REPUBLIC OF ZAMBIA
MINISTRY OF HEALTH

Health Literacy Manual

for people centred health systems

Zambia
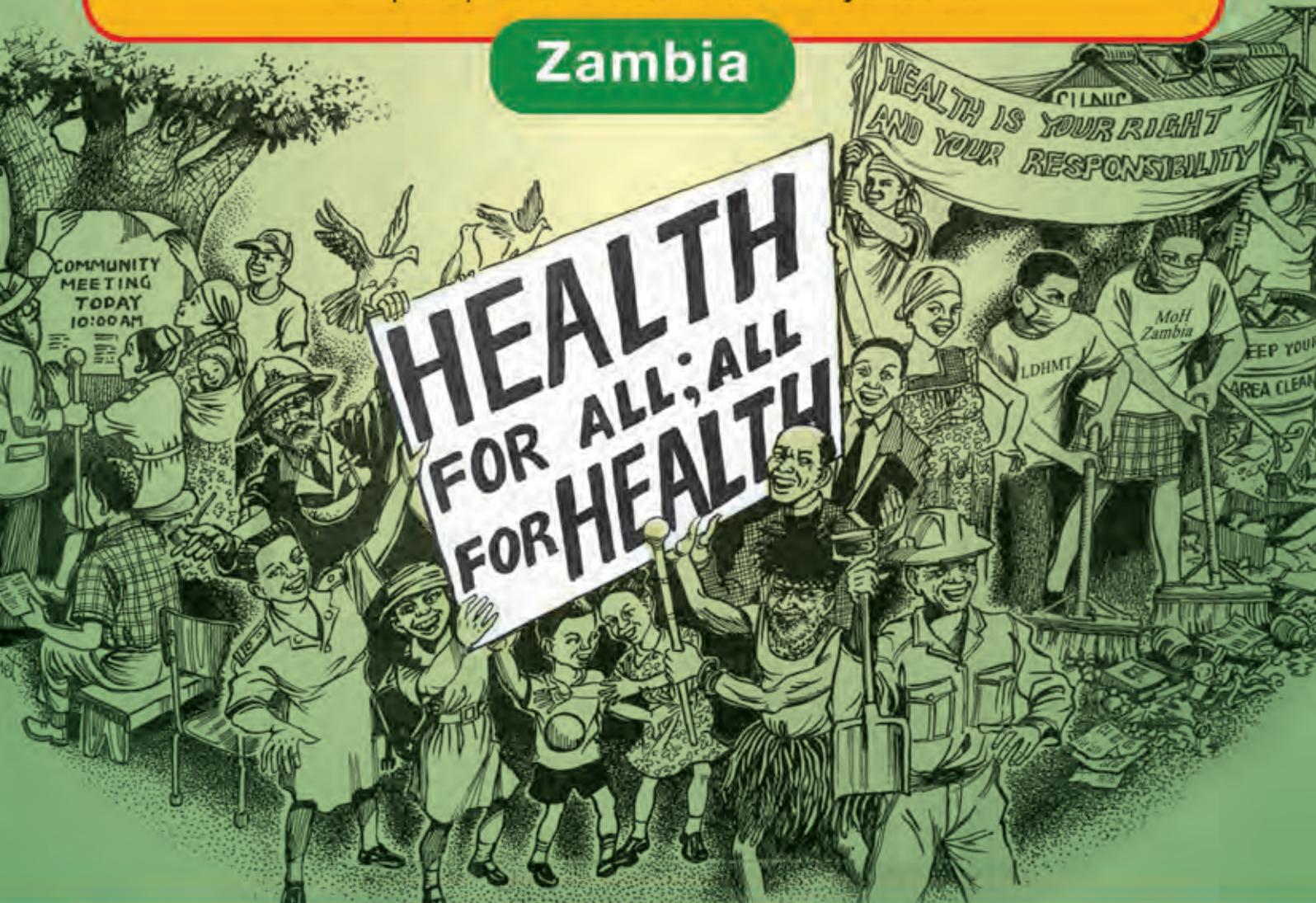
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Foreword

It is with pleasure and pride that the Ministry of Health presents the Zambia Health Literacy manual, developed with Lusaka District Health Office, Training and Research Support Centre (TARSC) in Zimbabwe and the Regional Network for Equity in Health in East and Southern Africa (EQUINET).

Health literacy refers to a process of reflecting on experience, informing and empowering people to understand and act on health information to advance their health and improve their health systems. It builds knowledge and capacity to act within a framework of Participatory Reflection and Action (PRA) that strengthens community level diagnosis, action and engagement with health systems.

The manual is an outcome of work we have been implementing to support and strengthen community roles in health and communication between health workers and communities. In light of the positive outcomes from pilot work done in the pilot areas of Lusaka District, the MoH in Zambia has decided to institutionalize the Health Literacy (HL) programme and scale it up to other health districts in the country. Health literacy will contribute to a movement to transform our society into a community of health literate men, women and children who will be the fertile soil upon which the seeds of healthcare will thrive.

As Government we consider community involvement key in the development of our country and essential in addressing the health inequities in the health service delivery system. We are particularly concerned with improving the status of our women through empowering them with reproductive health knowledge. As MoH we will ensure that the scale up of health literacy is included in the annual health plan. The MoH is also cognizant of the fact that improving community health outcomes requires support from many sectors. We appeal to all who have a role in health to contribute to this pioneering initiative.

We wish to thank the personnel at TARSC and the consultant and personnel at Lusaka District Health Office for their role in writing content for the manual, the peer reviewers of this first edition and all those who have contributed to it. We thank also CORDAID Netherlands through TARSC and EQUINET for their support of the work.
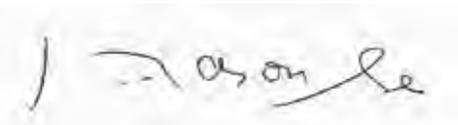
Hon Minister of Health Dr Joseph Kasonde
Lusaka, Zambia, November 2012

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Module 1: Introduction to health literacy

In this introduction we:
- share with you this manual and how we understand health literacy
- share how we understand health and why we need a health literacy programme that empowers communities for health
- introduce why we use participatory approaches, what they are and how to use them
- explain what you will find in this manual and how to use it

1.1 About this manual and our understanding of health literacy

This manual draws from regional work that aims to strengthen the capacity of facilitators and organizers in civil society organizations working at community, district and national level in East and Southern Africa to support **health literacy**. It services the intention of the Ministry of Health to scale up health literacy in Zambia, as described in the newspaper report below. It can be used by community members themselves but is aimed mainly at people who work with communities.

MINISTRY TO SCALE UP HEALTH LITERACY

Hon. Dr Joseph Kasonde, Minister of Health Zambia.

Times of Zambia July 27, 2012

HEALTH Minister Joseph Kasonde has said his ministry is hopeful that it will scale up health literacy programmes to all parts of the country. Dr Kasonde said in light of the positive outcomes from the pilot areas under the Lusaka District Health Management Team (LDHMT), the ministry wanted to institutionalise health literacy programmes to make it a national project. Speaking when he addressed a stakeholders meeting for the National Health Literacy Programme at Pamodzi Hotel in Lusaka yesterday, the minister said health literacy helped inform and empower people to understand health information to improve their health systems. "It also builds knowledge and capacity to act within a framework of Participatory Reflection of Action that strengthens community level diagnosis, action and engagement with health systems," he said.

The ministry was already involved in regional programmes with the Training and Research Support Centre (TARSC) in Zimbabwe, and the Regional Network for Equity in Health in East and Southern Africa (EQUINET). He said the scale up programme would be included in the annual health plan but that the ministry was also cognisant that improving health outcomes required support from many sectors hence the holding of the stakeholders meeting to pioneer the initiative. Dr Kasonde said building community and organisational level capacity in health literacy and setting up health literacy programmes would strengthen the relations between the community and health workers.

Director for Public Health and Research Dr Elizabeth Chizema made a presentation at the meeting in which she emphasised on the need to identify options for scaling up of the literacy programmes and the monitoring and evaluation framework for the scale up.

This edition of the manual was written by Training and Research Support Centre with input from Lusaka District Health Management Team to support the work of facilitators from the Lusaka District Health Management Team and Ministry of Health Zambia who work at national, district and/or local level to enhance community participation in health in Zambia. It is a resource in efforts to promote health at community level.

The three main aims of this manual are:
- To develop your understanding of health issues and your capacity to act on them.
- To strengthen your understanding of participatory methods that are used in health work so that you too can use them to support community awareness, knowledge and action.
- To enable you and the communities you work with to share experiences on health, reflect on your health situation, take appropriate actions, and work with others, including relevant authorities, to improve health.

This is why we call it health literacy.

Health literacy refers to people's ability to obtain, interpret and understand basic health information and health services, and to use such information and services in ways that promote their health. For example, it means that patients can understand the information given to them by health providers and participate in their treatment and care. Literacy is not simply the ability to read and write. It is also the ability to understand, communicate and use information to support action.

Health literacy should not be confused with 'treatment literacy'. Treatment literacy is a part of 'treatment preparedness', which refers to a person's readiness to begin treatment, and is used particularly these days when we are talking about people taking antiretroviral drugs to prevent or treat AIDS-related illnesses.

The following case study will help explore further what we mean by 'health literacy'

Read about the experiences of George Compound and Lusaka District Health Management Team and community Garbage collection programme and then discuss the questions that follow.

George Compound is a shanty township situated between Matero township in the east and Lilanda township in the north with about 300,000 residents. It is bordered by Lusaka's Heavy Industrial area to the South.

In 1990, Zambia experienced high rainfall between January to March resulting in flooding due to poor drainage in the area. This flooding caused the overflow of faecal matter and other human waste from poorly constructed and often times shallow pit latrines. This resulted in the first major cholera outbreaks in Zambia outside the areas perennially affected, including outbreaks in Lusaka's George compound. In 1991 and 1992, despite normal rainfalls, George compound again experienced a severe cholera outbreak. This later spread to other townships in Lusaka. Cholera centres were established throughout the City and the cholera cases were brought under control. Following these annual cholera outbreaks, the Zambian Government negotiated a developmental grant from the Japanese Government to provide clean water to George Compound. A feasibility study was implemented to establish the community's readiness to work with government authorities in solving their problems. Community members implemented a Water Service Sites Mapping. Through this they identified areas that were suitable for placing water taps and boreholes.

Boreholes and water points were constructed at these identified sites. The government then handed the programme over to the Lusaka Water and Sewerage Company (LWSC) for day to day management. LWSC established a community programme with water committees elected by the community , including 370 Tap

Leaders who were made responsible for the opening of water taps at scheduled times (morning and afternoon) and were also responsible for monitoring use of water at household level, so that the 210 litres of water allocated daily per household were fairly maintained. The introduction of clean water and its availability on a 24 hour basis ensured that almost all George Compound residents had access to safe drinking water. This drastically decreased the number of people drinking water from shallow wells. Diarrhoeal diseases became less common and cholera and dysentery have been under control, with very few cases reporting to George Urban Health Centre.

Community and Health Workers partnership in garbage collection, Chipata, Lusaka © A Zulu, July 2011

Noting the impact of garbage on health, in 2011 the Ministry of Health, through the Lusaka DHMT's skilled and trained Health Literacy groups, introduced a community awareness and mobilization programme on cleaning up garbage. Community members drawn from different social groups including the police, schools, churches, markets, water trust and other ordinary members volunteered for garbage clean ups in Matero, Chipata and Chilenje townships. Corporate and other sectors like MTN, Lusaka City Council, United Church of Zambia (UCZ) - Mandevu Constituency Member of Parliament (MP), Lions Club of Emmasdale, Barclays Bank, media- MUVI TV, ZNBC, and ZESCO were brought in by the community and LDHMT to provide cleaning equipment and other materials.

One year later, communities have taken responsibility in ensuring that their surroundings are kept clean.

Communities and health workers are working together not only on garbage collection but also in other health matters. The business community is more involved in community health and communities are identifying and solving their health issues in partnership with their services and drawing input from the business community. Lusaka District Health Literacy groups are now being consulted and replicating their experiences in other communities within the district.

Some community members responded negatively to the initiative at first, as they believed that it is the responsibility of Lusaka City Council to which the communities pay various levies to collect garbage and provide other municipal services. After much discussion and debate and watching the activities of others, they began to change their minds. Today they participate in the community health activities.

Source: MoLGH 2011; LWSC 2003

For reflection or discussion:

In the story above:
- What was the health problem (or problems)
- What was done about it?
- Were the actions successful?
- What do you think made them succeed or fail?

As you will see from the story above, being able to improve health often depends on:

- understanding what causes health problems;
- dialogue between the public and health services on these problems and how they can be dealt with;
- feedback from health services on how they are addressing health issues;
- community and civil-society organizations to support information-sharing, dialogue and community roles;
- mechanisms and tools that people, CSOs and health providers can use to discuss and make plans about health issues.

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Improving health goes beyond simply knowing about health. It is about being able to take effective action. So we are choosing to use the term "health literacy" because it goes beyond simply giving information, and supports reflection, dialogue, decision making and action.

1.2 How we understand health

What we understand by "health" is important. Health is not just about taking medicines or treating disease. It includes physical, mental and social health and well-being. It involves living and working in healthy conditions and having healthy practices and lifestyles. This means that improving health depends on actions to ensure that people get the health inputs they need, both within health facilities and in communities. To do this communities also need skills to act: skills to use services effectively, to organize social action, and to influence decisions about how resources are allocated and used.

Making sure that people obtain these inputs is also a matter of fairness and social justice. By this we mean that

- those who are less healthy and least able to afford health inputs get a greater share of the resources from health services;
- those with greater wealth contribute more to health services.

This is what we mean by 'equity in health'. However, as the Regional Network for Equity in Health in east and southern Africa (EQUINET) states, the way these resources are distributed is not just a technical decision: it is influenced by social norms, interests, lobbies and political decisions. So the values that society has, the political ideologies that govern it, and the ability or power that communities have to influence these decisions are also important. This makes empowering communities important for improving health.

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair.

Equity-motivated interventions seek to
- allocate resources preferentially to those with the worst health status
- to understand and influence the redistribution of social and economic resources for equity oriented interventions, and
- to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.'

EQUINET Steering committee, 1998

SECTION 1: Promoting Health

In Zambia child survival has improved in the past decade and the difference in mortality between rural and urban children has grown smaller. However there are still some quite wide differences. Children from households in Zambia whose mothers have no education are, for example, nearly one and a half times more likely to die before their fifth birthday than children from mothers who have higher education.

Zambia still has some way to go to meet its goals in health. For example, there have been less marked improvements in childhood stunting, although the negative trend of worsening nutrition has slowed or been reversed in more recent years. About 590 mothers die in pregnancy and childbirth for every 100 000.

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Source: CSO, MOH, TDRC, University of Zambia, and Macro International Inc. (2009).

For reflection or discussion:

In the example given above:
- Who do you think has the greater health needs?
- Who do you think gets the greater health resources?
- Is this equitable?
- What would you do to improve health in this situation?

We understand that, despite this, a lot of communities see health in terms of disease, and many people think about their health only when they are ill. We therefore discuss the common diseases in Zambia, what their symptoms are, and how people need to respond to them. This is not so that you can take over the role of health services. It is to enable communities to better understand how to use the services effectively, and how to follow up on their care. For example, if people know the symptoms of tuberculosis and report early to health services for treatment, they will infect far fewer people and the disease will not spread as widely.

We will also go further to discuss, share information and provide tools for dialogue on what causes diseases, including socio-economic, cultural or structural causes. This is to enable communities to share the information they have and to add new information to better understand how to prevent diseases before they occur, and plan actions for this. For example, if people know that cholera can spread through hand contact with those who have not washed their hands after using the toilet (because germs can be left on people's hands), people can plan information campaigns to promote hand-washing in all age groups, and can take extra measures during a cholera epidemic. Better still, knowing what causes diseases means that people can promote health in their community by changing the conditions that make them unhealthy. So if eating salt without iodine is leading to goitres, then we can make sure that we negotiate and make sure that salt is iodized.

As you will see, it is not only individual actions that people can take. Many actions need to be taken by people collectively, organized by their civil-society organizations or health systems.

Have a look again at the case study of actions in health presented on page 2-3, or discuss experiences of actions from within your own groups.

So acting on health, influencing decisions, communicating with heath workers, preventing disease, using services effectively and promoting health all depend on informed, organized communities. We recognize that communities have experience, knowledge and skills in health, that people who live in a situation have views on what is causing their ill health, and that people will act individually or collectively on things that they find important. Communities are a starting point for health actions. We will be discussing more about health, health systems and health actions in the next modules.

1.3 Using participatory approaches

Throughout the manual we use and provide tools for **participatory approaches** and methods. This is known as PRA (for participatory reflection and action) and is based on many well-established traditions that put participation, action research and adult education at the forefront of attempts to empower people. PRA has been developed in reaction to the "top-down" approach to development work, in which everything is decided and worked out from the top by external "experts" without involving those in communities, bringing them in only at a late stage, when issues have already been finalized.

PRA, by contrast, provides communities with opportunities to share information, experiences and views, and to contribute to decisions or plans being developed. It is based on the understanding that learning is a two-way process, not a situation in which ideas for development come only from people who are regarded as experts or educated. People in communities have a great deal of knowledge and experience, and learning starts with this. So PRA uses a variety of visual and verbal methods – including mapping, ranking and scoring, role play and drama, songs, case studies and many more – to provoke discussion, analysis and planning for action. PRA approaches are used to strengthen the power that people have to change their own lives, their communities and the institutions that affect them.

When communities identify a problem or see an opportunity to improve their lives, a PRA process can be used. A facilitator will help communities to:

- share information and think critically together about their situation and what they are doing, drawing on their experiences and knowledge;
- look for patterns to help analyse these experiences or situation. For example, a facilitator will ask for feedback on what is common about the experiences, what is different about situations of different groups, and so on;
- identify and obtain any new information or skills they may need; and
- plan for action.

This process is like a spiral, as we can see in the diagram.

practise skills, strategise and plan for action

apply in action

start with participants' experience

look for patterns

add new information and theory

THE SPIRAL MODEL

Source: Arnold, R et al (1991)

The spiral is not, however, a one-off process but a continuing one. Often the first plan of action will solve some aspects of a problem, or make some improvement, but it may not address all its aspects or go into its root causes. By setting up a regular cycle of reflection and action, communities can celebrate and learn from their successes, and can continue to find better solutions to their difficulties. Each time they move closer to achieving positive change in their lives. We can see this in the next diagram, with its series of cycles.

Source: Hope and Timmel (2001)
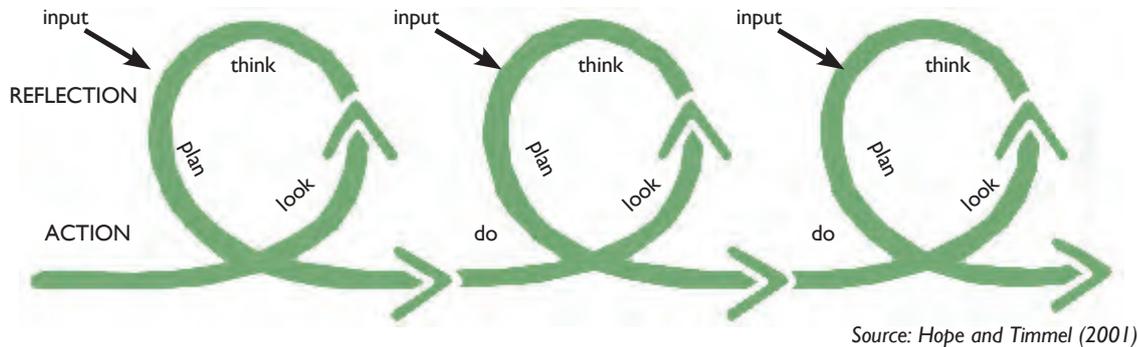
As we discuss later, we realize that people in communities are not all the same, and there are different ways of looking at things and different interests within the same geographical community. PRA approaches take into account the different, sometimes conflicting, interests in communities and don't try to force full consensus. The methods we include in this manual provide a number of ways in which different views can be listened to, and different skills and interests tapped, to achieve shared health goals.

The methods are diverse, and we don't cover all of them in this manual. When you work with PRA, it's easy to get carried away with all the exciting methods and tools, and to see them as an end in themselves. But it's not the activities or tools that drive the process; rather, it's the process itself that is key – the constant spirals of increasing empowerment in health and the goals they achieve.

When working through this manual, it is important to remember this. It is the reason why, in every model, informative text and participatory activities are woven together, each supporting the other as a way of deepening our collective understanding of how we can strengthen the link between knowledge and action. If you read only the information on health and health services, you will lose the engagement with the views, experiences and actions of communities. If you focus only on the activities, without integrating the health information and process, you will lose vital knowledge to inform that action.

