health promotion. Two mechanisms were developed to that effect: NHC and the Community Initiative Fund (CIF).

The CIF provides small grants to groups in the catchment area of the upgraded health centres with a view to improving health and strengthening the relationship between the health centres and the community. The NHCs manage the funds.

CHAPTER 2

Statement of Problem

A review of minutes of the NHCs shows that apathy was slowly becoming a common feature in the NHCs within the LUD. For purposes of this report, apathy refers to the absence or lack of interest or concern. This student's preliminary survey of the peri-urban NHCs showed that there was a decline in the number of people participating in these communities.

For example, in Mandevu, I was informed that only six people turned up for a NHC meeting on February 20, 1997. To solve this problem, the area HCSIC, Mrs Mary Katai said a one-day workshop had to be organised. The aim of the workshop was to sensitise the community about the importance of the NHCs.

In George compound, this student was informed that not a single NHC meeting took place from about January 1998 to April 1998 for reasons related to apathy. It is for this reason that this student decided to undertake this survey.

Objectives

The objectives of this attachment which resulted into this survey were:

- To find out the reason (s) for the poor attendance at the NHCs.
- To assess the level of community participation in the NHCs.
- To see how the NHCs could be used as tools for development.

Limitations

The attachment through which this survey was undertaken was limited to eight peri-urban areas of Lusaka. These are: Chipata, Mandevu, George, Kanyama, Chawama, Mtendere, Bauleni and Chainda. The unit NHCs which are found within the main Health Centres were not covered.

The survey further focused on the NHCs in Mandevu and George compounds. The two areas were randomly picked. Some chairpersons were not interviewed because they were not available at the time this student was going round.. However, the findings and the analysis of this report are representative of all NHCs. For purposes of illustrating a point, examples from outside Mandevu and George NHCs will be cited .

Methodology

The eight NHCs were surveyed over a period of three months. This is from mid-January 1998 to mid-April 1998. The data collection method for this attachment report included interviews, participation in the NHC meetings, observation, review of NHC minutes and evaluation reports.

Background to NHCs

The Ministry of Health (MOH) in collaboration with DHMT initiated the NHCs mainly in the peri-urban areas of Lusaka as part of the Health Reforms (HRs) between 1994 and 1995.

The general objective of the HR was to improve the health status of the people by providing equity of access to quality cost effective health care as close to the family as possible by the year 2000. This is popularly known as “Health for all by the year 2000.”

The NHCs were, therefore, key in achieving this vision.

The aims of the NHCs included the following:

- To play an advocacy row in disease prevention and control.
- To ensure that each family had a latrine.

- To dig latrines for those that did not have.
- To dispose off garbage within the community.

The NHCs have generally been operational for nearly three years now. How are they performing? Before answering this question, it is important that we appraise ourselves about the communities where this survey took place: Mandevu and George compounds.

CHAPTER 3

Malapodi/ Mandevu Compound

Malapodi/Mandevu compound is situated 5.8 kilometres north of the Lusaka City Centre. The 1997 CSO estimates the population of the compound at 42,000. The infrastructure found in Malapodi includes: a community centre, a primary school, a market, a health centre and tarred and gravel roads (Settlement Information Chart, Lusaka City Council 1994). Most of the housing units are self built and owner occupied though others are rented out to tenants.

The first settlers in the area came around early 1950s. It was during this time that small squatter settlements started. The freedom of movement which was given to every Zambian at independence in 1964, resulted into the growth of such settlements.

Malapodi compound got its name from a Mr. Malapodi who was an Italian farmer and businessman. The name Mandevu came from one of Mr. Malapodi's sons who was popularly known as 'Mandevu' (Nyanja word for "beard") because of his bushy beard. Residents are predominantly Zambians although it has a very high population of people of Zimbabwean origin with a reputation of keeping bushy beard. The NHC in the area became operational in 1995.

George Compound

George is a legal and recognized compound situated about six kilometres west of the Lusaka town centre. Its population is estimated at about 49, 000 (1997 CSO). George, who left Zambia in 1964, was a farmer. His farm workers used to live where the compound is located today (Schlyter and Schlyter, 1979). Lilanda, which developed on this part of land in 1960s, was the largest farm.

The compound has four primary schools, two community centres, two markets, communal water points per 25 houses, a HC and tarred and gravel roads. Residents are basically Zambians. Trading in food stuff is a common economic feature in the area.