In the spirit of starting with our own experiences, as outlined in the spiral model above, we include here an activity for facilitators so that you can explore your own experiences in using participatory approaches to health.

What are our experiences in using participatory methods?

Method: Group discussion
Approximate time: 40 minutes
Resources: Flipchart paper and marker pens
Procedure:
1. Divide participants into groups of about eight people. Give each group a piece of flipchart paper and some pens.
2. In groups, participants discuss the following questions (you can write these up on a piece of flipchart paper and put it up in the front of the room).
   • What are your experiences in using participatory methods in health? Tell your stories about what you did and why.

3. After 20 minutes, put all groups' flipchart sheets on the wall (or floor) and collectively identify the key features that made their work participatory. Make sure that the key elements of a participatory process, as discussed in this module, are included in these lists, e.g. the cycle of reflection and action, the focus on empowering communities, etc. This is a good time to discuss the spiral model in more detail.

1.4 The characteristics and roles of facilitators

The successful use of PRA approaches depends a lot on the role and skills of the **facilitator** – you! There are many skills a facilitator needs – both in what you do and how you behave. Some of these skills are borne from natural inclinations and experience; others you have to consciously learn. In this section, we discuss some of the skills you will need to be an effective health literacy (HL) facilitator, understanding that these skills are not learnt overnight and that you will continue to learn more about yourself and your work through the implementation of this programme. There are also some skills training activities in Module 8. This is an exciting, never-ending process. PRA practitioners who have been doing this work for years maintain that they never stop learning new ways on how best to approach and engage with communities, what tools to use and how to ensure that the programme moves forward toward a community-driven process of change.

The facilitators of the Zambia HL programme are community members and health workers drawn from community, government institutions and civil society organisations. They are individuals who are able to read and write, who have been involved in health and other social development activities in their community, who are chosen by the community together with the district health team, They are trained in health literacy skills. (the Glossary at the end of the manual gives a definition of 'health literacy' and a 'health literacy facilitator')

We have already talked about the understanding of health and empowerment that informs our approach to improving health. A facilitator builds on this by recognizing that local people are knowledgeable about the health problems in their area, are creative, and are able to explore, discuss, analyse and plan their health actions. They also understand that their role is to enable and support this.

What are the characteristics and roles of a Health Literacy facilitator?

Method:	Brainstorming with a picture, True/False statements
Approximate time:	90 minutes (45 minutes for each part)
Resources:	Flipchart paper, Bostik, list of statements, 4 containers – hats, bags, bowls – labelled "True", "False", "No consensus" and "Not sure".

This activity is targeted at trainee facilitators. It is divided into two parts. You can choose to do both, or just one or the other, depending on how much time you have and the level of experience of the participants. The first allows participants to generate their own list of characteristics; the second explores the more dynamic nature of participatory facilitation and gets people to examine some of the roles played by health literacy facilitators using PRA.

When we talk about the **characteristics** of a health literacy (HL) facilitator, we are looking at the distinct qualities of a facilitator, such as being non-judgemental, respectful, able to listen and ask the right questions, and recognize that we don't always have all the answers.

The **role** of an HL facilitator refers to what the facilitator should (or should not) be doing. It looks at the range of tasks a facilitator engages in, such as organizing sessions, encouraging participation, summing up what has been discussed, etc.

ONE: Characteristics of an HL facilitator (45 minutes)

1. Divide participants into groups of about 8–10 people. Give each group a piece of flipchart paper and a few pens and tell them to draw a picture of an HL facilitator on the flipchart paper. They should do this quite quickly.

2. When they have finished their drawing, ask each group to take up their pens and list, all around the figure, the key characteristics of an HL facilitator.

3. After about 15 minutes, ask each group to put their pictures on the wall. Let everyone walk around and look at the pictures. Then lead a discussion, drawing out the most common characteristics of an HL facilitator that are reflected in all the groups' pictures.

Big eyes make and maintain eye contact

Big ears listen carefully

Big head — good memory

Small mouth — talk less and be friendly

The sitting arrangement enables the facilitator to easily pick those who are lost and encourages participation, and makes it possible to assess and maintain class concentration.

Here, for your background information as facilitator (*please, don't show it to the participants!*), is an example of the drawing from a group in Malawi who did this exercise during the pre-testing of their literacy manual.
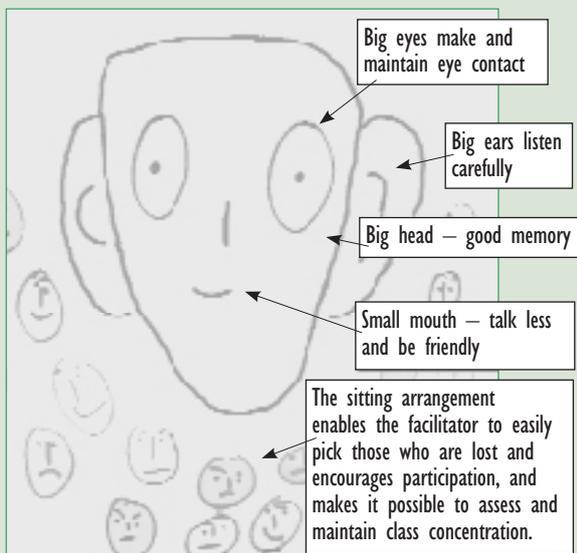
TWO: Roles of an HL facilitator (45 minutes)

If the group is not too large (less than 15 people) get everyone to stand in a circle. In the middle of the circle place 4 containers labelled "True", "False", "No consensus" (meaning that they do not all agree) and "Not sure" (meaning that they can't decide because they need more information). Give the group the statements below and ask them to put each one in the container that reflects their opinion about it. Encourage everyone in the group to give their opinion about where to place each statement, including the reasons why.

If you are working with more than 15 people, divide the participants into smaller groups and let each group discuss the statements and decide which container each should be put into. After approximately 30 minutes, ask one of the groups to put their statements on the wall under the four headings for all participants to look at. Ask the other groups to point out where their opinions differ. Use this time for everyone to argue their case until all the participants are happy with where each statement has been placed.

At the end of the session, summarize what the group has learnt about the roles of an HL facilitator and note where there is no consensus, or where participants need further clarification. Remember to address these unresolved issues later on in the training.

We provide a number of statements below. The first four are important and must be used when you do this session with a group for the first time. The rest can be used depending on the time available. You can also carry out this activity again in different sessions, using a different statement from the remaining 8 statements, so that you discuss the roles of a facilitator from time to time. As people practice health literacy work, their own understanding of issues will change, and this will give an opportunity to keep reflecting on what makes a good health literacy facilitator.

One of the points you may have found when you did the brainstorming activity above is that facilitators must have confidence in and respect for the people they are working with, and they must realize that they will also learn a lot from them. The facilitator's job is to create a situation in which the participants will be able to describe and analyse their common problems, seek new information, and find workable and relevant solutions. Facilitators are not there to provide the answers, but rather to ask the right questions.
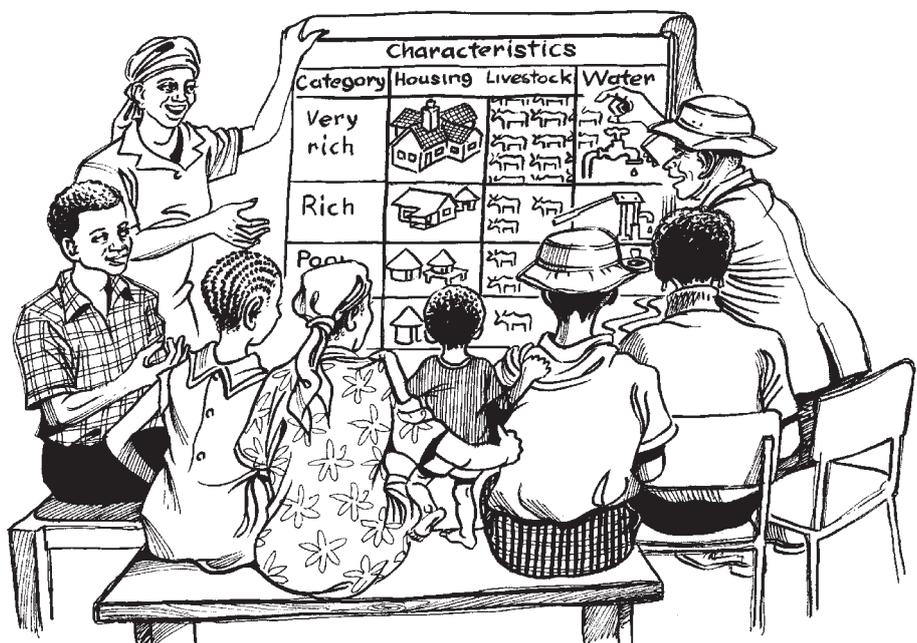
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Like all PRA practitioners, you, as a health literacy facilitator, will need to move away from the concept of "them" and "us" and recognize that health is an issue that affects us all.   Your attitude and behaviour is central – that is, listening to people's own knowledge with genuine interest and curiosity, creating dialogue between them and the health authorities, and involving people and institutions at all levels in decisions and activities.

This means that your approach changes from:

dominating	—— to ——→	empowering
closed	—— to ——→	open
individual	—— to ——→	group
verbal	—— to ——→	visual and verbal

What do these ideas mean?
How would they work in practice?
Can we discuss this?

While PRA sounds straightforward in theory, using it in practice is a different issue. Only a small part of your skills will be built by reading this or any manuals, or by the courses you do. You will also bring some skills with you from your past experiences. But the greatest learning will come when you start using PRA in practice, and when you get feedback from colleagues and communities.

To facilitate this process of learning, we suggest you get as much exposure as you can in PRA training and practice. In addition to the learning you will go through during implementation of the HL programme, you can also take advantage of other resources and training on PRA available in Zambia and in the region. See the list of resources and contact information at the end of this manual. The Zambia organisations leading this PRA work are Ministry of Health and Lusaka District Health Management Team, and they can provide more information on the issues in this manual.

1.5 A guide to the manual

This manual aims to help you organize this community experience and knowledge, add information that people may not have about their health, and support dialogue on health actions. We do this in a number of ways:
• We provide a range of participatory approaches that enable you as a health literacy facilitator to work with communities to strengthen their own information-sharing, knowledge, reflection and action.
• We provide health information that communities may need to have to support this.
• We suggest ways of drawing in other information, resources or people that may be needed to support health actions.

The manual is produced by Training and Research Support Centre (TARSC), Zimbabwe, who have written the core materials and produced the manual.

The Lusaka District Health Management Team provided Zambia specific information and photographs and have organised the peer-review and pilot-testing of the materials. Government and other published reports were used for additional information on Zambia. We have also drawn experience and approaches from another manual, co-produced by TARSC and Ifakara Health Research Development Centre, Tanzania, in 2006: *Participatory Methods for People Centred Health Systems: A Toolkit for PRA Methods*, by R. Loewenson, B. Kaim, S. Mbuyita, F. Chikomo, A. Makemba, and T. J. Ngulube.

TARSC is a non-profit institution that provides training, research and support to communities and their organizations to develop capacities, networking and action, and to interact with the state and private sector in areas of social policy and social development (www.tarsc.org).

The Ministry of Health is a government institution ensuring equity and access to cost effective, affordable, clean, caring and competent and quality health services as closer to the family as possible. The Lusaka District Health Management Team under Ministry of Health is responsible for delivering of quality health services as close as possible to households in Lusaka district. The authors of the manual are Dr Rene Loewenson, Barbara Kaim from TARSC, with inputs from Kenny Simamuna (consultant), Adah Zulu Lishandu, Dr Clara Mbwili Muleya (LDHMT) and Dr Elizabeth Chizema (MoH Zambia). Graphics were provided in the regional materials by Mashet Ndhlovu, editing and layout by Blue Apple Design. It is published by TARSC with support from Cordaid. Peer review of the manual was provided by Dr Catherine Mukuka (Health Consultant), George Sikazwe and Rose Masilani (MoH); and through pilot field tests in Lusaka and Chibombo districts.

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We hope that, after being trained in and using the manual, you, as a health literacy facilitator, will have a greater understanding of health and health systems and will be able to use participatory approaches to strengthen community knowledge, organization and power to act on health.

1.6 Working with the manual

There are eight modules in this manual, listed below. They are organized into three main sections:
*   Improving health
*   Strengthening people-centred health systems
*   Building effective and democratic civil-society organizations for health

How you work through these will depend on how you organise your "sessions" with the community. A session will be the time when you meet with community members and work through the issues in the manual, draw on community experience, listen to input from health-related and other organizations and discuss actions. A session can be half a day or it can be five days! Its length will depend on how communities are able to organize their time, what local people prefer, and what is most practical. Often a weekend is more practical, and facilitators will need to organize weekend sessions over several months to cover all the health issues. The manual is designed to give time between sessions for communities to gather information, talk to others, draw further views from communities, discuss issues and proposed actions, or to take actions.

The manual is designed to give time between sessions for communities to gather information, talk to others, draw further views from communities, discuss issues and proposed actions, or to take actions.

When you do your health literacy work, for any session you can choose a module from each of the three sections, or you can focus on one or two sections. It will depend on the issues identified by the communities and what information they want to discuss. Hence, for example, if people are concerned about clean water, what services there are for it and how to advocate for improvements, you could use:
*   SEC 1 Module 4: Healthy Environments
*   SEC 2 Module 6: Understanding Health Systems
*   SEC 3 Module 8: Organising for Health in Zambia

The modules in the manual are:

In the list above, some modules are "CORE MODULES". These are:

    Module 1: Introduction to Health Literacy

    Module 2: The Health of Communities

    Module 7: Community Roles in People-centred Health Systems

    Module 8: Organising for Health in Zambia

They provide essential information for the understanding of other modules. We recommend that you include all of these and, if you run health literacy programmes, that you use all of these at the appropriate place. Module 1 and 2 may be good starting points for your programme.

Some of the modules are called "OPTIONAL MODULES". They provide information on health and health systems. Which you use and when you use them depend on the issues that communities have identified as important in their area. You may also use part of a module in one session and come back to another part in another session. Hence, for example, in Module 6 on health systems, you may stop when you reach health financing and do it in a later session. You will find these priorities when you work through the core modules.

If, for example, communities mention that food and nutrition is a priority for them, you could then use:
- Section 1 Module 3: Healthy Nutrition
- Section 2 Module 7: Community Roles in People-centred Health Systems in your health literacy training to discuss the food and nutrition issue further.

Below we provide, as an example, how a health literacy facilitator, Robert Banda, used this manual to develop a health literacy programme in his area.

As you will see from Robert Banda's programme,
- You can use the parts of the manual that are most relevant, as long as you also use whatever these sections build on.
- You need to know the manual well so that you know what you will find in it and what you can use.
- There are many sources of information outside the manual, like the interested headmaster or the Youth vision Zambia leaflet in Robert Banda's plan.

Robert Banda's health literacy programme diary

I am holding health literacy meetings on Saturday of every weekend for a day.

WEEK ONE: I explained who I was, what LDHMT and Ministry of Health are, how we were going to work and we discussed how people understood health. I used

- Module 1.4
- Module 8.1
- Modules 2.1, 2.2 and 2.3

At the end of the session the group identified that they wanted to know more about how to protect children's and mothers' health and what to do about the lack of safe water. We agreed that people would find out more about what people in the community prioritized and we would meet next week.

WEEK TWO: We started the session with feedback on the priorities people had found and compared them with those we had raised and discussed them. A new priority, rough treatment by health workers, was raised by the community. We agreed to discuss this further next week. We then turned to Modules 5.1, 5.2 and 5.3

This took most of the day and we ended with a discussion of Module 8.2 as people had asked to know more about the Ministry of Health. We agreed that people would follow up on the child health and school health issues we had identified and bring the information found to the next meeting. I sent a message to that people wanted to know more about school health services and asked for more information on this, or for someone to come to our next meeting.

WEEK THREE: This is getting interesting! The headmaster has joined us as he heard the community discussing school health issues and wanted to explain what they are doing and the problems they face. We listened to him and asked questions and then I remembered the "But why?" method in Module 2 and we did this with him and some of the teachers to look at the causes of the problems. We then used Module 2.4 to discuss the actions we could take. A member from Youth Vision Zambia, working with youth brought a leaflet on the materials and training in this programme. By the end of the day we had an agreed plan of action with the schools. I haven't forgotten about the health workers. Next week we will go to Module 6, and do 6.1, and 6.5. The people who are coming to the sessions have grown in number – I need to find more benches!

Every week or weekend literacy session ends with a discussion of what communities can do to follow up on and use the information they have shared. The types of actions communities can take could for example be to share information on a health issue in their home areas through local meetings, talk to health workers about how to improve the security of drugs at the clinics, and so on. These are small steps, not long term plans and build on the learning to start actions and bring information back to the next literacy session. We suggest that you give people at least a few weeks between sessions for time to act , but you can discuss and agree on this with the community members. We suggest that the whole manual can be completed over a year of sessions with actions between sessions.

COMMUNITY PLAN

What will we do next?

At the end of your literacy session discuss with community members what actions will be taken before the next health literacy session
- How will participants give feedback to others in the community on what they learned and decided at this meeting?
- What actions can participants take and report back on before the next session?
- Who will lead these actions? Who else will be involved to help?
- What will be the role of the health workers and the local council?
- What information or report-back will participants bring to the next meeting?

Ask the community members what else they want to know about
- Identify the topics that people want to know about in the next session.
- Are there issues that communities want to know about or to raise with MoH?.

This discussion of what communities can do is used to develop a "COMMUNITY PLAN". Above we provide the guideline for you to use for the discussion of a community plan at the end of your literacy session:

As a facilitator you will also need to prepare your own "FACILITATORS PLAN". This sets out some of the points that you will need to think about, plan for or implement between one session and the next, to make a choice of what you will use in the next session, and to identify what information, or which resource people, you will bring to the next session. A guideline for the plan you develop at the end of one session and before the next is given below.

FACILITATOR'S PLAN

Think about the topics you will need to plan for or implement before the next health literacy session. Discuss with your colleagues your own skills as a facilitator and what you can do to improve them. Inform the district of the information came up at the meeting and of any follow up support you need.

What do communities want to hear about next?

- What new topics did the communities want to discuss at the next session?
- Which module(s) in the manual deal with these? How will you use them?
- Where else can you get information from? What other information will you bring?
- Who else will you need to invite to help you with this session?

What else do you want to include in the session?

- What other topics will you include in the next session? (Be sure you know why!)
- Which module(s) in the manual deal with these? How will you use them?
- What other information will you use and who else can you bring?

Reporting back to your health district

You will also be given separately a report back form to report back on
- Your literacy sessions, when you held them and who attended
- What issues and modules you covered
- The resource people you involved
- What issues and plans were proposed and are being followed up
- What comments you have or support you need
- Any other issues you want to bring to the attention of your health district or Ministry of Health.

This can be sent after each literacy session to help organise support to your work and to use the information for national level work.

You can use this discussion of what communities can do to develop a 'community plan'.

At the end of the manual, you will find a list of the published resources we have used. These will give you more ideas and information. We also give a glossary of terms used and what they mean, a list of the tools and methods used in the manual, and a list of abbreviations used and what they stand for.

You will also have a range of other materials to draw on:
- Handouts, posters and other materials for communities from other institutions.
- Videos, drama and other resources from institutions working in health.
- People with skills or roles that are important for your discussions and actions.

These are not included in the manual, but we have made some provision for you to build up your own "resource bank" for this, with a "pocket" in which to store useful pamphlets and materials for a session.

In summary

In this manual and course you will:

- Obtain basic information to build your knowledge about health, the main health problems that affect communities in Zambia and about how health systems operate.
- Find approaches and tools to use that promote participatory ways of organizing communities to share information, reflect on their health issues, and plan actions around these issues.
- Find suggestions of other resources and people that you can draw on to work with communities in health.

To end this module, and to inspire you to move on to the next, here is a poem written by Lao Tsu in China over 2,700 years ago, which is still an excellent guide for anyone working in health.

> *Go with the people:*
> *Live with them.*
> *Learn from them.*
> *Love them.*
> *Start with what they know.*
> *Build with what they have.*
>
> *But, of the best leaders,*
> *When the job is done,*
> *The task accomplished,*
> *The people will all say:*
> *'We have done this ourselves.'*
>
> Lao Tsu

Module 2: The health of communities

In this module we:
- discuss how we understand health
- explore how to identify community health needs and priorities
- discuss diseases and their causes
- discuss how we can reach all social groups with health activities

2.1 What do we mean by health?

Many people think that when we talk about "health" we are talking about diseases, such as tuberculosis and malaria. Certainly, not suffering from a disease is part of what we mean by being healthy. Health is, however, about much more than this. The World Health Organization (WHO) states in its constitution that:

...health is … not merely the absence of disease but a complete state of physical, mental and social well-being.