In 1964, the United National Independence Party (UNIP), the former ruling party, recognized the settlement and re-named it after the then Vice President, Kapwepwe. However, when Mr. Simon Kapwepwe left UNIP, the old name came back again (Schlyter and Schlyter, 1979).

Like in Mandevu, houses in George compound are mainly self-built and owner-occupied. In both compounds, Nyanja is widely used for communication purposes. The NHC in the area, was established between 1994 and 1995.

CHAPTER 4

Theoretical Background

The discussion of the NHCs cannot be complete without defining participation and development. A theoretical context upon which the NHCs can be understood needs to be explained. Development scholars have grappled with these concepts for decades now.

Participation

The word ‘participation’ has become part of the development jargon. A project proposal can rarely be funded without some provision for the ‘participation’ of the people (White, 1993). The definition of ‘participation’ changes according to the theoretical bias of the social scientist defining it.

It is relatively simple to say that participation is an important component of development and that ‘involving’ the unempowered poor is fundamental to development because it leads to the eradication of poverty and injustice (White, 1993). He further explains that there are two levels of participation: pseudo-participation and genuine participation.

Pseudo-participation is one in which the control of the project and decision-making power rests with planners, administrators and the community elite. In this type of participation, people are regarded as targets of development and not partners in development (White, 1993: 17).

Contrary to pseudo participation, in **genuine participation** the development planners, the local elite and the people work together throughout the development process. This type of participation empowers people to control their own action . Peoples' response in this kind of participation is greater because people themselves are involved.

Development

Development, like the term participation has no standard definition. Its definition depends on one's theoretical inclination. For instance, development scholars such as Schramm and Winfield looked at (national) development as:

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The economic and social changes taking place in a nation as it moves from a traditional to a modernized pattern of society, these changes are associated with division of labour, growth of industry, urbanization, and incomes, and the preparation of citizens-by literacy, education of citizens, and information-to participate broadly in national affairs (Kasoma, 1993 : 401)

Further, (Kasoma, 1993) explains that this tends to restrict the understanding of the term 'development' to mean only the economic and social aspects of the human environment. It does not include other aspects of life, such as psychological, philosophical, cultural, and religious.

Birou and Domergue saw development as the transition for some of the earth's populations from a 'dehumanized' to a more 'humanized' phase; or 'the advance of societies and their efforts at organization as a result of the action potential created by the continued growth of the applied sciences and productive technologies (Kasoma, 1993)

On the other hand, (Mwosa, 1993) argues that development is dependent upon which community one belongs to. He explains that to an urban dweller, development means more job opportunities, new buildings and better facilities while to a villager it might mean easier access to water, an irrigation scheme or primary health care.

It should be noted that development cannot be precisely measured. It is qualitative rather than quantitative. In cases where material push forward is involved, it is always accompanied by nonmaterial improvements in the human life situation which are difficult, even impossible to quantify. What may be measured is partial development but not total development.

Development as defined by Kasoma is:

The improvement in the human life condition at individual and societal levels which is achieved through desirable but
“fluctuating changes or adjustments in the environment
(Kasoma, 1993: 403).

Environment in his definition means the sum total of all that which goes into making the human life situation. This includes physical as well as psychological vicissitudes of the human condition.

A good number of people in the NHCs which this student visited, understood development in similar ways as it has been defined by above scholars. This conclusion was drawn from my interaction and experience with the local communities during my attachment at DHMT.

Each one of these definitions could apply depending on the people's felt needs and expectations in a particular area. In all the peri-urban compounds that I visited, people expected the NHCs to bring employment, better health facilities and housing.

Further, people tended to classify compounds in Lusaka Urban as 'developed' on the basis of the availability of facilities like water, schools, health centres, roads and electricity. Those compounds that did not have these facilities were said to be 'undeveloped.'

Mr Lazarous Chisulo of George compound informed me that he could not live in places like Chibolya compound because 'they are undeveloped.' He explained that the compound was 'undeveloped' because it lacked water infrastructure. The way Mr Chisulo understands development tallies with the way Mwosa defined development.

This student noticed that the degree of participation in the NHCs varied according to the circumstances. For example, some people participated because they were out of employment. Others participated for political reasons.

This student was told of some people that stopped participating in the NHCs after getting into political offices. Such individuals lacked genuine commitment because they were using the NHCs as platforms to ascend into power.

From the HR point of view, the aim of the NHCs is to ensure that 'health for all by the year 2000' is achieved. The promotion of primary health care through the NHCs is, therefore, very important in attaining this vision.

CHAPTER 5

Experience

My practical attachment at DHMT started on the 15th January 1998. This was a rainy day. The rain disturbed my programme as I had to wait for it to stop before starting off.

I disembarked at the Civic Centre Bus Stop and then walked to DHMT. This was because there was no direct bus to DHMT. On this particular morning luck was not with me because it started raining again when I was half way to DHMT.

I arrived at DHMT at 8:30 hours.

The technical advisor, Mr. Andy O'connel, who was directly responsible for my attachment, briefed me about the NHCs and introduced me to DHMT members of staff. I was also introduced to the Japanese International Corporation Agency (JICA) officials whose offices were within DHMT. JICA was working in collaboration with DHMT on Primary Health Care.

I was later able to learn and see many things through field visits with JICA experts. This gave me an opportunity to fully appreciate the roles of JICA, DFID and DHMT in promoting development especially among the under-privileged in the compounds..

For instance, I learnt that JICA made it possible for people of George compound to have an easy access to clean water. JICA put in place a water infrastructure that had solved the problem of water which was then rampant in the area.

At the time of writing this report, JICA and the NHC were in the process of building a fee-paying toilet at the main bus station in George compound. This was to enhance the general sanitation in the area.

In Chipata compound, for instance, I was privileged to see what DFID and CARE, peri-urban self- help (PUSH) had done to solve the problem of water. The two organisations put up a water facility in the area that had adequately addressed the problem of water in this compound.

The Chipata compound Resident Development Committee (RDC) chairperson, Mr Peter Chisenga, explained to me that labour for the whole project was provided by the residents themselves through voluntary participation. This included preparation of the erection of communal stand taps.

Upon completion, the project was handed over to the community. The RDC together with the NHC collect a small water fee which they use to buy water purification chemicals, pay electricity bills and other operational expenses such as lubricants.

The lesson I learnt from this experience was that for genuine development to take place, people should fully participate in the process and that development cannot succeed where force is used. People in this case were regarded as partners and not targets of development.

Emphasizing this point, (Koning and Martin, 1996) explain that participation in development builds rapport, confidence, unity and resistance to external exploitation and intimidation. The role of the expert should be confined to the identification of gaps and the building up of local capacity to fill them.

This is what DFID, JICA and the Human Settlement of Zambia (HUZA) were doing in Chipata, George and Bauleni compounds. Vandalism of water taps or thefts of pipes that used to be common then stopped because everybody was a guard. This is because this development was not imposed upon the people but was initiated by them as a result of their felt needs.

Development, forced on people, is persecution and enslavement.

Usually whenever there has been political or any other form of coercion for development, communities or peoples other than the coerced have benefited. True and sustainable development requires that the people for whom it is meant agree to the change and work toward that change (Kasoma, 1993 : 403)

Trips I had with JICA experts gave me an opportunity to practically understand the importance of the participatory approach in development. I also learnt practically that development can easily be achieved through combined effort of individuals, communities, NGOs and the government.

Moreover, I noticed that late coming for NHC meetings was a common characteristic. This was in spite of advance notice which was given to the people about the meetings. Late coming was common to both executive committee officials and ordinary members of the community.

On February 9, 1998 for example, this student was made to wait for nearly two hours for an NHC meeting in George compound. This was because nobody, including the officials, came on time for a meeting that was to start at 14 hours.

The Chairperson, Mr Jerrico Chambikwa, who apologized for the delay, had to cancel the meeting because of poor attendance. This experience clearly demonstrated to me that mobilizing people at grass root to 'participate' is not easy.

Mrs Tirawire Zulu of George compound cited the frequent postponement of the NHC meetings as something that was discouraging her from actively attending NHC meetings. Mrs Zulu told this student that the waste part was that notice for postponement was usually short.

When meetings are postponed, some committee members are not told. More importantly, last-minute changes cause disorder to an individual's routing which in turn creates a sense of frustration and loss of commitment to a cause (Chelston NHC Minutes, September 19, 1997).

To resolve this problem, it was suggested that whenever the chairperson was unable to chair the NHC meeting due to other pressing commitments, someone else should be delegated to do so in order to maintain the momentum of the NHC meetings.

Commenting on the meetings, the HCSIC in Chipata compound told me that time should be observed during meetings especially that NHC activities were voluntary. This she said was important because it builds mutual relationship between the NHC executive members and the community.

CHAPTER 6

Reactions and Perceptions of People About the Attachment

There was a mixed reaction from the NHC members and HCSICs about the attachment of this student. Some NHC members thought this student was the one who was blocking their CIF applications for 1998.