Keeping this definition in mind, let's look at the various ways in which different people understand health.

How do people understand health?

Method: Picture codes – drawing pictures or use pictures at the end of the module
Approximate time: 45 minutes
Resources: Flipchart paper and marker pens

This activity can be done either in the meeting room, working in small groups, or you can suggest to participants that they take a walk through a select part of their community.

Procedure:

1. Ask participants to identify a range of situations in their community that they think represent "good health". Such a situation might involve only one person (e.g. someone eating good food, or exercising, or sleeping under a mosquito net) or it might depict a group demonstrating a particular behaviour or activity (e.g. a group of farm-workers spraying a crop while wearing the correct protective clothing, or some pregnant mothers attending an antenatal clinic).

2. When the participants return to the meeting room, ask each to describe the different situations they saw. Probe a little to get a clear picture. Ask them to describe the age, appearance, etc., of the person or people they have identified. For some situations, you may also want to ask about the environment, what the people were doing, etc.

3. On a separate piece of flipchart paper for each, write up or draw FOUR of these identified situations. Choose the four that you think will lead to some discussion. If you write words or draw, make sure that the major features raised are included (e.g. "a young man with shiny skin, plump, well dressed, smiling and eating").

4. Stick the four flipchart sheets up on a wall or tree, or spread them on the ground or in another place where the participants can easily see them, sufficiently far apart from each other so that they can easily move around looking at the pictures without getting crowded in. For each picture ask the question, "Do you think this person/situation is healthy?" Ask them why they think so or why they don't.

5. Let the participants move around, looking at the pictures and discussing with each other what they see.
6. After about 10 minutes (or when you can see they are finished), bring everyone together to discuss the following questions:
   - When you look at these four pictures, which do you think shows the healthiest situation? Which seems the least healthy? Why?
   - What are the features of health?

Remember that you may not always agree as a group. Health has many different dimensions, and some may be more important to some people than to others. So let everyone have their say, avoid certain individuals dominating, and see how you can accommodate different views.

7. Note the words that they use to describe the features of health (e.g. words such as "happy", "well-fed", "has friends"). Using these words as a guide, discuss the group's definition of what it means to be healthy.
8. After participants have given their definition(s), read out the WHO definition of health and ask for comments. Compare the WHO definition with what they came up with. What is different and why?

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An alternative method is to divide people into four groups and ask them to draw or make a human statue representing a healthy person or situation. Or you can discuss pictures from newspapers or magazines. Alternatively, you could use the pictures labelled "How do people understand health" at the end of this module. But keep in mind that it's best to use local materials and examples.

2.2 What are the most important health issues in our community?

This is a question that the community should be the first to answer. While health workers and administrators may collect information on health, the community itself has as much to contribute on what its health needs and priorities are.

But is everyone in the community the same? Do we all see things the same way?

While "community" is used to define a group of people or families who live in the same area, not everyone who lives in the same ward or district is the same, and some have very different interests. So "community" is also used to describe people who live in different areas but share similar interests. Different social groups in one geographical area – men and women, people of different ages, people who have different levels of wealth, people who have different occupations – may have different health needs and may use health services differently. The same social group – like women, or youth, for example – may form networks across districts to promote their health and to make a case for the provision of services.

The Zambia Network of People living with HIV/AIDS (NZP+)

The Network of Zambian People Living with HIV/AIDS (NZP+) was set up in 1996 as the national organization for people living with HIV/AIDS (PLWHA). It aims to improve the quality of life of people living with HIV through support, communication and representation of people living with HIV. It also supports enterprise development activities to improve the quality of life of PLWHA. The network, a non-profit, non-governmental organization registered under Section 7(I) of the Zambian Societies Act, facilitates the formation of support groups nation wide and promotes and supports networking among PLWHA and with other organizations nationally and internationally. NZP+

NZP+ at Voluntary counseling and testing Day Commemoration, Lusaka 2008 © NZP+ 2008

thus not only facilitates the sharing of information, ideas, experiences and resources across support groups and people in Zambia, but also provides leadership and shared forums for concerted advocacy to ensure that policies and laws support the human rights of PLWHA.

For reflection or discussion:

Looking at the information given above, and drawing on local members of or officials from NZP+,

- How does the NZP+ bring people living with HIV and AIDS together as a network, locally and nationally?
- What support does the NZP+ give to its members?
- Do you know of any social groups that have networked across geographical areas to make their needs more visible? Which groups? What did they do?

An important first step in any health programme is to work with community representatives to identify the major characteristics of the community – including its boundaries, the social infrastructure (roads, water supply, schools, clinics and other public places), housing patterns, social groups and other features. One of the best ways to do this is to prepare a map. You will find that you come back to it throughout the community work, adding more information – such as where vulnerable groups can be found – or to see how things have changed over time. Like many of the other methods we use, the discussions that accompany the preparation of the map are

An example of a Social Map © TARSC 2008

as important as the map itself. Your aim is to have both a useful map and a useful discussion.

How can I describe my community with a map?

Method: Social mapping

Approximate time: 60–90 minutes, depending on the number of people involved

Resources: For a map on the ground – sticks, stones, leaves, etc.

                    For a map on the floor – chalk or charcoal

                    For a map on paper – pencils, markers, crayons, pens

                    Maps are best prepared on the ground using any locally available material (sticks, leaves, seeds, stones, etc.) or by simply drawing on the ground with a stick. A map can also be drawn directly on to a large sheet of flipchart paper. If you do draw it on the ground, make sure that someone copies it on to paper as soon as it is complete so that it can be used later.

Procedure:

1. Ask the participants to get into groups of not more than 10 people according some common characteristic, e.g. age, gender, occupation, or any other category that they choose.
2. Discuss with participants what they understand by the term "social groups". Ask them for some examples. Discuss how these social groups influence health and health systems within their community.
3. Then ask each group to draw a map of their community on the ground (using sticks, stones, leaves, etc), or on the floor, or on a large piece of paper. Instruct them to show the following on their maps:
   - Major landmarks, such as schools, clinics, shops, where people live, water points, vegetable gardens, etc.
   - Where social groups in their community are distributed, e.g. PLWHA, orphans and vulnerable children, widows, etc. For each social group, ask participants to come up with a symbol.
   - Clear labels with a key describing the symbols used.
4. Each group should then nominate one person to present their map to all the participants.
5. After each group has presented their map to the other groups, have a general discussion, focusing on the similarities and differences between the maps. Discuss:
   - Was there a difference between the maps that was the result of the age or gender of the group?
   - What have the maps shown about social groups in the area?
   - Do you think the different groups you have listed will have different health needs, and, if so, why?
6. If the maps were done on the ground, ask a volunteer from each group to copy the map on to a piece of paper.

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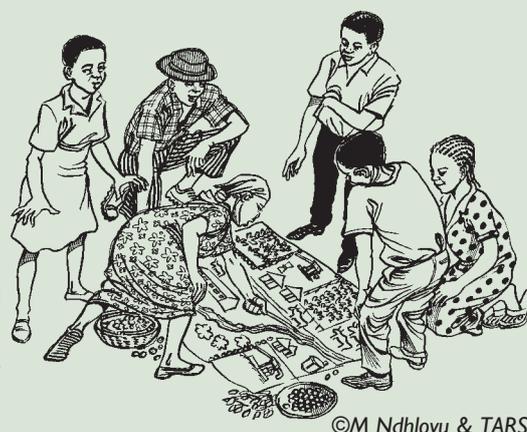
Another way of getting information for the social map is to do a "transect walk". You can do this before or after drawing a social map to inform or check people's perceptions of what is going on in practice. Transect walks are systematic walks across the community to observe a range of features, resources and conditions in the area. The walks often zigzag through the community. They may be done by community members and joined by other people who are knowledgeable about the area.

How can I find out more about my community?

Method: Transect walk

Approximate time: 90 minutes to half a day; a whole day if you want

Resources: Notepad and pens, a camera (if possible), members of the community to walk with you through their area.

Procedure:

1. Allow some time to plan the walk – where you want to go and what questions you want to ask. Make sure that the group identifies a volunteer to keep notes of the issues that are discussed during the transect and a good photographer if a camera is to be used.

2. If the participants have already drawn a map, observe and check information and issues that were raised then during the walk. Try to meet with a range of different people on the way, and to stop and have discussions with them. It is important to be observant on this walk and to ask probing questions. Also, ask your guides from the community what they would like to show you.

3. At the end of the transect walk, present and discuss the findings. If you prepared your social map before going on the transect walk, look at it again to see if any additional details can now be added.

Note: For more information on how to do a transect walk, look at the activity "How healthy are our environments?" in Module 4.

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For reflection or discussion:

Looking at the maps and the information from the transect walk,

- What did you discover that was new, especially in relation to the different social groups?
- Has your map and/or transect walk included all the vulnerable groups in your community?
- What has your map shown that is important for people's health?
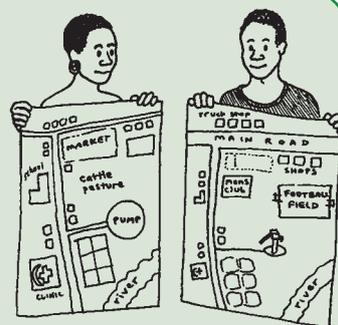
While your map and transect walk can highlight some of the important health issues in the community, the different social groups in the community should also have a chance to say what they believe their health needs and issues are. This is especially true for the most vulnerable, whose needs and views are often neglected.

What are the priority health issues or needs?

Method: Ranking and scoring
Approximate time: 40 minutes
Resources: Pen and paper, counters (stones or seeds)
Procedure:

1. Divide participants into groups by gender, age or by other social group. (One idea is to break them up into older men, younger men, older women and younger women, but make sure you are clear about how you define each of these groups. For example, is youth defined by age, or might it relate to some other criterion, such as marriage?) This division is important since health needs can differ by group. In these groups, ask participants to list the health needs in their community. They can do this on a flipchart or on the ground.

2. When the lists have been developed, give each participant three stones, beans or other counters available. Ask each of them to place their counters against the three health needs that they consider the most important and, therefore, need greatest attention.

3. Count the total counters for each item listed and write down the totals. Each group now has a list of three top priority health concerns.

4. Bring the four groups back together to share their findings. During the report back, ask each group to justify why they thought these three health needs need the most attention. (It's useful to get someone to write down a summary of what each group says.)

Then discuss the following:

- What were the difficulties in identifying the priorities? Were there differences within the group?
- How do the health priorities that the groups have identified differ? How do you explain the reasons for these differences?
- Do these findings reflect the views of everyone in the community? If not, who has been left out and how can their views be included?
- Who should hear about these findings? Who can act on them?

Communities will want to make the health services understand their health needs and priorities. The ranking method is one way of doing this, presenting and discussing the findings at a district health meeting or a health facility committee meeting. Communities can also gather information through:

- Informal discussions among community members.
- Formal gatherings at churches, schools, clubs, etc.
- Local meetings organized by influential people such as chiefs, religious leaders, politicians.
- Visiting health facilities to get information, and talking to various community-based health workers: traditional healers, local health workers, village health committee and traditional birth attendants.
- The media and community organizations.
- Obtaining and discussing the monthly returns of the health information system.

Health workers are an ally in this work. Engage with them and get their support for the transect walk, include them in the discussions, and hold meetings with them on the findings through joint health service–community committees.

Generally, in eastern and southern Africa, the most common health problems found in our communities are:

- nutritional problems, caused by inadequate food, by deficiencies in vitamins or specific types of food, or by an excess of specific foods.
- communicable diseases, those spread between people as a result of unsafe water, poor sanitation, inadequate housing, improperly prepared food, and sexual practices. Malaria is an example of an environmentally-caused communicable disease.

- conditions related to reproduction, sex, pregnancy and childbirth, such as HIV infection.
- conditions due to exposure to unsafe chemicals or hazardous work or lifestyles, such as liver disease.
- conditions due to ageing or genetic factors, such as Down Syndrome.

These health problems can occur together. For example, malnutrition in women can lead to complications in childbirth. Infection with a sexually transmitted infection can produce lesions that increase the risk of infection with other diseases, like HIV.

Our societies are also experiencing a double burden, as we suffer not only from poverty-related diseases (the communicable and nutritional diseases) but also from diseases that occur with development and urbanization. These include cardiovascular diseases – such as high blood pressure, stroke and heart attacks – and cancers from environmental conditions and unhealthy living practices. Stress is also increasing because of economic and social pressures; this can lead to mental illness or high blood pressure and stroke.

Statistics on health at health facilities

Health facilities collect information on a range of areas of health. Child health indicators are collected related to attendance and mortality under one and under 5 years; information from growth monitoring on nutrition, including malnutrition, childhood illness and vaccinations delivered. Information is collected on many indicators of reproductive health and safe motherhood, including family planning uptake, attendance at antenatal care; malaria in pregnancy, screening for health risks, supervised deliveries, delivery complications and neonatal and postnatal care provision. Facilities also collect a wide range of information on HIV and AIDS, including attendance and results of counseling and testing; uptake and follow up of prevention of Mother to Child Transmission; Anti- Retroviral Therapy and its outcomes and TB diagnosis and treatment outcomes. In addition to uptake of out patient and in patient care; transfers deaths and discharges in in-patient facilities, services also collecting management information of medicine supplies; health worker numbers, workloads and losses and financial data. Information is not only collected on services offered at facilities, but also on environmental health and the services for it (inspections; sampling disease control). Notifiable Diseases are documented to inform the public health authorities.

Source: MoH 2008

Zambia's top causes of child and adult illness are shown in the tables and charts below. In 2008, 2009 and 2010, malaria was the leading cause of sickness in both those below and above five years of age, and malaria occurred four times more in those below five years of age than in those older than 5 years.

Top Ten Causes of illness in Zambia 2010

Disease	Number of new cases per 1,000 for children *under* 5 years	Disease	Number of new cases per 1,000 for people *over* 5 years
Malaria	897	Malaria	203
Respiratory infection: non-pneumonia	744	Respiratory infection: non-pneumonia	184
Diarrhoea: non-bloody	285	Musculo skeletal and connective tissue – Non Trauma	55
Respiratory Infection: pneumonia	104	Genital-Urinary Diseases Other	39
Eye Diseases infectious	89	Diarrhoea Non-Bloody	35
Skin Diseases Non-Infectious	57	Trauma Other Injuries and wounds	34
Trauma (accidents, injuries, wounds, burns)	45	Digestive System Non-Infectious	30
Skin infections	42	Dental diseases	25
Skin infections	40	Respiratory Infection: pneumonia	18
Anaemia	36	Throat Diseases	15

Source: Ministry of Health 2010

For reflection or discussion:

Looking at the information given on the previous page
- What are the most severe health problems for children and adults in Zambia?
- Does the profile in the tables above reflect the situation in your area?
- How do you think the disease profile is different in your area?
- How do you think the factors causing deaths are different in your area?

Different social groups in Zambia are more at risk of different health problems. For example:

Children	experience malaria, respiratory, diarrhoea, HIV/AIDS and malnutrition.
Youth	are at risk of HIV/AIDS, STIs, teenage pregnancies and abortions
Women	suffer from HIV/AIDS, TB, pregnancy related ill-health, malaria, trauma resulting from gender-based violence, breast and cervical cancer, hypertension and diabetes.
Men	experience HIV/AIDS, TB, hypertension, diabetes, accidents and injuries.
Elderly people	have prostrate cancer in men, cervical and breast cancer in women, hypertension, arthritis

What are the top ten diseases in our area? How do they compare with community priorities?

Method: Semi-structured interview and analysis

Approximate time: 30–60 minutes

Resources: list of top ten diseases in your area (provided by a clinic health worker), list of community priority health needs, flipchart paper and marker pens

Procedure:
1. Either go to the nearest clinic or invite a nurse to come and tell you what the top ten diseases are in your area. He or she will be able to get this information from the health information system.
2. Compare this list with the list you generated earlier on the community's perceptions of their three top priority health needs. (You may have more than one list of priority health needs, drawn up by different social groups within the community. That's fine – include all the lists in your discussions). How do the two (or more) lists compare? What problems are common and which are different?
3. Now have a look at the links between the community's priority health needs and the top ten diseases reported by the clinic. List the community's priorities on the left-hand side of a piece of flipchart paper and the top ten diseases on the right, and then draw lines between them to show the links. For example, if the clinic reports diarrhoea in the top ten, and the community has identified access to clean water as a priority health need, then there's a direct link between the two.
4. When you've done this, see whether there are problems raised by the community that do not link with the clinic's top ten diseases. Which are these and why do they not link to the most common diseases?
5. Which of the top ten diseases do not link to the community's priority health issues? Why is this?

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6. Finally, discuss what this means for health planning? If planning is done in the community, what will be left out that is important to the clinic? If it is done at the clinic, what will be left out that is important to the community? How can this situation be avoided?

It will be useful if you can involve the clinic nurse in this exercise. It will help in building links between the clinic and the work you are doing with the community.

2.3 What causes disease?

Disease can be caused by many things. A person can be infected by germs like bacteria or viruses. Not eating enough good food can weaken the immune system that fights disease in the body, the immune system, and make it easier for diseases like tuberculosis (TB) to cause damage. There are also causes of these causes. Germs spread in unhealthy living and working environments. A poor diet can result from high food prices, or from unsafe foods (such as those high in sugar) being advertised and promoted. There are also causes of these "causes of causes" of disease. For example, poverty, or an inadequate number of inspectors to enforce public health and other relevant laws, can lead to unhealthy working or living conditions or to unaffordable foods.

Many of the 10 major diseases in Zambia are communicable diseases, which means that they are transmitted from one individual to another either directly by contact or indirectly by vectors like insects. The table below gives some examples and we will be discussing this further in later modules.

Disease	Cause	Risky environments
Malaria	Caused by a parasite and transmitted by female anopheles mosquitoes	Swampy and areas with stagnant water where mosquitoes breed.
Diarrhoea (non bloody)	Caused by use of contaminated water, unhygienic food preparation and handling and unhygienic disposal of excreta.	Residential areas with poor water and sanitation facilities.
Respiratory infection (non-pneumonia)	TB, Influenza and common cold, asthma, bronchitis are spread in the air between people	Poor and over crowded housing
Respiratory infection (pneumonia)	Different kinds of pneumonia are spread in the air between people	Poor and over crowded housing

Look at this example of Mr Mulenga, who has tuberculosis:

- Mr Mulenga has tuberculosis because he was infected with a germ. The germ came from someone in his workplace who coughed on him. (This is an immediate cause.)
- He was infected because he and his family live in a crowded place which is poorly ventilated with a lot of other workers, and it is easy for a germ that spreads in droplets in the air, as TB does, to pass between people in an overcrowded environment. (This is an underlying cause.)
- He lives in a poor work environment because he has not found a good job, and does not have the money for a better house (This is a deeper underlying cause.)
- He is fearful about raising the problems of poor housing because …
  Can you continue this?

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As Mr Mulenga's story shows, diseases occur because of the social, community and household environments we live in, the environments we work in, the food we eat, and our lifestyles. We will discuss this further in the next Modules. These health risks arise from socio-economic conditions we live in.

We also experience changes in our bodies (ageing, wasting of muscles, tooth decay, infections, depression) that can make us more at risk of ill health. We will discuss this further in Module 5. We may respond differently to these changes depending on our age, how well nourished we are, and on other personal features. These are individual factors that lead to ill health.

Underlying these individual factors are causes that come out of the environments we live and work in and the way in which we organize our societies. They include, for example, poor housing, unsafe or inadequate water, high food prices, overcrowding, lack of schooling, and/or the poor status of women.

The environmental causes relate to deeper structural causes, including
- How the wealth in a society is distributed and what incomes and assets people have.
- Social and cultural factors such as religious practices.
- How the laws and policies provide for rights to health.
- How the health services prevent and manage diseases.

The structural causes come from even deeper factors – the political beliefs and practices and the values and rights that define what individuals and communities can expect from society, and how the resources of society are used to address health needs.

Communities play a role in addressing health problems at each of the levels described above.

We can use the "But why?" method at any time to help people deepen their understanding of an issue. It is especially useful when people are not making progress in analysing a problem and need a quick exercise to help them see things differently.

What causes our health problems?