At the time of my attachment, some NHCs had their applications turned down for different reasons. As far as they were concerned this student was part and parcel of the decision-making process that rejected their proposals for funding.

For instance, one of the NHC members introduced me as: “ He is one of the officials who was sitting on our project proposals for Community Initiative Fund at DHMT.” This introduction had put me in bad light. However, after I explained to them the conditions under which these funds were given, they appreciated the reason why their proposals were rejected.

Some members regarded me as one of the politicians. This was because there was so much talk about the local government elections at the time. The people were suspicious about my interest in the NHCs. Although they did not say so, they thought I wanted the data for political campaign purposes. This notion was, however, cleared through my discussions with them.

In other NHCs that this student visited, members seemed fed-up with people asking questions about the NHCs. They complained that they did not benefit anything from people like me. They wanted to know what benefits they would have after submission of my findings to the higher authorities.

In most of the compounds I visited, garbage and lack of transport were common problems. Hence, some NHC members wanted to know if DHMT would provide them with transport for garbage collection. This made me wonder whether some NHCs knew the reason behind the establishment of the NHCs.

It is the opinion of this student that authorities should consider putting in place a budget whose objective should be to educate and inform both the NHCs officials and ordinary members about what the NHCs stood for.

However, some NHC members did look at me as a genuine researcher whose intentions were to strengthen the community partnership in the health delivery system. Such NHC officials were very supportive and happy with my visit to their respective areas.

Ms Christine Phiri, who is one of the founder members of Kanyama NHC was very excited with my visit. She said it was very encouraging to her to be visited by an official from DHMT or MOH. She added that this student's visit demonstrated that the MOH recognised the role which the NHCs were playing in the delivery of health services in the country.

Senior MOH officials should find time to visit the NHCs so that they could appraise themselves to some of the difficulties that we were facing. Such a gesture encourages NHCs to carry on with their programmes (Ms Christine Phiri's Interview, Kanyama HC, April 2, 1998).

The HC staff were very helpful to me because they knew the aim of my attachment. In fact some of them regarded me as part of a DHMT official. The reception which I was given by the HCSIC whenever I visited them was very good.

My attachment coincided with the time when interviews for joining the Central Board of Health were taking place. Many HC staff were anxious to know the outcome of their applications and subsequent interviews to join the board.

CHAPTER 7

General Observations and Comments

Poverty was preventing people from participating in the NHC activities. The word poverty brings to mind hunger and suffering. One thinks of people with little or no shelter, food, clothing and the sick without means of securing medical care (The World Book Encyclopaedia, Volume 15).

Poverty is a condition that exists when people lack the means to satisfy their basic needs. The identification of poor people depends on what constitutes basic needs. These may be defined as “narrowly” as “those necessary for survival” or as broadly as those reflecting the prevailing standard of living in the community (The New Encyclopaedia Britannica, Volume 14, 15th Edition: 935)

The first criterion would cover only those people near the borderline of starvation or death from exposure. The second would extend to people whose nutrition, housing and clothing, though adequate to preserve life, do not measure up to the population as a whole.

Every country, city, town or village has its poor and poverty-stricken people. However, being “poor” may not be a matter of lacking the necessities of life. Such a state may be merely comparative or relative.

For example, there are people who have the necessities of life but are considered poor when compared with those who have many comforts or have great wealth. A person may be poor in a city on an income that would make him or her prosperous in some small town.

Scholars like Peter Townsend describe those in any society as poor if they are unable to ‘participate’ in the activities and have the living conditions and amenities which are customary in that society. In the United Kingdom for instance, such things include birthday parties for children, summer holidays and evenings out (Seers, 1972).

This is the context in which poverty should be understood even in the compounds that this student surveyed during the attachment. In other words, poverty varied from compound to compound and from individual to individual.

Selling of food items was a common economic activity for survival in these areas. This student learnt that some parents were unable to send their children to school because they did not have the money to buy uniforms and other school requirements.

Mr Chambikwa for example, told me that poverty was preventing the community from participating in the NHC programmes in his area. He said people would rather ‘participate’ in food-for-work programmes because these were of immediate benefit to them.

Mr Felix Kakwende of Mandevu compound said it did not make sense to him to participate in the voluntary NHC programmes when his family had no food at home. He explained that he would rather spend time in an activity that would benefit his children.

The reason Mr Kakwende gave for not taking part in the NHC activities cannot be disputed as it is valid. One cannot work when one is hungry. In other words, it was very difficult for anybody to work on an empty stomach.

Many of those that participated in the NHCs in George and Mandevu compounds were either self-employed or were doing some small-scale businesses. Those in regular employment or big businesses often excused themselves on account of work.

This student learnt that it was difficult to effectively publicise the NHC programmes without transport or public address systems. It was even more difficult to do so in areas that were too big to be covered on foot. These were some of the problems which were negatively affecting the publicity of the NHC activities.

Ms Heldah Chileshe of George compound told me that bicycles could go a long way in solving the problem of transport for purposes of communicating messages within the communities. A fundraising programme to that effect was due to kick off at the time of this interview in some of the NHCs that this student visited.

It was further observed that people were more enthusiastic in the NHCs which had received CIF. It was clear to me that given necessary support, the NHCs could prove to be a practical strategy which the MOH could use to attain health for all by the year 2000.

This student noticed that there were no exchange visits among the NHCs. This is one aspect that should be encouraged in view of the fact that it promotes interaction and sharing of knowledge, ideas and experiences at various levels in society.

Chainda HCSIC, Mrs Beatrice Zulu said apart from sharing experiences and knowledge on matters of common interest, visits of this nature created a sense of oneness among the people. Nearly all NHC members liked this idea and promised to implement it.

I also observed that the voluntary spirit was more pronounced in the NHCs which had more Christian organisations such as churches. In many cases, church members were more active in spearheading and implementing voluntary NHC projects.

Perhaps the health authorities should seriously consider to involve the churches much more than they are doing at the moment. The advantage was that these institutions were already well organised with a strong sense of voluntarism in whatever project they were involved in.

I observed that the so called grassroot people out there were very active and knowledgeable about their felt needs. This, I noticed during the meetings in which I was privileged to attend in the course of my attachment.

The people were not only capable of identifying problems that affected them but also of finding solutions to those problems without depending on outside experts. This student was impressed to see that both men and women were active in contributing ideas during the NHC meetings.

The lesson I learnt from this was that some traditions that prevented women from expressing themselves in the presence of men were fading away. In fact it was observed that sometimes women were even more active and aggressive than men in contributing ideas during these meetings.

Because NHC meetings were held within the HCs, some people tended to regard them more as MOH 'departments' than a community based institution. The opinion of this student is that these meetings should be decentralised to the community centres, schools, markets or churches.

The view of Mr John Phiri of George compound was that NHCs were mere implementers of the MOH programmes. He argued that NHCs were not recognised beyond the polio immunization period. Mr Phiri said NHCs were only active each time the MOH wanted to publicise something.

To address this concern, DHMT was encouraging the people to start holding NHC meetings from schools, markets or any other place which could be agreed upon by the communities themselves. At the time of writing this report, some NHCs had already started holding their meetings from such places.

CHAPTER 8

Findings and Discussions

Other than poverty which has already been explained elsewhere in this report, NHCs lacked experience in community mobilisation because they were still new. Lack of constitutional guidelines on the other hand was causing factions in the NHCS.

Lack of publicity about the existence and roles of NHCs, poor recording and storage of minutes as well as the issue of incentives to members were some of the contributing factors to what appears to be peoples' apathy towards the MHCs.

Some NHCs were too ambitious in their choice of projects. Others embarked on projects that were outside their technical capability. Indeed, some of such projects turned out to be 'white elephants' up to the time of writing this report.

Kalingalinga water project is one good example. This project never took off because NHC members bought wrong pipes and they did not consult the Lusaka Water and Sewerage Company (Kalingalinga NHC Minutes, August 6, 1996).

NHCs in Lusaka or Zambia in general lacked experience because they were still in their infancy stages. As a result, they were not in a position to effectively organise and mobilise the community. This had an impact on the effectiveness of the NHC (O'Connell, 1995).

Lack of constitutional guidelines was badly affecting the running of the NHCs at the moment. For instance, the tenure of office for executive committee members did not exist at all.

This resulted into the 'overstaying' in office by the first executive committee officials.

I was informed that these officials had now become ineffective and dictatorial in their administration. Calls for their 'impeachment' were gaining momentum every day.

Such calls were worse in George compound where two factions were created. One group was in support of the current chairperson, Mr Chambikwa, while the other was against him. This had affected the rate of attendance in the NHC projects in the area.

Mr Chambikwa was 're-elected' chairperson in the area in December 1997. However, some people there have not recognised him as chairperson. In fact he has been accused of having stage-managed the whole election process.