Method: 'But why?'
Approximate time: 5–30 minutes, depending on how much discussion you want it to generate
Resources: none
Procedure:
1. Work in pairs, or in small groups, or as one large group. How you choose to do this depends on what you decide to use the "But why?" method for.
   - If you want to train participants in how to use this method, break them up into pairs. You can get each pair to decide on a particular health problem, or you can put a whole set of questions in a hat and each pair can choose a question to work on. One of the pair asks the questions ("But why?") and the other answers. Back in plenary, ask participants what they learnt from doing this exercise and how they think they can use it with community members.
   - If you want a group to explore some of the underlying causes behind a particular health problem, you may want to break the participants up into smaller groups of 6–8 people, or you could even stay as one large group. In either case, ask for one person to volunteer to answer the "But why?" questions. Keep going until the group feels they have got an increased understanding of the number of causes behind a particular problem.

2. You can ask any type of question, or you can make a statement. For example: "Why are so many people getting malaria in our community?"; "What are people dying from in our community?"; "People don't go to the clinic any more when they are sick"; "My friend has high blood pressure"; 'Why is the nearest health clinic over 20km away?". The others ask "But why?" and the person answers. Keep going, asking "Why?" and letting that person answer, until you think it's gone far enough. Just make sure that, whatever the question, you are not trying to get lots of people to answer at the same time. This activity works better when only one person is answering, whether in plenary, in smaller groups, or in pairs.

3. Follow this up with a discussion focusing on the following questions (you may need to adapt these depending on the topic you are covering and the way you want to use this method):

- What were the underlying causes behind this problem?
- Which of these underlying causes do you think you and your community can address? How?
- How has this activity changed the way you think and act on this health problem?

Here is an example of how the "But why?" method can be used to get to the underlying causes of a problem:

'The child has a septic foot.'	*'But why?'*
'Because she stepped on a thorn.'	*'But why?'*
'Because she has no shoes.'	*'But why has she got no shoes?'*
'Because her parents can't afford to buy her any.'	*'But why can't they afford to buy her shoes?'*
'Because they are paid very little as farm labourers.'	*'Buy why are they paid so little?'*
	... and so on.

Source: Hope and Timmel (2001)

You can see from this example how causes move from the immediate to structural and, as we dig deeper, to the underlying political systems and values of our societies. Looking at the underlying causes of any problem is important because the action you collectively choose to take may be better linked to one of the underlying causes rather than to the actual problem itself. It doesn't mean that you have to act on all the underlying causes you identify – some may be outside your control!

There are other methods to get at the causes of our health problems. For example, we can also use picture codes, case studies or any other activity that gets participants to do a causal analysis through questions and further probing. You can go to our table of activities at the beginning of the manual where you will find the places in this manual where all the different methods and activities can be found.

2.4 What can we do about these causes?

The first priority is to promote health and prevent ill health so that people do not fall ill.

This is best done at the level of the whole population so that health is promoted and disease is prevented for the public as a whole. The public health system provides the methods for this, through measures like spraying for mosquitoes, prohibiting smoking in public places, promoting healthy foods, and so on. In addition, once illness occurs, disease needs to be detected and treated early. This involves actions both from communities and health services, such as case-tracing of TB in families, telling partners about sexually transmitted infections, and helping to supervise treatment. Thirdly, health services need to take steps

- to make sure that diseases that can't be treated, such as diabetes, are managed and do not damage health; and
- to rehabilitate people whose health has already been damaged.

What can we do about our priority health issues?

Method: Group work and stakeholder analysis

Approximate time: 50 minutes

Resources: List of community priority health needs and their causes (as discussed earlier in this module), small pieces of paper and marker pens, pins

Procedure:

1. In plenary, look at the priority health needs you identified earlier, and at what is causing them.

2. Choose one health issue to discuss, or go into groups and divide the issues between the groups, one per group. Write down the actions that you think can be taken to address the issue or problem, using a separate piece of paper for each action. Look at the causes, too, as actions can also be taken on the causes of the problem.\

For example, your problem may be that mothers are not attended by health workers when their babies are being delivered.

HL Community members and stakeholders Planning Meeting, © A Zulu 2012

- One action may be to make sure that there are trained health workers in the clinics to assist in deliveries.
- However, if the mothers cannot get to the clinic because transport is unavailable or too expensive, then a different action will be necessary – perhaps to make sure that mothers have money for transport, or to build waiting mother shelters.
- But if mothers do not have money for transport because they are unemployed, then an action may be to organize a community fund to support these transport costs, or to organize activities so that women can raise funds for these needs.

Look again at the priority health needs you identified earlier, and at what is causing them.

3. When you have identified all the actions, assign different members of the group to different stakeholder groups in the community, such as youth, women, men, businessmen, health workers, and so on. Ask each person to stand up, and pin a label on them so their role can be easily identified. Ask the rest of the group to put their action papers next to the person who they think is primarily responsible for taking a lead on that particular action. Assign all your actions to the stakeholders you have identified. If you have forgotten a stakeholder for an action, add them now!

4. When you have completed, discuss the following:
   - Who is most commonly responsible for acting? Who is least often responsible for acting? Why?
   - Who will find it easiest to act? Who will have most difficulty? Why?
   - Have any of these actions been tried before? If so, what happened and why? What do the health workers think? What do the community leaders think?
   - Which of the priority issues can the community act on next with some chance of success?
   - Who will lead these activities? Who will be approached or involved for assistance?

2.5 Rising health problems: alcohol and substance abuse

In Zambia as in many other countries, rapid changes in society, urbanization, unemployment, pressures including peer and commercial pressures, stress and availability of alcohol and other substances are leading to many people consuming alcohol, tobacco and other harmful substances. Some people can be overheard saying "it's unusual for a Zambian not to drink!", implying that drinking alcohol is a norm. However this is not true, because a lot of people do not drink alcohol. A social acceptance of alcohol or substance abuse can nevertheless lead to regular consumption that can be harmful to health or lead to addiction.

Zambia has a youthful population, with many youth out of school, or unemployed and actively seeking employment in a market where jobs are scarce. The lack of job and recreation opportunities and a proliferation of low priced alcohol packaged in small sachets, popularly known as "Tujilijili", raise the risk of alcohol consumption in some young people. As a result in 2012 the Zambian government banned the sale of Tujilijili sachets and strengthened the laws that prohibit the sale of alcohol to people below the age of eighteen years, and that control the opening hours of places that sell alcohol, such as bars. The Ministry of Youth, Sport and Child Development has also introduced a Youth Empowerment scheme to strengthen support for young people to establish small to medium business enterprises.

Alcohol and drug abuse in our community

Method: Letter to agony aunt
Approximate time: 70 minutes
Resources: Copies of the letter and aunt's response, one per group.
Procedure:

1. Divide up into groups of about 6-8 people, with young people under 25 years in one set of groups, and older people in the other groups.
2. Give each group a copy of the question card and talking points (you can photocopy them on one piece of paper, back to back. Or copy the information on a large piece of flipchart paper for everyone to read).
3. Give each group approximately 20 minutes (possibly longer) to read the letter from Alex and discuss the Talking Points. When they are ready, give them Auntie's response and the Action Points to discuss (approximately another 20 minutes but may be longer)
4. When the groups have completed their action plans, bring everyone back to plenary. Give them a little time to discuss what they thought about Alex's letter and Auntie's response. Reflect on any differences in the discussions from the youth and the older people. Then review their Action Plans.
5. If possible, ask a representative from UYDL or any other organization involved in the prevention of alcohol and substance abuse to join the discussion and to give feedback and support.

Dear Auntie,

My name is Alex. I am a 16-year-old boy and I live in Lusaka. The other night I went out with my friends to listen to some music. As usual, we drank a few beers, and it was really fun. Hey, the lights were dim and my body moving to the music. No worries, you know, just me, the beer and, of course, the girls…!!

But then, everything went wrong. My girl friend said something to me and for some reason that made me really angry. I can't even remember what she said. Perhaps it was something about another guy, or something I felt the fire go to my head and the next thing I knew I'd pushed her to the ground and was beating her up!
Auntie, how could I do this? I never thought I' could beat up a girl! I thought drinking was OK. Most of my friends drink. Some of them even smoke marijuana. And I often see people as old as my parents drinking and smoking as well. Now, I just don't know what went wrong?

Auntie, what do you think I should do?
Alex

Talking points

i.   What do you think about Alex's story? What advice would you give him?
ii. Do young people in your community drink too much? What about adults?
iii. Why do you think people abuse alcohol and take drugs? What do you think can be done to deal with these underlying causes?

iv. Make a list of all the drugs (including alcohol) you know about. Use either their official name or the name that is used 'on the street'. Go through your list and discuss:

- What are the effects of these drugs? Are they different depending on the drug?
- Which drugs are not harmful?
- Which drugs are harmful? How?
- Which drugs create dependency (ie your body gets addicted to the drug and it is hard to stop)?
- Which drugs have the worst withdrawal symptoms when you try to stop using them?

If you don't know the answers to these questions, take some time to go and talk to someone who can help you. The letter below provides some points for you to discuss further.

Answer letter:

Dear Alex,

It's true that many people – old and young – drink. And some of them take drugs such as marijuana. But as you've seen for yourself, things can go very wrong when you overdo it. You were obviously very drunk when you hit your girl. When you are that drunk, you can do all sorts of things that you may regret later, like getting into a fight or having unprotected sex. Many road accidents in Zambia are caused by drunk drivers.

Go out and have a good time with your friends. That's fine. But make sure you all behave responsibly. It is NOT acceptable that you beat up your girl. You cannot treat anyone –woman or man – in that way. So, if that's the way you behave when you are drunk, have one beer, not five. Learn about the effects of drinking or taking drugs such as marijuana. Keep your senses about you. And talk to your friends so that you can support each other. If they don't listen to you and continue to get really drunk whenever you go out with them, think again about whether you want to spend time with them in a bar. There are other things you can do when with your friends.

And, by the way, it's also not OK for adults to drink too much. They also get into all sorts of trouble when drunk. You are nearly an adult yourself, so perhaps it's time you started thinking about ways in which you can help your community to prevent harmful use of alcohol and drugs. Think about it.

I hope you'll have the courage to go and apologise to your girl. Find ways to make sure you never do this again.
Auntie

Letters adapted from Kaim, et al (2005)

For reflection or discussion:

Looking at the information given above
- What do you think of Auntie's advice? Is there anything you would add or change? Discuss this with your group.
- Roleplay: In your groups, decide that half of you are young people and the other half are adults. Act out a situation where you have come together to discuss what you can do to prevent the abuse of alcohol and drugs in your community.
- When you have finished the roleplay, discuss what ideas surfaced. Was there a difference in the attitudes and suggestions coming from the youth and the adults? What does this mean in terms of developing a community action plan? Now work together to design an action plan to prevent drug and alcohol abuse in your community.

You may want to contact a local organization to help you design and implement your plan. The Zambia Youth Vision is one such organization that can take up alcohol and substance abuse prevention in communities and schools. Find out more about them.

2.6 Our right to health

With so many competing pressures we will be lucky if we get resources for these issues!

Health should not be a matter of luck. Health is a right. People should be able to claim this right. Every group in the community has the same right to health. The differences between people – whether they are rich or poor, young or old, male or female – does not mean that they have a different right to the highest standard of health possible. Article 12.1 of the United Nations Convention on Economic, Social and Cultural Rights states that the right to health includes three key elements:

* timely and appropriate health care.
* the right to the underlying conditions that determine health, such as access to safe and drinkable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including those on sexual and reproductive health.
* the participation of the population in all health-related decision-making at community, national and international levels.

Zambia, like other countries in the region, has ratified the UN Convention on Economic, Social and Cultural Rights. The Committee that monitors this agreement has said that the countries who have signed it have the following minimum obligations related to health:

* to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
* to ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
* to ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and drinking water;
* to provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
* to ensure equitable distribution of all health facilities, goods and services;
* to adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process.

For reflection or discussion:

Looking at the information given above
* How do the different rights to health listed in the CESR compare with your definition of health? What was similar? What was different?
* How do the priority health issues that you raised compare with the rights to health listed in the CESR?
* What do you think the community can do to claim and achieve these rights?

The strongest way to protect these rights is through the country's constitution. Countries also have a range of laws, policies and charters that identify these health rights, and programmes to protect and implement them.

The current Zambia Constitution provides that

Article 12 (1): A person shall not be deprived of his life intentionally except in execution of the sentence of a court in respect of a criminal offence under the law in force in Zambia of which he has been convicted.

Article 12 (2): A person shall not deprive an unborn child of life by termination of pregnancy except in accordance with the conditions laid down by the Act of Parliament for that purpose.

Article 13 (1): A person shall not be deprived of his personal liberty except as may be authorized by law in any of the following cases: (g) for the purpose of preventing the spread of an infectious or contagious disease; and (h) in the case of a person who is, or is reasonably suspected to be, of unsound mind, addicted to drugs or alcohol or a vagrant, for a purpose of his care or treatment or the protection of the community.

Article 24: Protection of young persons from exploitation.

(1) A young person shall not be employed and shall in no case be caused or permitted to engage in any occupation or employment which would prejudice his health or education or interfere with his physical, mental or moral development: Provided that an Act of Parliament may provide for the employment of a young person for a wage under certain conditions

(2) All young persons shall be protected against physical or mental ill-treatment, all forms of neglect, cruelty or exploitation.

(3) A young person shall not be the subject of traffic in any form.

(4) In this article "young person: means any person under the age of fifteen years.

New rights are being discussed in the **DRAFT Constitution of Zambia in 2012 which** provides for the following health rights:

Article No. 55 - Children's rights
Section 5 (f), and it states that:
Every child has a right to adequate nutrition, shelter, basic health care services, social protection and social services.

Article No. 62 - Economic and social rights states that:
(1) A person has the right to-
    (a) the highest attainable standard of health, which includes the right to health care services and reproductive health care;
    (b) accessible and adequate housing;
    (c) be free from hunger, and to have access to adequate food of acceptable quality;
    d) clean and safe water in adequate quantities and to reasonable standards of sanitation;
    (e) social security and protection; and
    (f) education.
(2) A person shall not be denied emergency medical treatment.
(3) The State shall provide appropriate social security and protection to persons who are unable to support themselves and their dependants.

Article No. 66 - Consumer rights states that:
(1) Consumers have the right to-
    (a) goods and services of reasonable quality;
    (b information necessary for them to gain full benefit from goods and services;
    (c) the protection of their health, safety and economic interests;
    (d) compensation for loss or injury arising from defects in goods or services; and
    (e) fair, honest and decent advertising.
(2) This Article applies to goods and services offered by public entities and private persons.

Article No. 67 - Environment states that:
A person has the right to a clean and healthy living environment.

Looking at the rights to health in the current constitution
- Are they being met? If so, how? If not, why not?
- Are the rights being proposed in the Draft constitution more protective of health? Why?
- What other laws do you know that protect the right to health in Zambia?
- Where can you find information on the health laws that apply in your area?

Communities have both the right and the responsibility to know what the constitution says about health issues, and also what specific laws and regulations there are and what they say, but they rarely do. How many health-related laws, for example, could you name and/or describe? The information sheet below provides a list of some of the health-related laws in Zambia. Laws are usually drafted by the executive (such as the Ministry of Health) and passed by parliament. Ask the health authorities in your area what laws they mainly use in their work. There are for example laws that provide for minimum safety requirements for work environments and for providing for workers occupational health.

INFORMATION SHEET 2a: Zambia's health laws

Zambia has a number of laws that promote public and workers health including:
- Public Health Act
- Bio-safety Act No. 10 of 2007
- The Food and Drugs Act, Chapter 303 of the laws of Zambia
- Education Act
- Environmental Management Act (EMA) No.12 of 2011
- Extermination of Mosquitoes Act
- Factories Act
- Local Government Act
- National Health Services Act
- Prisons Act
- Town and Planning Act
- Water Act
- Water Supply and Sanitation Act, 1997
- The Water Resources Management Act No. 21 of 2011
- The Standards (Compulsory Standards) (Declaration) (No.)order, 2011
- The Liquor Licensing Act No. 20 of 2011
- The Mines, Quarries, works and machinery Act
- The competition and Consumer Protection Act (CCPA) No. 24 of 2010

Some examples of the protections from these laws are shown below:

Major Laws/Acts	What they Protect
Environmental Management Act (EMA) No.12 of 2011	....protects people from a variety of environmental issues including climate change, pollution and electronic waste.
Bio-safety (Genetically Modified Organisms (GMO)) Act No. 10 of 2007	...prohibits import of Genetically modified organism for food, feed or processing, protecting human or animal health, biological diversity, non genetically modified crops or the environment from any risk from GMOs

The Water Resources Management Act No. 21 of 2011	…protects and preserves water resources and the ecosystem, ensures the right for people to draw or take water for domestic and non commercial purposes, and that poor and vulnerable members of the society have adequate and sustainable source of water free from any charges
Water Supply and Sanitation Act, 1997	…regulates the provision of water and sanitation
The Food and Drugs Act, Chapter 303 of the laws of Zambia	… protects the public against health hazards and fraud in the sale and use of food, drugs, cosmetics and medical devices
The Liquor Licensing Act No. 20 of 2011	…regulates the manufacture, possession, sale and supply of intoxicating liquors, protecting the public from their negative effects.
The Standards (Compulsory Standards) (Declaration) (No.)order, 2011	…protects the public from being exposed to sub-standard products by manufacturers.
The Competition and Consumer Protection Act (CCPA) No. 24 of 2010	….protects consumers from goods and services that may be harmful to them.

For reflection or discussion:

Looking at the list of health laws above and the areas they cover.
- What areas of health rights do you think may not be adequately protected in this list?
- Find out if there is a law that covers these areas?
- If not, what can communities do to promote changes to old or outdated laws or to advocate for new laws to protect health rights?

Invite the local council health executive officer, the environmental health officer, the labour or factory inspectorate and environmental management official to your meetings to discuss the laws in your area. They will be able to brief you on what laws there are, and you may want to ask them some of these questions:
- Are there laws that relate to the priority health issues identified in the community?
- Who passes these laws?
- Who enforces these laws?
- What problems do officials in the state face in enforcing laws?
- What can communities do to ensure compliance with these laws?
- What happens when people or institutions break these laws?

While the constitutional provisions and laws are a "bottom line" for protecting rights to health, they exist only on paper unless they are enforced. Laws are enforced by authorities, but more commonly as a result of society knowing its rights and taking collective action. This may mean a range of things – from making sure that business does no harm to health, to protecting rights to freely associate in civil society organisations, to making sure that your sexual partner does not infect you with a sexually transmitted infection.

In summary

In this module we have
- Developed a definition of health;
- Learned ways of mapping and understanding the different social groups in, and the features of, our community;
- Explored how to collectively identify health needs and the causes of ill health in our community, listening to what vulnerable groups have to say;
- Discussed ways of raising these needs with health authorities; and
- Obtained information on the rights to health, how they relate to our understanding of health and health priorities, and whether our laws protect them.

If your literacy session covered these issues, remember to save time to go back on all the issues you discussed in the session to draw up your community plan.

COMMUNITY PLAN

What will we do next?

At the end of your literacy session discuss with community members what actions will be taken before the next health literacy session
- How will participants give feedback to others in the community on what they learned and decided at this meeting?
- What actions can participants take and report back on before the next session?
- Who will lead these actions? Who else will be involved to help?
- What will be the role of the health workers, the local council or others in your setting?
- What information or report-back will participants bring to the next meeting?

Ask the community members what else they want to know about
- Identify the topics that people want to know about in the next session.
- Are there issues that communities want to know about or to bring to the attention of the district health team?

Remember also as a facilitator you will also need to prepare your own "FACILITATORS PLAN" to plan your next session. Agree with the participants on when this will be and what information each will bring to that session. Start your next session by discussing the feedback from the communities, what was done, what people achieved and learned from this, and what needs to happen next, before you begin with new modules.

Think about the topics you will need to plan for or implement before the next health literacy session. Discuss with your colleagues how you can improve your facilitation skills. Inform the district health team of the information that came up at the meeting and of any follow up support you need.

What do communities want to discuss in the next session?

- What new topics did the communities want to discuss at the next session?
- Which module(s) in the manual deal with these? How will you use them?
- Where else can you get information from? What other information will you need to bring?
- Who else will you need to invite to help you with this session?

What else do you want to include in the session?

- What other topics will you include in the next session? (Be sure you know why!)
- Which module(s) in the manual deal with these? How will you use them?
- What other information will you use and who else can you bring? ?

Picture codes for Activity in Section 2.1 How do people understand health?

These four picture codes are found as loose-leaf inserts at the back of your health literacy file. You can use them with the first activity in Module 2 (on page 17).