In an interview with me at George HC on February 9, 1998, Mr Chambikwa explained that poor attendance at the NHC meetings was because of communication break-down and not because people did not like him as chairperson.

He informed me that the resignation of the publicity secretary weeks after he was elected, had created a problem of communication in the NHC. The result was that NHC programmes and information could not be disseminated to the people effectively.

The draft constitution proposes a two-year tenure of office for executive members. However, some people were opposed to this saying it was too long. Instead, they suggested that a one-year tenure be adopted. They further argued that the shorter the term the more effective the office bearer would be.

The HCSIC for Chawama, Mrs Febby Sinyenga, was strongly against the two-year tenure of office because apart from being too long, it would result into complacency on the part of the leadership. She said when the tenure of office was too long, leaders become dictatorial.

Mrs Sinyenga went further to propose that there should be a clause in the constitution to stop old executive members from seeking re-election. She said this would give others, with new ideas, a chance to take up leadership positions.

Ms Rudia Chilufya, who is the HCSIC at Kalingalinga agreed with Mrs Sinyenga. In an interview with this student in February 1998, she explained that unless a leader proved hard-working by the number of projects initiated, one-year tenure of office was enough.

Contrary to this view, others suggested that a three-year tenure of office was appropriate. Those advocating for a three-year period argued that one-year tenure was too short for one to be able to effectively prove himself or herself to the people.

Mr Mulenga Phiri, a resident of Mandevu compound told me that quality leadership can be assessed over a 'reasonable' period of time. He said you do not change leadership for the sake of changing because history has proved that some new leaders were no better than old ones.

Another problem affecting the NHCs was poor keeping and recording of minutes. In some cases, minutes were written on ordinary pieces of paper. These minutes were often kept by the secretary at his or her house. Members' access to such records was, therefore, limited.

Minutes were also rarely circulated to the members. Instead the secretary only read them at the start of another meeting. Sometimes meetings went ahead without following the standard procedure of going through the previous minutes and approving them as a true reflection of what was discussed.

We sometimes send our minutes for typing at DHMT. However, the only typist available at DHMT was usually too busy with work from within DHMT. It was, therefore, difficult for us to have the minutes well recorded and kept (Kalingalinga HCSIC Interview, March , 1998)

The leaders claimed they could not distribute the minutes because there was no paper, a type-writer and a typist. The NHCs could not afford to buy paper, type-writers or to hire typists because they did not have the money. What about the money DHMT gives them for NHC meetings?

The Kanyama HCSIC, Ms Mary Chikwanda, informed me that DHMT had given specific instructions regarding how the money for the NHC meetings was to be used. She said this money could not be deviated for any other purpose.

Indeed, minutes for 1995, 1996 and part of 1997 could not be found in the NHCs that were surveyed. If at all these minutes were there, it was difficult to find them. Record management was very important in any organisation because lack of it created problems of accountability, continuity, monitoring of progress and abuse of office.

Records about the NHCs are very important not only to health authorities but also to development planners, policy makers and researchers. The information about NHCs could prove to be very critical for future planning and budgeting in the country.

In fact this student had a feeling that some of the press reports to the effect that resources were mismanaged in certain NHCs had something to do with poor recording and storage of information on the part of the NHCs themselves.

A good example was the media report which alleged that CIF money was not well used at Chawama NHC. After the higher authorities at DFID/DHMT checked their records, they found out that nothing was mismanaged and that the claim had no basis.

Further, this attachment revealed that the way people perceived the NHCs was also affecting their commitment to participate in the NHCs. It should be stated that perceptions are very important because they influence peoples' attitudes and behaviours.

Those interviewed informed me that the NHCs were actually thought of as disguised wings of the ruling Movement for Multiparty Democracy. What this means is that those that did not agree with the vision of this party could not participate in the NHCs.

Some members of the community indicated to me that initially they used to come for NHC meetings and projects in large numbers because they thought that NHCs were charitable organisations where they could receive free food or clothes.

Others perceived the NHCs as potential employment organisations where they could get employed. Those that had such views were very active because they wanted to enhance their employment opportunities.

The people could not be blamed for perceiving the NHCs in that way because at the time, the country had just undergone major political and economic changes that had far reaching consequences on their life styles.

For instance, the liberalisation of the economic system meant retrenchments and closures of some of the companies. The result was that many people found themselves without jobs. It is these people that used to patronise the NHCs with a hope that they would find employment.

These two perceptions explain why the attendance at the NHCs was overwhelming during the initial stages. Mr James Mutale, a resident of Mandevu informed me that he did not want to associate himself with the NHCs because he perceived them as organisations for the low status people in society.