Picture 1

Picture 2

Picture 3

Picture 4

Module 3: Healthy nutrition

In this module we:
- discuss the basis for good nutrition in food sovereignty
- outline people's nutritional needs and what happens when they are not met
- explore how to manage people with special nutritional needs

Inadequate food and poor diets underlie many common health problems. Conversely, good nutrition is the basis for good health. For example, improved nutrition in mothers improves birth weight, child survival, and adult health and productivity. Our body has fighter cells in our immune system to fight against infections. We talk more about this in Module 5. If people have poor nutrition their immune systems are less able to fight or recover from infections when they are in their body. Infections also affect nutritional status. Malaria contributes to anaemia in pregnancy and can lead to low birth weight. If people with HIV infection have poor nutrition, their disease progresses faster. Anaemia due to malaria is a common cause of death in children. Anaemia due to lack of Iron causes poor growth in children and also affects their mental development and ability to learn.

3.1 Food sovereignty in communities

As shown in the diagram, a key underlying cause of good (or bad) nutrition lie in how food is produced, distributed, made available, marketed, prepared and consumed, and in the underlying factors that affect these patterns. In a situation where food is a global commodity that is priced and sold to earn profits, it is possible for people to go hungry even where food is available, if they cannot afford to buy it. Food producers themselves may not have enough if they do not get a price that enables them to meet their household expenses from what they sell. Processed foods sold on the market, whether imported or produced locally, may not be as healthy as unprocessed foods, even if they are cheaper or convenient. For **food security** people need access to good-quality food, sufficient amounts of food, and a regular supply of healthy food.
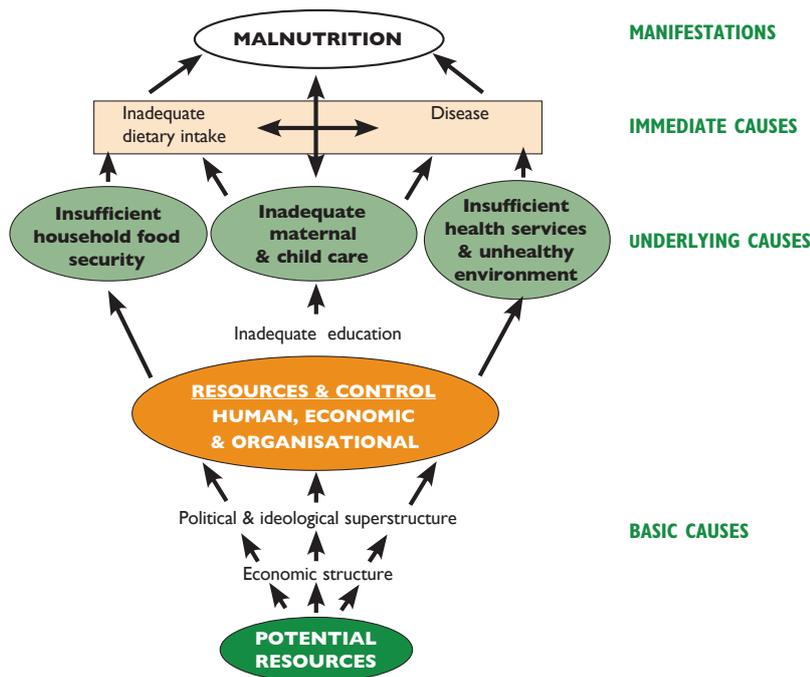
To support these needs, people have called for **'food sovereignty'**, to give people – especially smallholder producers, and particularly women – greater local control over food. The box below highlights some of the measures necessary for food sovereignty.

Food sovereignty requires:

- Prioritizing food production for domestic and local markets, based on peasant and family farming of different crops suitable for local environments;
- Ensuring fair prices for farmers, which means the power to protect internal markets from low-priced imports;
- Access to land, water, forests, fishing areas, and other productive resources through a process that fairly and transparently distributes resources to producers to achieve more equitable ownership of these assets;
- Recognizing and promoting women's role in food production and giving women decision-making powers over productive resources;
- Community control over productive resources, as opposed to corporate ownership of land, water, and genetic and other resources;
- Ensuring the free exchange and use of seeds by farmers, which means not allowing companies to patent privately (or license for their own exclusive use) life forms like plants, and not using seed or growing foods that have been genetically modified;
- Public investment in support of the productive activities of families, and communities, geared toward empowerment, local control and production of food for people and local markets.

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For reflection or discussion:

Looking at the outline of food sovereignty above
- Which of these features are currently practised in your area? Which are not?
- How does this affect access to healthy food in the majority of households?

The story in the activity below (not a true story) further explores how people experience and strengthen food sovereignty.

Strengthening food sovereignty in communities

Method: Story with many gaps; role play

Approximate time: 50 minutes

Resources: Copies of the case study (given in the box below), enough for one per six people

Procedure:

1. Tell participants that they are going to be working in groups reading a case study, but that the story has lots of missing pieces of information. Their role is to look at the story and fill in the gaps, based on their own understanding of the situation. Let them look at copies while you explain the task. Make it clear that in the **Action** section, they need to choose two different sets of people who would have two different views of the causes of the problem.

2. Divide participants into groups of about 6 people and give them approximately 30 minutes to work on the case study (perhaps less; check in with the groups to see how they are doing.) The groups will need to prepare a report-back, either as a role play or a report (but tell them in advance that not all the role plays will be performed).

3. Back in plenary, one group who prepared a role play volunteers to perform it and answer any questions. The other groups then comment on what they did differently in their stories, and why.

4. In the plenary, discuss the following questions:

   • What did you learn about who is affected by hunger and malnutrition in your fictitious communities and what is causing it? Did different people have a different understanding of causes and, if so, why?

   • Did men and women have different explanations? Why?

   • What actions did you chose to implement? Again, were there differences in your groups and, if so, why?

   • How do these case studies relate to the situation in your own communities? What would you do differently? And what would you do the same?

The case study

The setting: In a small rural community in ……………….. (country), with a population of …………………… inhabitants, men …………………….. (type of work) and women ………………………………… (type of work). The number of children at school is …… % and the rest ………………………………. (what they do/who they are). There are a number of social and health structures in the community including …………………………………… These structures are/are not functioning because …………………………..

The problem: There has been little rain for the last few years and there is a shortage of ………………….. Malnutrition is on the increase, especially in the following social groups in the community …………………….. There is also a high incidence of disease, such as ……………………………………

Action: A dynamic community leader from …………………………. (type of organization) organizes a community meeting to discuss the problem. At the meeting, the men say that the reason why people are hungry is not only because of the drought but also because …………………………………………………
They propose the following action ………………………………………………
The women, talking amongst themselves say that there are other reasons too. They say that ………………………………………………………………………

They propose the following action ……………………………………………….
The women raise their views in the meeting. There is discussion and the meeting agrees that they will deal with the hunger in their community by doing the following ………………………

The health services will be asked to ……………………………………………..
with support from ……………………………………………………………………..

In addition, they decided that ……………………………………………………..

The meeting then nominated a committee to make a detailed action plan.

> But why specfically focus on women?

Women have a crucial role in producing food and in ensuring that household members have adequate food. They often have to do this without resources and sometimes without power to achieve this. Women are responsible for 80% of food production in Africa, including the most labour-intensive work, such as planting, fertilizing, irrigating, weeding, harvesting and marketing. Women achieve this despite unequal access to land, credit, seeds and fertilizer and information. If women farmers are given equal access to these resources, they can, in fact, not only increase agricultural productivity but also produce food and use this production to improve household nutrition and the well-being of children.

Doing something about food sovereignty calls for joint policies and work across sectors. (See, for example, Information Sheet 3a below.) While policies exist, they are not always fully implemented, and people's control over local resources for food production varies greatly.

Women selling food in informal markets, N'gombe, Lusaka © A Zulu 2009

INFORMATION SHEET 3a: Food security in Zambia

In Zambia a high proportion of both rural and urban households are vulnerable to food insecurity. Both chronic and transitory food insecurity are prevalent. For rural households, food entitlement is linked to agriculture, while crop production risk is a primary determinant of food insecurity. Causes of food insecurity for rural households are insufficient food production capacity, lack of income and unfavorable climate conditions. Urban households depend on wage or self employment and are more susceptible to insufficient income and price increases for food and other basic necessities such as fuel and housing. In recent years there has been an increase in urban malnutrition.

Percentage of children under five years who are stunted

National average: 45%

Luapula 56%
Northern 49%
North Western 44%
Copper Belt 44%
Eastern 50%
Central 53%
Western 36%
Lusaka 37%
Southern 36%
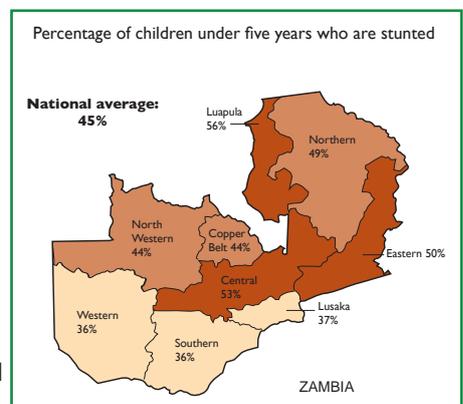
ZAMBIA

Using data from Zambia Demographic and Health Surveys (DHS) 2007, 45% of children under 5 are stunted or too short for their age. This indicates chronic malnutrition. Stunting in Zambia is more common in rural areas (48%) than urban areas (39%). Stunting is least common among children of more educated mothers and those from wealthier families. Wasting (too thin for height), which is a sign of acute malnutrition, is far less common (5%). Fifteen percent of Zambian children are underweight or too thin for their age. The negative trend of worsening nutrition has slowed or been reversed in recent years. Rising differentials between rural and urban areas in 1996-2002 have fallen by 2007. Stunting continues to show clear differentials by wealth   and education, but there is evidence that here too there has been a narrowing of the gaps across groups.

Among the babies for whom birth weight information was obtained in the survey, 9 percent had a low birth weight (less than 2.5 kg). Mothers younger than age 20 are about twice as likely to have low birth weight babies (15 percent), compared with mothers age 20-34 (8 percent) and mothers age 35-49 (7 percent). First-born children are more likely to have lower birth weights (14 percent), compared with higher-order birth, 7 to 8 percent of which are low birth weight. Among the provinces, Luapula has the lowest percentage of low birth weight babies

Nutrition-related indicators	2007 ZDHS
% children under 5 years who are stunted	45%
% children under 5 years who are underweight	15%
% of children under 5 years who are wasted	5%
% newborn with low birth weight	9%

Source: CSO, MoH, Macro International 2007

(6 percent) and Northern and North-Western provinces have the highest (11 percent).
Children under the age of five and women of reproductive age (15–45 years) are generally most vulnerable to nutritional disorders.

In order to ensure that households and individuals have access to a sufficient quality and quantity of foods, government has set policy that it will:

- Promote increased food diversification, production, processing, storage and consumption.
- Promote use of all available food resources for improvement of nutrition status.
- Support and promote micronutrient supplementation and food fortification.
- Set minimum living wage package for all persons in employment to enable them afford nutritionally adequate food basket.
- Formulate and support clear policies to guide and control the informality traded food sector (MoH, 2009).

After stalling mid-way through 2000s, the agricultural sector has since 2006 shown positive improvements in performance leading to increased output in key crops such as maize, groundnuts, tobacco. There have also been policy changes leading to the split and creation of a separate Ministry of Livestock and Fisheries to re-organise the sector more effectively (UNZA, MoH, TARSC 2011). Food is produced in Zambia by large scale commercial farmers, mainly for export and livestock, and by small scale peasant farmers, most of whom are women, mainly for home consumption. Households may face pressures to sell food for cash and storage of food is also hampered by poor storage facilities. In recent years the demand for money for fees for services and household needs has led smallholder food producers to sell their crops, increasing household food insecurity. At the end of every farming season rural Zambians in the rural areas construct food hoarding pens known as "Ubutala". Seasonal green vegetable leaves like 'Chibwabwa", beans leaves, and "Kachesha" are preserved using natural sun light. Zambia has rejected genetically modified foods since 2000. However economic liberalization has brought fast food chains from outside Zambia. This has led to a change in Zambians' eating habits, with increased consumption of fast foods, mainly by those living in the urban and peri-urban areas. This diet can lead to weight gain, hypertension, diabetes, obesity and cancers, discussed later in this module.

Sources: CSO, MoH, Macro International 2007, MoH 2009, UNZA, MoH, TARSC (2011) Cooke and Downie (2010)

Looking at the information above
- Which people are affected by household food shortages? Why?
- What measures are being taken to avoid or deal with household food shortages?
- What health problems do people face as a result of changes in food patterns? How do these differ between rural and urban areas? How do they differ between children and adults?
- Who is most at risk of poor nutrition?

While many of the actions lie outside the health sector, local health services can play a role in promoting food sovereignty. For example, home-based care-givers, orphan committees, agricultural extension officers and health workers can jointly ensure that food, school-fee relief, and health care go directly to families that most need them.

For reflection or discussion:

Looking at the issues that affect food sovereignty in your area
- What could the health sector do to improve local control of and access to food and inputs for food production?
- What can the health sector do to ensure the marketing of nutritious foods?
- What is the health sector doing?

3.2 Healthy diets

Good nutrition is not just a matter of the quantity of food, it is also about the quality. Let's take a look at what people are eating in your area and whether the foods you are eating are healthy or not.

How healthy are the foods we eat?

Method: Three-pile sorting cards
Approximate time: 30 minutes
Resources: Three containers – e.g. hats or bowls; marker pens and flipchart paper

Procedure:
1. Divide the participants into groups of no more than 10 people
2. Tell each group to make a list of ALL the foods they eat in their area, both the foods they grow themselves and those they buy from others. They should write each food item on a separate piece of paper.
3. When they have completed their lists, ask them to place each piece of paper into one of three containers labelled "healthy foods", "unhealthy foods" and "not sure". Everyone in the group should agree that the food item is either healthy or unhealthy. If there is no agreement, put the paper into the "not sure" container.
4. When they have finished putting all their pieces of paper into one of the containers, ask them to continue working in their groups to discuss the following (you can write these questions on pieces of paper or on a piece of flipchart paper for all groups to see):

- Take a look at what type of foods you put in the "healthy foods" container. What makes these foods healthy?
- Do the same for the type of foods in the "unhealthy foods" container. What makes these foods unhealthy?
- Finally, discuss how you are going to find out more about the foods that are in the "not sure" container.

5. Back in plenary, ask each group to summarize what they learnt about the healthy and unhealthy foods. Compare the findings. Finally, summarize what participants are saying about the nature of healthy foods.

When we judge the quality of foods we look at what they contain and also how safe they are. The basic nutrients we need are shown in the box below. Carbohydrates, proteins and lipids (fats and oils) are needed by the body in large amounts. Other substances like vitamins or minerals are needed in very small quantities, but the body suffers if it doesn't have them.

Major nutrients

Water: considered the most significant nutrient for survival, though it does not provide energy.

Carbohydrates: organic compounds found in foods and used for energy; found, for example, in sweet potato, cassava and maize meal.

Proteins: necessary for growth and the repair of body tissue and cells' found, for example, in fish and meat.

Fats and oils: a source of concentrated energy and fat-soluble vitamins; found, for example, in milk, groundnuts and vegetable oil.

Vitamins: organic substances required by the body in minute amounts for metabolism; found in different foods, but especially in fruit and vegetables.

Minerals: inorganic substances that the body needs in minute quantities to maintain good health; found in different foods, but especially in fruit and vegetables.

Fibre: dietary material that is not digested but that helps intestines move food; found in different foods, but especially in fruit and vegetables:

For discussion with a health worker:

Look at the list of locally consumed foods you made and at the information about different nutrients and then discuss with a health worker
- Which foods provide each of the nutrients above?
- Are any nutrients missing from or inadequate in people's diets?
- Which foods are more healthy? Which are less healthy?
- What are the effects of not eating enough of these nutrients?
- What are the effects of eating too much of these nutrients?
- How should food be cleaned and prepared to make it safe?
- How should food be prepared for young children?

The table below shows the nutrition content of some indigenous foods in Zambia

Food	Role in the body
Grains, cereals, and tubers	
• Mungaiwa/umungayiwa (straight-run mealie-meal from maize) • Musozya (maize samp or hulled dried maize) • Maila, amasaka (Sorghum) • Nzembwe, amale (millet) • Umupunga (Rice) • Tute (Cassava tubers) • Ifyumbu, chimbwali (sweet potatoes)	• Provide energy • Provide minerals and vitamins particularly B vitamins (riboflavin, thiamine, niacin, B6 and B12, folate) if the skin and kernel of the grains/cereals are eaten whole. • Some refined cereals are fortified with vitamins and minerals.
Indigenous vegetables and legumes	
• Kalembula (sweet potato leaves) • Katapa (cassava leaves) • Ibondwe(amaranthus) • Nshaba, nyemu, imbalala (groundnuts) • Cilemba, nchunga (beans) • Ifipushi (pumpkin)	• Provides proteins, vitamins (especially vitamin A) and minerals; dark green leafy vegetables and yellow, orange, and red vegetables and fruits are rich in vitamins • Provide phytochemicals that may strengthen the immune system • Provide fibre
Wild fruits	
• Mabuyu (cream of Baobab) • Infungo • Masuku • Masawu • Inji • Mmabungo • impundu	• Provide Vitamin C and some minerals • Provides phytochemicals that may strengthen the immunity system
Edible insects	
• Dried finkubala (caterpillars) • Inswa (termites) • Inshonkonono • Makanta (grasshoppers)	• Provides proteins and some vitamins and minerals.
Small animals	
• Imbeba (bush mice) • Imfuko (moles) • Sikaele(squirrels) • Impanya, kalulu (rabbits)	• Provides protein, some vitamins, and minerals including iron and zinc.
Local beverages	
• Mabuyu, orange,pawpaw or lemon juice • Mantamba, maheu, chibwandu, munkoyo (non-alcoholic drinks made from grains)	• Provide vitamin C • Provide B vitamins

Source: MOH, 2011

Energy foods

Rice, millet, sorghum, maize and bananas are the most important carbohydrate energy foods in sub-Saharan Africa. In Zambia beans and sweet potatoes are high energy foods. Rice, millet, sorghum and maize can be stored in granaries for several seasons. Fats are another source of energy in the diet. Vegetable oils and peanut oils are common sources of fat.

Body-building foods

Meat, fish, milk and eggs (collectively called animal proteins) are foods that provide the necessary materials for the construction, repair and maintenance of the body's living tissue. They are rich in proteins that are also important for the immune system and resistance to illnesses. Meat, fish, eggs, chicken and milk are important sources of animal protein, rich in iron, preventing anaemia. Vegetable protein foods usually also contain iron but in a lower quantity and quality. Kalembula and finkabula are traditional food sources of protein.

Protective foods

Vitamins, minerals and water are grouped under the name protective foods. These foods are needed to help the body digest and use other foods. Fruits and vegetables are protective foods because they are rich in these vitamins, minerals and water. Vitamin A builds resistance to infections, is necessary for child growth, and is found mainly in green leaves and "yellow" foods like yellow maize, carrots, lemon and pumpkin. Vitamin C improves absorption of iron and calcium found in many fruits like oranges and tomatoes. Mabuya is high in Vitamin C. Vitamin B1 is found mainly in cereals, beans, meat and fish and supports the nervous system. Vitamin B2 Riboflavin supports vision and the health of the skin and is found in yogurt, meat, milk, peanuts and poultry. Red meat, fish, poultry, cheese and eggs provide iron, which is used to make the blood cells that transport oxygen. Calcium, found in dairy products, secures strong bones and teeth.

Food safety

We would be worried about food safety if food is stored for too long, if it contains harmful chemicals or germs, or very high levels of an unhealthy nutrient (such as sugar or salt). To ensure that food is safe, people need to know when it was manufactured and when it should no longer be eaten. We can tell this from the container, where

- A **"Sell-By Date"** will be given, which tells the store how long it can display the product for sale. A product sold after this date is not considered safe.
- A **"Best-If-Used-By (or -Before) Date"** will be given, which is a recommended date for best flavour or quality. It does not refer to safety.

The general appearance is important. Never use food that has a foul odour, or is in a can that is leaking, bulging, rusting or badly dented, or is in a jar that is cracked or has a loose or bulging lid. The Competition and Consumer Protection Act (CCPA) No. 24 of 2010 provides for labelling and other requirements of food safety. Food items are supposed to carry a label with the sell-by date, the quantity, and the nutritional content. If it is not properly labelled you can

- Refuse to buy it.
- Return it to the shopkeeper for immediate replacement on the basis that is it not properly labelled or is unsafe.
- Take it to the Ministry of Health to test whether it is safe.

For reflection or discussion:

Go back to the exercise you did earlier on 'How healthy are the foods we eat?' Look at the list of foods you eat in your area. Then discuss the following questions:
- What foods would an adult / a child in your area eat in a day?   (you can try this for a male adult, a female adult and / or a child)
- How much does this daily intake of food cost? (estimate!)
- How would you change this to make the diet more healthy?
- How much does this new daily intake of food cost?
- Discuss the differences in the two diets? Which is more likely to lead to obesity?
- What stops people from eating more healthy foods?
- How can we deal with those obstacles to promote more healthy diets?

3.3 What happens when people do not get adequate healthy food?

When families or communities have got to the point where they are struggling with food shortages, it is usually a sign that they are under tremendous stress, and that many of their usual social and economic safety nets have fallen away. There are many health problems that can arise due to too much or too little food, such as obesity, high blood pressure, diabetes, gout, heart, liver and kidney problems. In this module we discuss only a few conditions as examples. As it is not possible to cover all the possible problems, ask your local health worker to come and talk about the other nutrition related problems people want to hear about, and to provide further leaflets on these problems from the Ministry of Health.

What happens to people when they do not have enough food?

Method: Life history and well-being map

Approximate time: 45 minutes: 10 minutes to discuss Mwanza Mpundu's story; 20 minutes to produce the well-being map; 15 minutes discussion

Resources: Copy of sample well-being map drawn on flipchart paper or photocopied; flipchart paper and marker pens

Procedure:

1. Start by showing participants the example of the well-being map below. This is the story of a man – Mwanza Mpundu's (not his real name and not a real person) – who is now in his 70s. Both he and his wife are not well. He is struggling to feed his wife and five orphaned grandchildren. Explain how the horizontal axis represents time and the vertical axis represents well-being. Well-being is measured not just by how much money people have but also by their happiness and security.

2. Discuss with participants what this well-being map tells us about Mwanza Mpundu's life. Discuss what they think is going to happen to him and his wife and the children now that both he and his wife are struggling to feed the family and keep the children clothed and in school. Keep this discussion short since you want to leave enough time for group work.

3. Divide participants up into smaller groups of about 6–8 people. Tell them that they are going to develop their own well-being maps of an imaginary person from a particular social group in their community (such as a teenager orphaned at birth; a formal-sector worker who lost her job; a fisherman; a farmer; or a person from some other such group).

4. Ask them to share their stories on what they know happens in their community when there are food shortages. Who is most affected? What happens to them?

5. After about ten minutes, ask participants to decide on a fictitious person whose life they will put into well-being map to illustrate the major points made in the discussion. Make sure that the well-being map looks at the causes leading up to the food shortage, as well as showing what happened to that person/family when they didn't have enough food and how they coped.

6. Display all the groups' maps on the wall. Look at the range of "stories" reflected in the maps and then lead a discussion focusing on the following questions:
   * Which social groups are reflected in the well-being maps? Are these the vulnerable groups most affected by food shortages in your community? Who else is affected?
   * What were the events leading up to the food shortages?
   * What was the impact on the individual and his/her family?
   * What do the maps show about the impact of food shortages?
   * What coping strategies are reflected in the maps? What else could these families have done?

Mwanza Mpundu's well-being map

Well-being

Time →

Moved to Lusaka for work

Got married

7 children born

Well-being fluctuating around stable average

1932　1945　1950

3 children die during 1970s. Both parents deeply affected by grief and stress

Stress affects his ability to work

Well-being declines

1970s

2001. Daughter dies. Remittances from her stop. Three orphans. Mwanza's wife leaves Lusaka for home village. Builds 2 houses. Wife cares for grandchildren.

2003. 2nd daughter dies. Remittances from her stop. Two orphans join wife in rural home.

2005. Too old to work. Loses job in Lusaka. Further reduction in household income. He returns to home village.

His legs swell. She goes blind in one eye. Difficult to cultivate land. Cannot afford transport to reach clinic. Receive food from non government organisations. 2 grandchildren chased from school, for non-payment of school fees.

2000s

Source: Adapted from Bird, 2006

When households do not have adequate food, children and women are sometimes the most affected and are the first to show signs of malnutrition. This is why we often measure the nutritional status of children under five years of age as a way of telling how adequate nutrition is in that whole community.

It is important to know the signs of malnutrition for where it may occur. Children can suffer from stunting, wasting or may be generally underweight. Stunting is when a child has a very low height compared to other children of the same age and is an indicator of long-term or chronic malnutrition. Wasting is when a child has a very low weight compared to other children of the same height, and is an indicator of acute malnutrition. It points to a loss of muscle mass. Kwashiorkor refers to a form of protein deficiency where the person suffers anaemia, pot-belly, a loss of skin colour and change of hair colour, usually to a reddish tint. It is due to inadequate protein and energy, so that proteins are used for energy. Marasmus is a nutritional disorder in children where the body becomes wasted owing to energy deficiency.
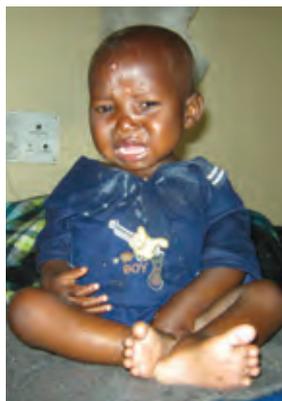
A child with kwashiorkor
Source: A Zulu Lishandu 2009

A child with marasmus
Source: content.answers.com

The Shakir Strip

Even if malnutrition has been identified in a community it does not mean that all the children in the community are undernourished. Children are monitored regularly by child health services at clinics and their weight-for-age and immunization details recorded on a children's clinic card Children with faltering growth or malnutrition can be identified in the community using a "mid-upper-arm circumference" (MUAC) Shakir Strip that measures the mid-upper-arm circumference. Children with a mid-upper-arm circumference below 12.5 cm are severely malnourished. Those with a mid-upper-arm circumference of less than 13.5 cm are malnourished.
The Shakir Strip can be used as follows:
- Feel the tips of both the shoulder and the elbow.
- Place one end of the tape at the tip of the shoulder and the other at the end of the elbow.
- Mark the mid-point of the upper arm.
- Now place the tip of the strip at the mid-point of the arm. Wrap the strip around the mid-upper-arm of the child at the marked point and thread the thinner end of the tape through the hole at the wider end of the tape.
- Make sure the tape is not too loose or too tight around the arm.
- When the tape is correctly positioned around the arm, check and record the colour of the tape at the point where the thinner end of the tape crosses the ZERO mark.

Children within the green zone of the tape are well nourished. Those within the yellow and red zones of the tape are at risk and malnourished. They must therefore be fed and their state of health closely monitored. Screening should be carried out regularly.
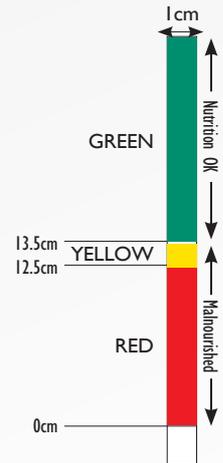
Measuring arm circumference to monitor child nutrition, Malawi
Source: B Goddard in Equinet SC, 2007

Growth monitoring in Zambia is carried out from birth to 5 years, with weighing of children on monthly basis up to 23 months and provision at health facilities of talks on child improved feeding, immunization, family planning and malaria. Growth Monitoring Promotion Programmes are used to detect early growth faltering, including in child HIV cases, and to identify infections and any other causes of growth faltering that require urgent action. A new Children's Clinic Card has been introduced that includes new immunizations discussed later, attention to issues for children with HIV and that is one colour for male children (blue) and female children (pink).
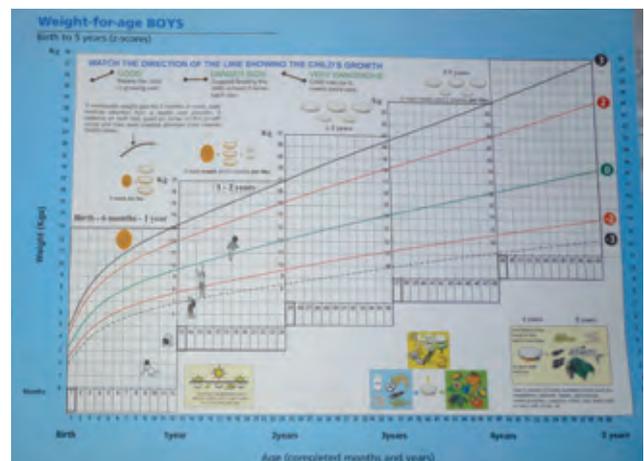
Child health card, Zambia

There are many other community interventions. They include monitoring growth, selecting foods that are locally available and highly nutritious (like groundnuts and beans), encouraging their growth, and promoting their use in child feeding. This can be done in collective production plots organized by the community. They can be sited next to pre-school centres so that they promote the care and feeding of young children, as well as immunization and health education. It creates a community-level infrastructure of feeding points and food-production plots, with child-care centres to which recuperating undernourished children could be discharged.

- Has a nutrition survey been done in our area? If so, what were the results?
- How can the community be more involved in monitoring the growth of children?
- How can we promote the children's Health Card as a tool for growth monitoring?
- What supplementary feeding do we have in our community? What improvements can we make, including using locally produced foods?
- Are any children with nutritional needs left out?

The effects of food shortages, however, affect more than children. An undernourished, anaemic mother gives birth to an infant with low birth weight who immediately starts life at a disadvantage because of poor nutritional status. If as a female adolescent she enters womanhood and pregnancy malnourished, the cycle continues. This makes it important to focus on female nutrition throughout the life cycle from infancy through to adulthood. This also improves health in old age.

3.4 Nutrition needs of special groups

As we have seen, not everyone in the community has the same nutritional needs. Children under five years, adolescents or pregnant women have special needs. Furthermore, some groups, like people with HIV, people with diabetes or those recovering from illness have to pay extra attention to the food they eat for their health. In general, everyone should do this, and the diets recommended for people with diabetes would, for example, be healthy for most other people in the community.

Which groups in our community need special attention on nutrition?

Method: Spider diagram

Approximate time: 60–90 minutes

Resources: Flipchart paper and marker pens. If possible, try to invite at least one health worker to contribute to the discussions

Procedure:

The objective of this activity is to identify the social groups that may be most vulnerable to malnutrition, and to consider why this might be the case.

1. Divide participants into small groups of about 6–8 people. Ask each group to draw a spider diagram (as shown) where each "leg" of the spider represents a group with particular nutritional needs. Remind them to refer back to their social maps and earlier general discussions on health in the community.

2. After about 10–15 minutes, ask participants to come back to plenary and to put their spider diagrams on the wall (or floor). It is NOT necessary for every group to report back. Instead facilitate a discussion in which you identify the groups with greatest nutritional needs from all the spider diagrams. Agree on three of these to discuss further.
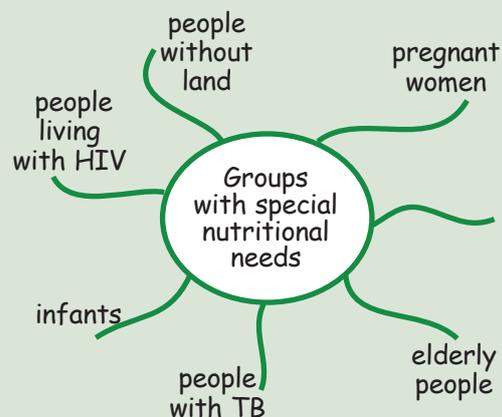
Example of a spider diagram

3. Break into three discussion groups, each taking one of the identified vulnerable groups. Each group should then discuss the needs of this sector, focusing on the following questions:

- What do and don't you know about the nutritional needs of this vulnerable group and how they can be met? What additional information do you think you need on this issue?
- Why do you think this problem exists? (Remember to look at causes of causes, and the food sovereignty issues, too.)
- What can you do as a community to promote good nutrition in this group?

For the discussion you can refer to Information Sheets 3b to 3e below on the needs of special groups. We also suggest that, if possible, you include a health worker in your discussions.

4. Back in plenary, each group reports back on its ideas. End by developing an action plan for the community to follow (see Module 4 for information on how to develop a community action plan).

INFORMATION SHEET 3b: Nutrition in Children

Breast milk contains all the nutrients that children need in the first six months of life. Supplementing breast-feeding before the baby is six months old is discouraged because it increases the likelihood of contamination, putting infants at risk of diarrhoeal disease. At a later stage of the baby's development, breast milk should be supplemented by other liquids, and eventually by solids or mushy foods. Babies thus need:

- An early start to breast-feeding and exclusive breast-feeding for 6 months;
- Energy-dense and micro-nutrient-rich complementary foods from the age of 6 months, with continued breast-feeding for 2 years and beyond.

Queuing up for Child Health week Makeni Lusaka 2010 © A Zulu

- Integrated Management of Childhood Infections (IMCI), an approach that ensures that health workers check for and manage all the health issues that children face when they report to health services.
- Vitamin A supplementation and immunization against preventable diseases.

Although breast milk is considered the best nutrition for a child, HIV-positive mothers have a one-in-three chance of infecting their breast-feeding babies with HIV through breast milk. At Ante-Natal Clinics in Zambia, health workers advise HIV positive mothers on breastfeeding options (breastfeeding or replacement feeding). Replacement feeding (Infant formula) is advised only when it is acceptable, feasible, affordable, sustainable and safe for them and their infants . (See Sipiwe's Story in Module 5 for an activity that addresses these issues). It is thus important to encourage HIV positive mothers to breastfeed exclusively, to join mother support groups and to take their ARVs consistently.

Up to the age of five years, children are at risk of energy and micro-nutrient deficiencies, and can face nutritional losses as a result of frequent infections from, for example, diarrhoea, malaria and acute respiratory infections.

This can continue during the pre-school years, and has implications for mental development and learning ability. While older children are at less risk of dying from malnutrition than infants, they suffer from chronic development problems if the nutritional needs to support their "growth spurt" are not met.

Improving child nutrition is essential to improve child survival. If moderately and severely malnourished children are identified before they become critically ill, they can be treated at home through community-based care, staying within their family and avoiding the risk of being infected whilst in hospital.

INFORMATION SHEET 3C: Women's nutrition during pregnancy and breast-feeding

Women have many roles that demand good nutrition, not just for themselves but for their children's health. Functions like reproducing, nurturing, caring and producing can all be affected when women are malnourished. Anaemia in pregnancy, one of the leading causes of mothers dying in Africa, was estimated to affect half of the pregnant women in the region in 1998, and to lead to low birth-weight babies.

Some women spend years of their lives either pregnant, breast-feeding or both. Women do a great deal of physical labour, including during pregnancy. The "maternal-depletion syndrome" describes what happens to the reserves in a woman's body under conditions where the body does not have time to replenish itself. Nutritionally stunted women have a higher chance of obstructed labour. Food taboos may be dying out in some areas, while in others they still limit what a woman can consume (especially during pregnancy and lactation). Antenatal and post-natal care is important for women of reproductive age. Services such as monitoring of weight-gain, distribution of iron/folate tablets, and the identification of risk factors such as malaria and anaemia are provided at these clinics.

Adolescent and adult women thus need:
• A diverse diet that is rich in energy and micro-nutrients.
• Access to family-planning services to delay the first pregnancy and space births.
• Prevention and treatment of Sexually Transmitted Infections (STIs).
• Increasing food intake, reducing workload and de-worming.
• Targeted food supplementation of the malnourished.
• Supplementation with iron/folate and with multi-vitamins/minerals during pregnancy.
• Improved environmental sanitation and personal hygiene.

At Ante-Natal Clinics in Zambia, health workers: -
• Encourage pregnant women to increase food intake during pregnancy.
• Monitor weight gain in pregnancy.
• Counsel pregnant women about reducing energy expenditure.
• Encourage pregnant women to eat a variety of foods (diet diversification) and micronutrient supplements such as Iron, Folate, Iodine and Vitamin A containing foods.

Spouses and close household or community members provide local foods to the expecting mother and help prepare food for her.

INFORMATION SHEET 3d: Nutritional needs of people with HIV

HIV-infected people suffer from reduced food intake owing to appetite loss, difficulty with eating owing to mouth and throat sores, the side effects of medication, and depression. HIV hinders the optimum absorption of nutrients, while fevers and repeated infections increase demand for nutrients. The therapy for this is both nutrition and ARV therapy. Good diet is needed to support Antiretroviral Therapy (ART), and people taking ART need to eat, despite the side effects of nausea and vomiting.

Good nutrition is particularly important for People living with HIV and AIDS (PLWHA). PLWHA need to eat a variety of foods to strengthen their body's protection and recovery from diseases, to delay the progression of HIV and AIDS, and to boost immunity. PLWHA need to eat a lot of energy-giving foods, and drink at least eight glasses of boiled, clean, safe water a day. PLWHA are advised to reduce the intake of refined sugars like cane sugars and sweetened juices because they encourage the virus to multiply. PLWHA are also advised to limit oils, coffee, tea and soft drinks. PLWHA are encouraged to eat or drink

- Unrefined instead of refined maize meal
- Whole wheat porridge
- Brown or whole wheat bread
- Brown sugar instead of white sugar
- Finger millet
- Well-cooked meats, for easy digestion
- Soya foods, legumes and dairy products
- Fresh fruit or vegetable juices
- Commercial vegetable or meat soup instead of using oil to prepare the gravy
- Half-cooked vegetables, to preserve their nutritional value
- Pure honey, in small quantities, for energy and vitamins and to relieve coughs, wounds and burns

Vitamin and mineral supplements are not an alternative to a good, balanced meal. While adequate vitamins are good for health, taking too large a dose of some (like Vitamins A and D) can be harmful.

Some PLWHA can get nausea from foods with a strong odour, and they need to work out, with a health worker's advice, which foods to avoid. People can also become dizzy as a result of inadequate food intake that weakens the body, or of anaemia – when the blood cell count is low. For this they should eat iron-rich foods such as liver and green, leafy vegetables.

Community based HIV and AIDS support groups can share lessons on nutrition and hygienic food preparation and grow food for income generation and supplementing their own food needs.

PLWHA commonly experience diarrhoea and vomiting, and it is recommended that they drink sufficient fluids, such as water or diluted fresh fruit juices, eat small frequent meals, eat fermented foods like sour porridge, sour milk or yoghurt, and avoid very fatty foods. To counteract vomiting, it is suggested that they take frequent small meals, eat slowly and chew well. Cool or cold foods are better tolerated than hot ones. An oral re-hydration solution, as discussed in Information Sheet 4a in Module 4, should also be given to prevent dehydration and other imbalances.

Tuberculosis (TB) is a common infection associated with AIDS. People with TB are advised to eat a high-protein diet, with meat, if available, dark-green, leafy vegetables – such as pumpkin leaves (chibwabwa, bondwe), rape and spinach – or yellow vegetables. PLWHA suffer from mouth and throat ulcers and thrush. When this happens, they should avoid eating hot, sweet, fatty or spicy foods and switch to liquid or semi-liquid foods. Cleaning the mouth with bicarbonated water also helps.

INFORMATION SHEET 3e: Hypertension and Diabetes

Hypertension is a major cause of ill health in Zambia, and can lead to heart disease, strokes, kidney failure, and poor quality of life. It can lead to early disability and death. In a recent study among adults in Lusaka, 38% of the men and 33% of the women had hypertension, a very high rate. While blood pressure can rise with age. being overweight or obese, having high levels of blood cholesterol, having an inactive lifestyle, drinking alcohol regularly and having diabetes is associated with increased blood pressure. Overweight people are advised to lose weight and people are encouraged to exercise at least 20 minutes daily and to reduce their intake of salt, fat and alcohol.

Diabetes means that your blood-sugar (or glucose) level is too high. While glucose comes from food, is made in the body and needed for energy, too much glucose in the blood isn't good for your health. Your body produces a substance called insulin, which converts glucose or sugars in the body into energy. People with diabetes have a problem with their insulin, and glucose builds up in the blood and passes out of the body in the urine. So the body loses its main source of fuel, even though the blood contains large amounts of glucose. People can inherit problems with insulin, or they can emerge when there is too much demand on insulin, such as in overweight adults.

The steps to prevent diabetes are the same as those for general health:
- Eat the sort of nutritious, low-fat, whole-grain foods that we have described in this section on nutrition.
- Limit the amount of sugar and sugary foods in the diet.
- Stay active and ensure doing something every day that involves physical activity.

Healthy eating, physical activity, and taking insulin are the basic therapies for diabetes. The amount of insulin must be balanced with food intake and daily activities. Blood-glucose levels must be closely monitored through frequent blood-glucose checking. People with diabetes also monitor their blood-glucose levels several times a year with a laboratory test. When blood-glucose levels drop too low, a person can become shaky, confused and faint. They can also faint if their glucose levels are too high. Healthy eating, physical activity, and blood-glucose testing are the basic

Syringe for insulin

Source: www.fotosearch.com/photos-images.diabetes

management tools for diabetes. In addition, many people with diabetes need oral or injected insulin to control their blood-glucose levels. People with diabetes need to manage their blood sugars and blood pressure to keep them at a stable level. This means that they should maintain regular contact with the health services to monitor their diabetes control and their general health.