Mr Layton Nkamba, who used to work for one of the banks that was liquidated, informed me that his perception of the NHCs was that they were security associations whose basic objective was crime prevention especially in the shanty compounds.

Mr Nkamba was confusing the NHCs with the Neighbourhood Watch Committees (NWCs), which were popularised by the Zambia police service a couple of years ago. Until this student explained the difference to him, his picture was that both meant one and the same thing.

Mr Bright Kachimba, resident of Mandevu told me that he did not want to participate in the NHC activities because he feared contracting diseases especially in sanitary related projects. People sharing Mr Kachimba's perception always stayed away from the NHCs.

Mrs Charity Makata of Mandevu compound told me that there was no need to attend NHC meetings when there was no cholera cases reported in the area. As far as she was concerned, one attended NHC meetings when there was cholera outbreak in the community.

This answer gives you an idea of how ignorant people were about the NHCs. Not enough awareness-creating activities were in place in these communities. This should act as a signal for the authorities to think of publicising the NHCs.

These issues need to be addressed quickly. The picture emerging from this attachment indicates that people were not fully participating in the NHCs due to poverty, misconceptions and lack of publicity.

Mr David Malutu of Chainda compound, lamented that transport and lack of facilities like megaphones, were factors that were making it hard for the NHC executive officials to effectively mobilise the communities.

It was even more difficult to publicise the NHCs in areas that were too big. Chainda HCSIC, Mrs Beatrice Zulu, informed this student that money was being sourced from farmers and business people in the area to buy a vehicle. She said the response was encouraging.

Mrs Zulu explained that NHC members in big catchment areas were spending a lot of money attending to NHC meetings and activities especially when such programmes were carried out at a central place.

A sales person who is ignorant about the product that he or she is selling cannot succeed. To be able to market something, one should have adequate basic knowledge about that particular commodity.

In a similar way, the communities cannot be expected to participate in the NHCs when they did not know about them in the first place. It is, therefore, very important to publicise these community based development organisations.

There was a mixed reaction among the NHC members on the issue of incentives. Mr Jim Lubilo of Kanyama said an award should be considered for committed members. He said time and energy individuals spend ‘participating’ in the NHC activities should be taken into account.

For every hour spent ‘participating,’ there is an opportunity cost: that is, the fact that the villager may be foregoing more productive activity if the participatory process does not lead to benefits, either in the long or short term (White, 1993: 18)

Mrs Mary Mwamono of George compound argued to the contrary when she said ‘participation’ in the NHCs was based on voluntarism. She explained that individual participants in the NHC programmes should not be given any incentives at all.

Voluntarism is a theory or doctrine which regards ‘will’ as the fundamental principal or dominant factor in the individual or in the universe (The Oxford English Dictionary, 1991). Hence, ‘participation’ in the NHCs should be without any compulsion, constraints or undue influence by others.

This student gathered from field experience and interaction with the NHC officials that a mere visit to the NHCs, particularly by senior DHMT/MOH officials was a better incentive than money or material awards.

CHAPTER 9

Recommendations

1. Poverty

The revelation that poverty was hampering peoples' participation in the voluntary NHCs' work should be of great concern not only to the health authorities but also to the individuals and the community in general.

The fight against poverty begins from an individual. It is at this level where this battle can be won or lost. In other words, an individual initiative is very important in the process of getting rid of poverty. This calls for positive attitude on the part of the individuals themselves.

At a NHC meeting in Chilenje, which I was privileged to attend, one official simply declared that 'no funding no work' on the project. At the time of my visit, the NHC in the area was on a grass cutting project in order to get rid of mosquitoes.

This person's view was finally taken as an official position for the meeting. This was despite 'protests' from other members who were willing to organise tools from the community and carry on with the project. This is a good example of a bad individual attitude towards development.

It is this attitude that perpetuates dependence not only at individual and community levels but also at the national level. The role of the community should be to encourage such individuals to develop a spirit of self-reliance.

The lesson that I learnt from this incident was that without trained leadership in any situation, 'self-appointed' individuals, like the one above, would continue to monopolize and impose their opinions on others.

2. Non-Governmental Organisations

The Non-Governmental Organisations (NGOs) can also play a critical role in development. The Human Settlement Association of Zambia (HUZA) was doing a commendable work in Bauleni compound by helping the residents to build permanent housing units.

This is an example of the supplementary role of NGOs in the development process. The role of the government should be that of creating good environment for development. In other words, government should provide water, schools, hospitals, roads and electricity.

This attachment report recommends that individuals, the communities, the NGOs and government should work together as the case is in Bauleni, George and Chipata compounds .

3. Awareness

It is only when people are aware about an issue that they are able to do something about it. As the situation is now, many people do not know about the existence or the roles of the NHCs in their localities.

Against this background, this student recommends that DHMT prepares a budget for sponsoring community awareness activities such as drama. I was privileged while on this attachment to watch the Tigwirizane Drama group when DFID was officially handing-over Chawama HC to DHMT.

The group put up an impressive awareness-creating play whose theme was to prevent vandalism of community property. Mr Jackson Zimba, who was present at this colourful ceremony told me that the message was well packaged and delivered in a very entertaining manner.

Community sensitisation through drama within the communities can help to address the wrong picture which some people have about the NHCs. Considering the fact that the NHCs did not receive enough publicity in the initial stages, it is important that the wrong picture is corrected now.

Drama is not only effective, entertaining and appropriate but is also less expensive. From what I was able to see and my interaction with the officials of the NHC, RDC DHMT, DFID, JICA and NGOs while on this attachment, I am certain that the NHC can be a viable tool for development in the communities.

On the question of venue for the NHC meetings, as already alluded to elsewhere in this report, **it is recommended that these meetings take place at schools, markets, churches or any other venue which can be agreed on by the community itself.**

I noticed that in certain NHCs, they had already started holding meetings from outside the HC premises. This move would help to reduce postponements of NHC meetings for reasons of the venue being 'booked' for other programmes.

This student experienced such a situation on February 7, 1998 in Chelston. The NHC meeting could not take place because the national tuberculosis and chronically ill community monitoring organisation was using the venue. Postponement of NHC due to lack of a venue would be a thing of the past. The holding of meetings in the communities will also bring the people closer to the NHCs.

4. Guidelines

Reports have indicated that lack of guidelines was causing frictions between NHC officials and the HC staff in some areas. This is an issue that needs to be addressed as soon as possible especially since the HC is central in facilitating the NHCs programmes.

There is no doubt that a draft constitution which was developed in conjunction with the NHCs would address this problem. This document was receiving further comments from the general membership of the NHCs in various areas.

This student was privileged to have a look at this document and was satisfied that it would be a constitution that would meet the aspirations of all the people concerned. Once finalised, the problem of guidelines will soon be a thing of the past.

Terms of references are very important aspects in any organisation because they make continuity possible. **It is against this background that this report recommends that an office at a district level is created to coordinate and help in the formulation of NHC operational guidelines.**

It would be the responsibility of this office to act as a data bank where information about the NHCs would be processed and stored possibly in a computer. Commenting on this recommendation, Mr Lubilo said this would also strengthen the administrative structure of the NHCs.

5. Incentives

Calls for incentives cannot be glossed over. They have to be looked at seriously. **This student recommends that a token award be worked out.** The modalities should, however, be left to the individual NHCs. These incentives can be in different ways. One of the ways is to exempt NHC members from paying medical fees.

Conclusion

People appreciated the role of the NHCs and were generally willing to participate in their activities. This student's attachment at DHMT showed that poverty and misconceptions about the NHCs were key factors that were preventing people from participating.

Apart from that, peoples' ignorance about the existence and functions of the NHCs was also contributing to the so called apathy in the NHCs. In this students opinion, heavy publicity should have been done in the initial stages of the NHCs.

I also established during the attachment that those who participated in the NHCs were generally active and knowledgeable in identifying problems which they were facing. They could also find possible solutions on their own problems without outside intervention

The attachment also showed that it was important for development planners to encourage genuine dialogue and participation in the development process.

Development could easily be achieved through partnership with the community. This was demonstrated by the peri-urban self-help (PUSH-CARE) Water Project in Chipata compound.

The fact that NHCs are community based and driven, distinguishes them as more suitable and appropriate development strategies. Once fully established and operational, the NHCs will no doubt prove to be important tools for achieving health for all by the year 2000.

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Appendix

List of HCSICs met during data collection for this report.

Chipata	-	Mrs F Kunda
Mandevu	-	Mrs M Katai
George	-	Mrs A Katuta
Kanyama	-	Ms M Chikwanda
Chawama	-	Mrs F M Sinyenga
Bauleni	-	Ms D F Zulu
Kalingalinga	-	Ms R Chilufya
Mtendere	-	Mrs C Matibini
Chainda	-	Mrs B Zulu