In summary:

In this module we have

- Developed an understanding of food sovereignty, discussed the barriers we face in strengthening food sovereignty and how we can address them.
- Discussed what constitutes a healthy diet, and what foods need to be promoted at local level.
- Explored what happens to people's health when they do not get adequate food.
- Discussed how to monitor and meet the nutritional needs of children at individual and community level.
- Discussed how to monitor and meet the nutritional needs of other groups, such as pregnant and lactating mothers, and people living with HIV or diabetes.

If your literacy session focused on nutrition, remember to save time at the end to go back on all the issues you discussed in the session to draw up your community plan.

COMMUNITY PLAN

What will we do next?

At the end of your literacy session discuss with community members what actions will be taken before the next health literacy session
- How will participants give feedback to others in the community on what they learned and decided at this meeting?
- What actions can participants take and report back on before the next session?
- Who will lead these actions? Who else will be involved to help?
- What will be the role of the health workers and the local council?
- What information or report-back will participants bring to the next meeting?

Ask the community members what else they want to know about
- Identify the topics that people want to know about in the next session.
- What do people want to know about or to bring to the attention of the district?

Remember also as a facilitator you will also need to prepare your own "FACILITATORS PLAN" to plan your next session. Agree with the participants on when this will be and what information each will bring to that session. Remember to start your next session by discussing this feedback.

FACILITATOR'S PLAN

How will you prepare for the next session?

Think about the topics you will need to plan for or implement before the next health literacy session. Inform the district health team of the information that came up at the meeting and of any follow up support you need.

What do communities want to hear about next?
- What new topics did the communities want to discuss at the next session?
- Which module(s) in the manual deal with these? How will you use them?
- Where else can you get information from?
- Who else will you need to invite to help you with this session?

What else do you want to include in the session?
- What other topics will you include in the next session? (Be sure you know why!)
- Which module(s) in the manual deal with these? How will you use them?
- What other information will you use and who else can you bring?

Module 4: Healthy environments

In this module we:
- discuss what we mean by healthy living and work environments;
- present information on major diseases spread through living, work and community environments and how they can be prevented or managed;
- raise discussion on actions that communities can take to improve environments, and outlines the resources available to communities for this.

Healthy environments cover the places in which we live and work, as well as the places where we interact within our community. These include adequate, safe and decent shelter, water, sanitation and waste disposal; decent and safe working conditions; and community environments where there is safe transport and services that do not pollute. They also mean environments in the community that are free from the risk of violence, such as adequately lit urban areas where people can walk safely, free from fear.

4.1 Safe water, sanitation and housing

When we talk about safe household water we are talking about
- Where the water is obtained from – its source.
- How much water is available for use by households.
- How water is collected and stored.

All of these aspects are important to promote health and prevent water-borne disease. Safe water comes from springs, covered wells and uncontaminated boreholes. Hand or electrical pumps are usually used to extract the water, or as filtered stored water, or treated and piped water. Households ideally need between 100 and 200 litres per person per day for health and hygiene needs.

The ventilated improved pit latrine

In Zambia the most common safe rural sanitation is through the Ventilated Improved Pit Latrine (VIP). As the figure shows, this is a pit toilet with a pipe fitted to the pit and a screen at the top outlet of the pipe. The smell is carried upwards by the chimney effect, and flies are prevented from leaving the pit and spreading disease. According to Zambia household surveys in 2007, it was estimated that 58% of the population had access to safe drinking water (88% of urban and 43% of rural population), while significantly less, 24%, have good sanitation facilities (37% urban and 11% rural) (CSO, MoH, Macro International, 2007). Urban people more commonly use flush toilets compared to rural people. Squat and pit toilets that do not have sewers or methods for controlling flies are not safe.

odours out

screen to trap flies

spiral 'house' made of local material

pipe

cement slab

moving air

flies go up pipe
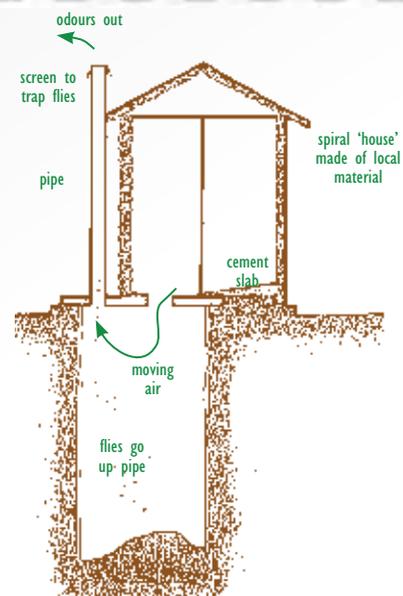
Source: www.ugandanetwork.org.uk/images/vsvippit.gif

The Government of Zambia has a duty to ensure that people access safe water and sanitation. In 1997 the government adopted the Water Supply and Sanitation Act. Two ministries in Zambia have core responsibilities for water and sanitation. The Ministry of Energy and Water Development (MEWD) lead the water sector and are responsible for water resource management, and the Ministry of Local Government and Housing are responsible for water supply and sanitation in urban and rural areas. Zambia's Water and Sanitation sector Vision is *"a Zambia where all users have access to water and sanitation and utilise them in an efficient and sustainable manner for wealth creation and improved livelihood by 2030"*, and it's sector Goal is *"to achieve 75 percent accessibility to reliable safe water and 60 percent adequate sanitation by 2015 in order to enhance economic growth and improve the quality of life"* (Ministry of Finance and National Planning 2011)

Ventilated improved toilet, Ngwerere

© Rueben Zulu 2007

The Ministries work with the National Water and Sanitation Council (NWASCO) and the Devolution Trust Fund (DTF). At sub-national level Commercial Water Utilities (CUs) provide water. Locally, water is managed through District Councils, Water Point Committees in rural areas and organisations such as Water and Sanitation Association of Zambia (WASAZA). Water Point Committees manage community water points and kiosks.

Safe sanitation is provided through ventilated pit latrines or flush toilets that are able to dispose safely of human excreta, while hygienic refuse and waste-water collection is also important for health. Poorly managed solid waste is known to contribute to the breeding of vectors/rodents which in turn contribute to the transmission and spread of vector/rodent related diseases in the community e.g. plague, cholera, etc. There is a growing problem of solid waste, particularly in urban areas. The waste comes from household and industrial activities and has led to uncollected heaps of garbage, especially the densely populated townships.

The story below highlights that it is the people in these structures and agencies that make the difference in improving access.

Community-Led Total Sanitation (CLTS)

UNICEF and Choma District Council report on the success of Community-Led Total Sanitation (CLTS) in Zambia's Southern Province. In two months, the local population using a toilet has risen from 23 to 88 percent, without outside funding for building latrines.

Trained government facilitators take villagers through a process of 'guided discovery' that makes them feel uncomfortable about open defecation. Group activities and humour help them to understand that it is unhygienic, unpleasant and unnecessary. Activities include asking villagers when they last defecated in the open and calculating the total amount of shit the village creates every year. Villagers lead facilitators on a walk through the community showing each other where they shit. A piece of shit placed next to food demonstrates how flies contaminate food with faecal matter.

The costs of building a toilet and healthcare expenditures are also compared. Such exercises illustrate the scale of the problem and lead to a desire for change. Villagers then develop an action plan to stop open defecation, and design latrines based on their own innovations. A Sanitation Action Group monitors progress.

The report suggests that although the programme took place in the wet season, it has been a success:

Villagers in Kebengele village decide to take collective action against open defecation, © Petra Bongartz, 2008

- Many new latrines have been built.
- The project has been most successful in places where few toilets existed before.
- In densely populated communities households may share toilets.
- Traditional and civic leaders are crucial for implementing and sustaining the project.
- Local people have developed great pride and a sense of ownership of their toilets and in ensuring their villages are clean.
- Existing sanitation projects that have had limited impact can adopt a CLTS approach to scale up access.
- While the quality of constructed toilets is variable, a majority meet the Government's definition of 'adequate' sanitation and many have been incrementally improved over time.

Local chiefs are keen to use the approach in all their communities. It has already expanded to more than half of the villages in the entire district. Traditional leaders and district staff need to continue to monitor the programme to assess its long-term sustainability:

- Chiefdom-level verification committees must verify reports from community sanitation action groups; district level certification committees should certify villages as open defecation free (ODF).
- Wards could set up verification committees to create formal links with district councils.
- Villages that are ODF can display a signboard that shows their success.
- Additional handwashing and hygiene promotion can ensure positive health outcomes.
- Technical advice to sanitation action groups, including on toilet buildings and sanitation platforms, pit lining and sites can help to improve the longevity of sanitation infrastructure.
- Artisan Associations can market their latrine construction services and set up demonstration latrines to show different technologies.

Source: Harvey and Mukosha 2008

In rural and less densely populated communities, households dispose of their solid waste through refuse pits – holes dug in the ground at least 1m deep, sited 20m away from the house and 30m away from the water source; though burning – usually dry solid waste heaped in a designated place away from homes and burned; and through compositing – for disposal of organic solid waste like leaves and grass in pits to make compost for fertilizer.

Burning is also a good method of disposing of infectious materials and is commonly used in hospitals for wastes such as syringes, needles, used drips, soiled beddings, placentas etc in specially built incinerators at very high temperatures.

For reflection or discussion:

- What lessons are there from the story on Community-Led Total Sanitation?
- How could the same lessons be applied to the problem of solid waste?
- What actions do you think your community could take to manage solid waste in households, in communities, and at local government level?

District councils in Zambia are responsible for solid waste management; but have inadequate funds for this. Some councils have set up partnerships with communities to manage solid waste. Communities are being sensitized on the need to manage solid waste and how to separate and dispose of waste at both household and community levels. Community Based Enterprises (CBEs) are being engaged by councils in day – to – day collection of solid waste from households at a minimum monthly fee agreed upon by the community, council and the CBE. The CBEs then transports the waste to council designated waste disposal sites. Both the CBEs and respective councils benefit financially from the arrangement. The community and household environment remain clean and are devoid of garbage related diseases.

4.2 Safe work environments

Safe health promoting work environments are free of hazards to health. A hazard is any condition in the workplace that can cause illness or injury or in any way impairs the mental, physical and social wellbeing of workers. Workplace hazards can be divided into six main categories:

1. **Physical**, or hazards in the physical environment. They include temperature; noise; vibration; lighting; electrical hazards; dusts; radiation.
2. **Chemical**, including solids (dusts, fumes and smoke), such as nickel dust; liquids, such as benzene and gases and vapours, such as carbon monoxide. Chemicals can get into the body in three ways: through breathing, through eating and by being absorbed through the skin.
3. **Mechanical**, due to movement and problems with machinery, access ways (stairs, gangways, working platforms), falling and moving objects and vehicles.
4. **Biological** hazards are due to live material, whether animal, vegetable, bacteria or viruses.
5. **Ergonomic** hazards arise due to work postures, the intensity of work or other factors that cause physical stress. They arise when the work is poorly planned and organised to suit the characteristics and abilities of the people doing it. This happens when workers stand all day, have difficult work postures, extreme or repetitive movements, lift heavy loads or have poorly designed tools.
6. **Psychosocial and work organisation** hazards are probably least recognised of all. They occur due to oversimplified, monotonous jobs , jobs which are carried out in isolation or hazardous conditions, jobs where the demand is too high, the work pace too fast or the hours too long.

Some hazards are very obvious. It does not take an expert to know that a worker lifting a 100kg bag of sugar is doing dangerous work. There are also hazards that are not immediately obvious that call for measurement with equipment, such as dust or chemical levels. You have your own built in monitoring equipment: eyes, ears and nose!   The best way to find out what hazards exist in your workplace is to do a thorough workplace survey. This involves walking through the workplace noting the hazards you see, smell and hear and that workers tell you about.

How healthy are our environments?

Method: Social or workplace map, transect walk or workplace survey and discussion
Approximate time: This activity is divided into 3 stages. Combined, it may take the whole day to complete, but see suggestions below.
Resources: your community social map, pens and notepads, camera (optional), flipchart paper and marker pens
Procedure:

We can look at this in three stages. You can do it all at the same time, or you can do part of the session, then carry out the second part (the transect walk) in the community between sessions, and finally take the feedback in another meeting. Combined, it may take a whole day to complete. You can arrange it in the way that works best for you..

The three stages are as follows:

- First use the community's social map or a workplace map to discuss the features in the environment and how they may affect health.
- Then go on a transect walk or worksite survey to verify what you have discussed and add new information.
- Finally review the information you have gathered and get advice from others to plan actions based on the information gathered. If you do a workplace survey the information should be discussed with the workers for their inputs and recorded with the health and safety committee.

ONE: Developing the social or workplace map (approx. 1 hour)

1. In Module 2 we described how to draw a social map. Have a look at the map you drew and identify the environmental features you may have already included, for example:
   - places where people live – housing
   - water, sanitation, waste-collection and dumping points
   - transport, sources of pollution, places where animals and people mix
   - features of the community environment, like areas where people walk that are poorly lit, or places that are unsafe

If you have done a workplace map identify the different hazards you have noted in the work environment.

2. Add others that you think you may have missed in the first map. Listen carefully to what participants are saying and, if necessary, 'interview the map'. Do this by asking questions to help them probe deeper into identifying and understanding the environmental risks in their community. These may be within their households, their workplaces or at a wider community level. Ask a member of your HL facilitation team to document the discussion. It will be useful information for later planning.

3. If you chose to do the next step of the transect walk as a community activity, then prepare for it first in the meeting and agree what will be done and what will be reported back next time you meet.

TWO: Going on a transect walk (or worksite survey) (2-4 hours)

1. In Module 2 we described how to do a transect walk through the community. If you want, you can divide up into two or three groups, each going in a different direction.

2. Plan the route of the walk and aim to visit at least five homes to meet with household members and to visit the community facilities. Discuss with your team what information you want to obtain or check during the transect walk; make a list of these questions to refer to during the walk.

©M Ndhlovu and TARSC

3. Take a few hours to walk around. Ask lots of questions, but keep focused on your main objective – to explore the environmental health situation of the community in relation to housing, living environments (water, toilets, waste, etc.) and community environments (roads, facilities, animals, etc.). Look for pollution and where it is coming from. Think about what environments exist for different age groups – what might not be a problem for an adult may be more difficult for a young child.

4. When you do your survey, try to explore the environments carefully. Often waste and other hazards are not immediately visible and you need to look behind walls or walk around buildings to see where hazards accumulate. Try to find out what lies behind what you see.

5. Ask questions that help you to understand what you are seeing:
   - Who uses or is affected by this environment? What problems do they experience?
   - Why is this happening? What are the causes?
   - How do community members see these environmental features? What is important to them?
   - What are community members doing about their environments?
   - What signs are there of change in environments (for good or bad) and why have these happened?

THREE: Reflection and Discussion (approx. 1 hour)

When you meet again, compare what you have found:
   - Add to your social or workplace maps.
   - Make a list of the major environmental features you saw in the area.
   - Discuss your maps and your list. Where are things changing for the better? Where are things changing for the worse?

Either working in plenary, or by dividing the participants into two groups, do the following:
   - Prioritize three areas where environments are having a strong, positive impact on health, and discuss how this improvement could be spread more widely.
   - Prioritize three areas where environments are having a strong, negative impact on health, and discuss what actions could be taken to correct this.

If you worked in two groups, make sure you leave enough time for report-back and discussion.
Living and working in a healthy environment is essential for good health. Do you remember our discussion on health rights in Module 2? The right to adequate safe water is one of the rights in the United Nations Convention on Economic and Social Rights.

Governments are obliged to ensure – through a national plan, for example – access to safe sanitation and to the minimum amount of safe water that is essential for personal and domestic use to prevent disease, especially for disadvantaged and marginalized groups. This means that people should have access to water within walking distance of their homes.

Let's look more closely at access to safe sanitation as an example. Community rights to sanitation call for government to increase progressively the number of people who have access to safe sanitation. This means ensuring that everyone can access these essential environmental inputs at a standard necessary for their health. It is especially important for marginalized and vulnerable groups.

TOTAL SANITATION ROLL-OUT

CHIEF Macha and his chiefdom in Choma have made history and for the right reasons. Last Saturday UNICEF honoured the chief, who through his efforts has made his area open defecation-free (ODF), as a UNICEF Zambia Supporter for Sanitation.

In November 2009, Chief Macha's chiefdom, about 100 kilometres north of Choma, became the first in Africa to achieve ODF status.

In Chief Macha's kingdom, the air is unpolluted and diseases such as cholera are minimal because people no longer answer the call of nature in vegetable and maize gardens nor behind their houses.

Chief Macha has been a major force in the implementation of the Community-Led Total Sanitation (CLTS) – a UNICEF-supported strategy, and last October, President Sata also honoured him with the title of Officer of the Order of Distinguished Service for his work.

CLTS is a community-based strategy where villages and urban neighbourhoods work as a community to adopt improved sanitation and hygienic practices and construct latrines on their own and so far 600 communities countrywide are now ODF.

This is a lesson all communities should learn throughout the country. It is important to construct good toilets and we don't always need Government to do so. To construct a pit latrine or dry toilet, all we need are a few lessons and labour as most materials such as wood and bricks can be found everywhere. It boggles the mind how any household can use their backyard as a toilet. Such people should be punished if Zambia is to attain the millennium development goals on increasing sustainable access to sanitation. In Chief Macha's chiefdom, community members mark houses, churches, shops, and areas where defecation occurs. Wherever human excreta are located, they are collected and a 'walk of shame' for culprits is conducted through the village.

Every year, especially in the rainy season, diseases such as cholera break-out and some people lose their lives. This could end with proper sanitation and access to clean, safe drinking water. We have the power like Chief Macha to contribute to this. He did not just sit and grumble, he swung into action and got results. He made his area a safer place to live and also made history.

For reflection or discussion:

- What lessons are there from the story above?
- What do you think local communities should do to ensure access to safe sanitation for all in your area?

This is not simply a matter for top down planning. Communities can play a key role in delivery on these rights, as indicated in the story below.

In recent years, some threats have emerged to these basic conditions for health:
- Public investment in water, sanitation and housing has fallen, and the supply to the public has therefore remained constant or also fallen.
- Households have become poorer and thus less able to invest in these inputs for themselves.

In many countries some people fail to access these essential inputs, either because they are not supplied at all, or because they can't afford them if they are supplied. When water services are fully commercialized, rising prices affect the community's access to them.

The story below describes this situation.

What happens when water is privatized or commercialized?

Method: Case study and picture code
Approximate time: 45–60 minutes
Resources: Zambia case study. If possible, involve representatives from local government or residents' associations.

Case study from Zambia

The Zambian Government established the National Water Supply and Sanitation Council (NWASCO) under the Ministry of Local Government and Housing in year 2000 by an Act of Parliament. This was aimed at regulating commercial water utilities at national, provincial and district levels. This led to the formation of many Water and Distribution Boards throughout the country.

The Lusaka Water and Sanitation Company was formed as a commercial water entity. It embarked on the establishment of zones in order to administer its mandate. The Lusaka West Zone covers Barlastone, Chaisa, Chazanga, Chipata, Chunga, Garden, George, Kabanana, Matero, Lilanda, Twikatane and Zingalume. The company formed Water Development Committees throughout the zones. Through these committees the company has unpaid volunteer members who are in charge of water taps called Tap Leaders. . They are given a token commission based on the number of households drawing water at each water station. The community pays a prepaid monthly water charge of Thirteen Thousand Kwacha (K13, 000) per household and also carries out Bucket Sales at Two Hundred Kwacha (K200)

Water kiosk, John Laign compound   © A Zulu October 2012

per 20 litre container. The Zone has a monthly target of five hundred million Kwacha (K500, 000, 000). There is no free water band for minimum needs for poorest households. The water kiosk in the peri-urban areas of Kitwe is another mechanism for sale of water. People buy safe water from a tap which was built by the commercial utility. Filling up a 20 litre container is five times cheaper than in the days when commercial trucks delivered the water. The price is K200 per 20Ltrs container.. Countrywide finding and introduction of water kiosks is being undertaken by the Devolution Trust Fund (DTF). The majority of the water vendors running the kiosks are women, who have a .sub-contract with the commercial utilities.

Procedure:
Start by talking with participants about what they know about water commercialization and privatization. Do they have any experiences of them? Do they know how it works?

1. You can probe further by asking some or all of these questions:
   • Were there any levels of water use provided free to protect reasonable access in low income groups?
   • Why do you think governments are moving away from public to private ownership of water resources? Is this a good thing, or not? Why?

Keep the discussion short, and end by commenting that this activity will look at the impact of water privatization in communities through discussing the case study further.

2. Divide participants into two groups. Ask each group to discuss the Zambia case study.
    • Who do you think gains from commercializing or privatizing water supplies? How?
    • Who do you think loses from commercializing or privatizing water supplies? How?
    • Why are water services being commercialized or privatized? Whose interests and voices influence the decisions?

3. When the groups are finished, bring them back to plenary. Go through the first 3 questions and discuss how the case study helped clarify the answers to these questions. Then move on to discuss the following additional questions:
    • What do you know about the situation in your area. Is water being sold? Are any for-profit companies involved in the sale of water? Do any local people face barriers to accessing water? What are these? If possible, try to arrange for representatives from local government or residents associations to come to this discussion and make their contributions.

Ensuring quality water and sanitation services is everyone's business. Communities can participate in the Village Development Committee and the Neighbourhood Health Committee to plan the interventions related to their environments. In these committees, they will work with local organisations, elected and other leaders in the community, such as chiefs, councillors, church leaders, Parent-Teacher associations (PTAs), teachers, women's clubs, drama clubs, the market development committee, community health workers and traditional birth attendants (TBAs).

4.3 Diseases spread through unsafe water and poor sanitation

Communities that do not have adequate safe water or sanitation have a greater chance of environmental diseases.

What diseases do we have from unsafe water and sanitation in our community?

Method:	Three-pile sorting cards
Approximate time:	60 minutes
Materials:	A set of picture cards under the heading "What environmental diseases do we have in our community". You can use the six pictures overleaf, or you can draw your own stick figures of the same or other actions. (The quality of the art doesn't matter; sometimes less artistic pictures give rise to a better discussion.)

Procedure:

1. Get the participants to form a circle.
2. Two or three volunteers come into the centre of the circle. They study the set of cards and then sort them out into three piles – GOOD, BAD, NEUTRAL – according to their effect on the level of environmental diseases in the community. This shouldn't take too long. Other members of the group think about whether they agree or disagree with the choices they see.
3. The volunteers then present their decisions to the other members of the group, who comment on their choices. They explain the diseases they think are caused by these conditions.
4. Ask a group from the participants to use the Information Sheets 4a to 4d below on different diseases to see whether everyone agrees with the volunteers or not.
5. Ask a local health worker to be part of the discussions so he or she can respond to questions. Ask him/her not to tell people what to do, only to respond to questions or give advice if asked.

6. The volunteers can move their cards into a different pile in the light of this information or of people's opinions.

7. The facilitator can also make comments if she/he feels that some aspect has been missed.

8. Based on the discussion, have a more general discussion on environmental diseases in your community:
   - What are the most common?
   - Where are the places that they are most likely to occur? (You can put them on your social map.)
   - What actions can you take to prevent them?
   - What do people in the community need to know to manage them early?

TIP: this approach – the three-pile sorting – can be used for any of the other environmental diseases and many other issues as well. You can make or find your own pictures – they don't need to be fancy – stick-drawings are fine. Instead of using pictures, you can also write the activities on separate slips of paper, e.g. washing hands, sleeping under a mosquito net, etc., if the group is literate enough. The same approach can also help with planning – necessary steps or actions are sorted according to who should be responsible for them.

Examples of the kinds of cards you can use or make for the sorting activity. You will find a loose insert with these pictures in the back of your folder.

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INFORMATION SHEET 4a: Diarrhoea

Diarrhoea is the frequent passage of loose stools, often with stomach pains, nausea and vomiting. It affects all ages and is more dangerous in children under 5. It can cause severe dehydration. If you take a pinch of skin on the abdomen and it doesn't go back when you let go, it is a sign of dehydration. Other signs include passing less urine (and it becomes darker), and drowsiness and thirst. There are three clinical types of diarrhoea: acute watery diarrhoea - lasts several hours or days, and includes cholera, acute bloody diarrhoea - also called dysentery; and persistent diarrhoea lasts 14 days or longer.

Diarrhoea is usually a result of poor water, unsafe sanitation, poor food hygiene (e.g. uncovered food), and unsafe waste disposal. To prevent it, it is necessary to deal with these environmental inputs. Boiling drinking water is one option when water is contaminated with germs, but a more long-term solution is to ensure that safe water is accessible to all households.

In Zambia, diarrhoea is the third leading cause of clinic visits and death for children under five years of age, after pneumonia and malaria. Every year, about 15,000 of Zambia's 2.4 million children under five die due to diarrhoea. In Zambia, from 2008-2010, diarrhoea was consistently ranked as the third highest cause of visits to health centres across all age groups.

Diarrhoea can usually be treated safely "at home" and normally goes away by itself within a week. Seeking medical attention is advised if the person has another condition as well as the diarrhoea, if there is blood or pus in the faeces, if the diarrhoea is accompanied by a fever, or if it continues and dehydration is noted. Diarrhoea is more dangerous for infants and thus merits closer attention.

The most important action is to replace the lost body fluids by giving a salt and sugar solution, or a commercial oral rehydration solution, or plenty of fluids (e.g. Mahewu, thin porridge). This should be done immediately at home and every time stools are passed.

Preparation of salt and sugar solution (SSS)

How to prepare the salt and sugar solution:
- use a clean 750ml bottle
- pour in 750ml of safe water, i.e. bottled water or water from a tap or closed well, or boiled and cooled or treated water
- add half a level teaspoon of salt
- add six level tablespoons of sugar
- Mix and taste the prepared SSS
- Give the solution frequently, and after each bout of diarrhoea or vomiting, until the patient is seen by a health worker.

WATER + SUGAR + SALT

Those affected should get food to replace the nutrients lost.

INFORMATION SHEET 4b: Cholera

Cholera is a severe diarrhoeal disease that can affect any person. It is spread through drinking water in dirty containers that have been contaminated by germs through the improper disposal of human waste. People get it by eating food that has come into contact with cholera germs from human faeces or vomit from an infected person, by eating unwashed fruits or food not well cooked, by not washing their hands with soap after using the toilet, or by changing soiled linen from an infected person.

Cholera was reported in Zambia in 1977/1978, and then cases appeared again in 1982/1983. The first major outbreak occurred in 1990 and lasted until 1993. Since then cholera cases were registered every year except in 1994 and 1995. Generally most cases are recorded in the fishing camps of the rural areas and in the peri-urban areas of Lusaka and Copperbelt provinces. In Lusaka, cases and deaths mostly appear in the western suburbs of the city where access to safe water and good sanitation is poor.

People affected have severe profuse watery diarrhea which looks like rice water and are severely dehydrated due to loss of body fluids. They have body weakness, stomach cramps, dehydration and may vomit. It takes between a few hours and about three days for people to start showing symptoms of cholera after they have been infected.

Cholera can be prevented if water is stored in clean, covered containers with small openings to get the water out. Long spoons could also be used to prevent dirty hands being put in water. It is recommended that all unsafe drinking water is boiled or treated with chlorine. Human excreta should be promptly and safely disposed of in a toilet, and hands must be washed thoroughly with soap or ash under safe running water after using the toilet. It is therefore recommended that households:
- keep food covered
- use and drink water from safe and protected sources
- wash their hands with soap or ash after visiting the toilet, and before handling or eating food
- avoid eating uncooked food unless it can be peeled or shelled, and cook food thoroughly, or reheat it thoroughly, and eat it while still hot
- wash fruits and vegetables thoroughly, one by one, with safe, running water.

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The most important action is to replace the lost body fluids by giving salt and sugar solution (see the discussion on diarrhoea for the recipe) or oral rehydration solution or plenty of fluids (e.g. thin porridge). This should be done immediately at home, and a health worker informed as soon as possible. Suspected cholera cases need immediate attention at health facility for assessment and rehydration. If they have severe symptoms they should be transferred to cholera treatment centre. Cholera can be treated adequately and successfully by replacement of fluids and a nutritious diet. If dehydration is not improving after 3 days, then give an appropriate antibiotic. Currently in Zambia, the antibiotic of choice is erythromycin.

If people in the community show signs of cholera it is important to make a report immediately to the nearest health centre for further assistance; keep the patients suspected to be suffering from cholera where they are in order to prevent its spread; and keep the number of people visiting and looking after these patients to the fewest possible. Those caring for people with cholera should not directly handle clothes that have been in contact with faeces and vomit. They should be put into the toilet or buried where there is no toilet, and ashes, bleach or chloride of lime sprinkled on the faeces or vomit. Dirty linen and clothing should be soaked in bleach. Dry the linen in the sun. In communities affected by cholera it is necessary to avoid holding gatherings like weddings, meetings or parties; communal preparation of meals should be avoided; water from unsafe sources must be boiled; and water should be drunk only from protected sources, e.g. from boreholes. People should never shake hands where there is an outbreak, and should wash their hands using safe running water after taking anything to the waste system, before handling food, after visiting the toilet, before handling food, before eating meals, and after handling soiled linen. If a person dies of cholera, avoid touching/washing the body, and bury the deceased the same day. All burials should be supervised by health workers.

INFORMATION SHEET 4C: Malaria

Malaria is a parasitic disease caused by the infection of red blood cells with malaria parasites. It is also an environmental disease, as mosquitoes breed in places where there is stagnant water, open waste, and where people live next to animals. The parasites come into the human body from the bites of the female anophelene mosquito. Malaria is most common during the rainy season, when the temperature and rains are good for the breeding of mosquitoes. Malaria is endemic in Zambia with seasonal and geographical variations. In 2007, 4.3 million cases of malaria (confirmed and unconfirmed) were reported countrywide with 6,149 deaths. The annual malaria incidence was estimated at 358 cases per 1,000 population in 2007, a drop from 412 cases per 1,000 population in 2006 (MOH, 2008). Northern and Eastern provinces had the highest annual incidence of malaria, while the disease was lowest in Lusaka province. Malaria is a serious public health problem in Zambia with the incidence nearly tripling in the past 23 years and case fatality increasing nearly 5-fold (MoH 2009).

Children under 5 and pregnant women are most at risk. The signs of uncomplicated malaria are fever and chills, body weakness, headache, nausea, vomiting, lack of appetite, joint pain and muscle pain. Symptoms of complicated malaria are convulsions, severe anaemia, signs of blood circulation failure (shock) and kidney failure. Pregnant women affected by malaria suffer from low birth weight babies, and malaria can cause brain damage and death.

Malaria can be prevented by killing the mosquitoes that spread it. This can be done by spraying indoor walls with a residual insecticide that is not harmful to health, and by draining stagnant pools to prevent them breeding. Windows and doors can be screened with netting. People should also avoid being outdoors after dark if possible, as malaria mosquitoes usually feed in the early evenings and dawn. And they should cover their arms and legs in the evenings, using local insect repellents, burning insecticide coils, and using nets at night.

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Zambia has several prevention strategies, including use of Insecticide Treated Mosquito Nets (ITNs), Indoor Residual Spraying (IRS); and Intermittent Presumptive Treatment (IPT) with prophylaxis during pregnancy. ITNs are being distributed by the National Malaria Control Programme (NMCP) and all sleeping spaces in all households should be covered by an ITN. The NMCP prioritizes children under five, pregnant women, PLWHIV and the elderly as they are the most vulnerable to malaria. ITNs are effective, easy to use and can last up to 5 years. They offer year round protection.

Household spraying is based on mosquito behaviour. Scientists have observed that, after biting, the female anopheles mosquito rests on a wall for a few hours to digest the blood. By applying a small amount of insecticide to walls and ceilings, the mosquitoes will absorb the chemical once it lands on the wall and will die eventually, thereby preventing it from spreading malaria. IRS is widely used in the urban and peri-urban areas where houses are close together and most are made of brick walls. Household residual spraying is done with an approved and effective insecticide at least annually or during the hot and rainy season when malaria is common.

Pregnant women are more vulnerable to suffering from malaria because during pregnancy the body has a reduced capacity to fight illness. A pregnant woman can have malaria without showing signs and symptoms. It is estimated that malaria is responsible for 20% of deaths of pregnant mothers in Zambia. During antenatal care, Intermittent Presumptive Treatment (IPT) is given to prevent malaria during pregnancy. It should be implemented together with other malaria control measures that are listed earlier.

Mosquitoes breed from stagnant or slow moving water. These could be open wells, empty tins and packs, drainages and pot holes. Communities should fill standing water pools; drain and fill ditches; remove piles of rubbish; introduce living organisms like fish that eat mosquito larvae and put chemicals in the water that kill mosquito larvae (larviciding). Screens can be put on doors, windows and the eaves of buildings particularly households and public places such as schools, health facilities, hotels, restaurants and places of work. This is meant to prevent mosquitoes from entering human dwelling places.

In 2003 Zambia introduced a new malaria treatment policy with the first line therapy being Artemisinin Combination Therapy (ACT). This was due to wide spread resistance to malaria treatment. It is important that any person, especially children and pregnant women diagnosed with malaria should be treated with appropriate antimalarial medicine.

INFORMATION SHEET 4d: Bilharzia

Bilharzia is an infection from a parasite that breeds in fresh-water snails and is spread through faeces or urine from infected persons. The parasite affects the bladder, liver and intestines, and can cause prolonged anaemia and long-term organ damage if not diagnosed and treated early.

A bilharzia snail

Bilharzia is found in most lakes, rivers, streams and dams, especially close to the water's edge. This means that swimming, wading or rafting in bodies of fresh water that are moving slowly or stagnant – such as lakes, ponds or slow-moving rivers, or using unheated fresh water from these sources for bathing – can expose one to the parasite.

Within days of being infected, a person may develop a rash or itchy skin. Fever, chills, cough and muscle aches can begin within 1 or 2 months of infection. Most people have no symptoms at the early phase of infection. For people who are repeatedly infected for many years, the parasite can damage the liver, intestines, lungs and bladder. Treatment with Praziquantel will eliminate the parasite.

4.4 Diseases spread through overcrowded or unsafe housing

Overcrowded housing leads to airborne diseases, which are spread through coughing or sneezing. It can also lead to social problems and diseases relating to them, such as the reproductive health problems discussed in Module 5. Poor ventilation in housing can lead to diseases of the breathing (respiratory) system. For example, having wood fires in a closed room can cause children to suffer from acute respiratory infections, a leading cause of child deaths.

For discussion with a health worker:

- Which social groups live in unsafe housing? Where are they in the community?
- What health problems do they suffer as a result? How can you recognize these diseases?
- What actions are being taken to deal with them? What else could be done?

One of the most common diseases from unsafe and overcrowded housing is tuberculosis (TB). TB affects all age groups, but is most common in very young, very old, ill or malnourished people. TB occurs in people whose immune system, the system that fights disease, has been weakened by poor diet, stress, HIV infection or other illnesses that reduce immunity.

TB is caused by a germ that damages the lungs and other parts of the body. Patients spread TB when they cough or sneeze. People close-by breathe in these germs from the air and can develop TB, especially if their immunity is weak. People who live in overcrowded conditions with poor ventilation are most at risk of infection with TB. As many as 100,000 Zambians have active TB. The number of cases of TB reported each year has more than tripled in the last 10 to 15 years, largely as a result of the HIV epidemic. People with immune deficiency are more likely to suffer from TB disease. Most people infected with TB are not sick and are not infectious to others. One third or more Zambians carry TB bacteria in their bodies, but it is inactive until their immunity is reduced. The TB is not active, and can remain so for life. Only people who are sick with active pulmonary TB (that is, TB of the lungs) are infectious. When they cough, sneeze, spit or even talk they propel TB germs into the air, which can infect other people.

HIV is an infection that weakens a person's immune system. For this reason people who are HIV-positive have a greater chance of being infected with TB. TB is, however, curable even in the presence of HIV. Appropriate treatment of HIV-positive TB patients increases survival time by two years, on average. In Malawi, Uganda, Zambia and Zimbabwe, between 45% and 65% of TB patients are HIV-positive, and TB is increasing owing to the increased risk of active TB in people with HIV.

TB usually affects the lungs but it can spread to other parts of the body. When people are exposed to the TB germs and become infected, they have TB infection but may not show any signs of disease. For this the infection needs to progress to TB disease (called active TB). If TB is left untreated, it can permanently damage a person's health and cause death.

These are signs of TB infection:
- Coughing continuously for two weeks or more, and producing sputum that may have blood in it
- Fever
- Loss of appetite and weight
- A feeling of tiredness all the time
- Difficulty in breathing and chest pains
- Severe sweating during the night

TB in children is more difficult to recognize, but the signs include:
- Weight loss without any obvious explanation
- Two or more episodes of fever without any obvious cause
- Painless swellings of the lymph nodes
- Coughing for more than two weeks

Children may be suspected to have TB if they have been in close contact with someone who has active TB of the lungs, if they themselves have a strongly positive tuberculin skin test, and if they have clinical signs and symptoms.

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To confirm the diagnosis the germ that causes TB is detected in sputum. If this test is negative, a chest X-ray is helpful in diagnosing TB. For children under 10 years of age, a chest X ray is an important procedure for diagnosing TB.

Preventing TB calls for improved housing, avoiding overcrowding, having good ventilation and early detection. People with active TB should also cover their mouth and nose when sneezing, and dispose of sputum very carefully. If possible, children should not sleep in the same room as infected adults.

Untreated, a person with active TB will infect, on average, 10–15 people each year. So, while it is important to treat those with active TB, it is also important to prevent the transmission of the disease to the people they contact. Treatment is by Anti-TB Drugs which include: Isoniazid (H), Rifampicin (R), Ethambutol (E), and Streptomycin (S). Within one or two weeks of starting treatment, people who are sick with TB are generally no longer infectious to others. TB treatment takes 6–8 months and continues after symptoms have disappeared. With such a long period of treatment, a system of Directly Observed Treatment (DOTS) is used so that people can complete the treatment at home, avoiding hospitalization, with relatives, family or community members supervising treatment. Under DOTS, the health worker or a designated instructed observer: -
- administers the anti-TB drugs and observe the patient take them
- records drug intake daily, immediately after each intake
- records patient's identity and address accurately
- educates the patient and his/her relatives on the importance of DOTS for the sake of the patient's own health
- Ensures that treatment defaulters are easily traced. He/she work with community based agents, e.g. community health workers (CHWs) and community based organisations (CBOs) in tracing defaulters.

Treating HIV-positive TB patients is more difficult, as they may react badly to some drugs. In people with HIV infection relatively cheap drugs can be used for the prevention of TB infection.

Further efforts need to be made to ensure that particular groups can access and stay on treatment. Women are often reluctant to seek treatment and care for TB or HIV because
- they have limited access to information about symptoms and treatment;
- they need to get permission from, or be accompanied by, a male member of the family in order to visit a health centre;
- they lack the time because of work and family demands; and
- of stigma, such as that due to TB's links with HIV.

Because TB drugs can lead to side effects like nausea, abdominal and joint pain, orange urine, skin rash and deafness, special effort needs to be made to encourage those on treatment to stay on the treatment. The DOTS helps in this, as do supportive and informed communities.

Making a community action plan for TB

Method: Action planning
Approximate time: Two hours, possibly longer
Resources: slips of paper, big flipchart sheets, scissors, pens. Invite a health worker, such as an environmental health officer, to the discussion

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Procedure:

1. Have a look at the information on TB in this module. Better still, invite a health worker (such as an environmental health officer) to discuss the problem of TB, how it spreads and how it is prevented and managed in the community. Use leaflets from the Ministry of Health to provide further information.
2. Get the participants to work in two groups. Later you can compare and combine the information from the two groups.
3. The groups will brainstorm all the steps that need to be taken to solve the TB problem in their community – by everyone from individuals/households to government.
4. The groups will write each solution on a strip of paper.
5. Sort these into piles according to who needs to take the action.
6. Write the name of the 'doer' on each paper, e.g. Health worker, family member, local council, etc.
7. Lay them out on the ground in chronological order – i.e. what must come first, second, third, etc. If two things can happen at once, put the papers next to each other.
8. Look at the ones that say what the health services should do. Discuss these with the health worker.
9. Take all the community-level papers and use them to make an action plan, using this table:

Action needed	Who is responsible?	By when	Expected result	Support needed

Remember to think about what you and others can practically do; if something is impossible, see what measures can be done.

If your literacy session covered healthy environments, remember to save time to go back on all the issues you discussed in the session to draw up your community plan on what communities can do to improve environments. These actions may include, for example, surveying their own environments, identifying problems in the environment, as well actions and organisation to promote improvements. Remember to encourage co-operation with the wide range of officials and sectors who are responsible for environments.

In summary:

In this module we have
- Used a variety of participatory ways of finding out and discussing the health risks in our environment and what we can do about them at local level
- Looked at what happens when water is privatized
- Discussed diseases that can arise from unhealthy environments like diarrhoea, cholera, malaria, and tuberculosis, and learned what we can do about them
- Explored how to develop a community action plan to improve environmental health

COMMUNITY PLAN

What will we do next?

At the end of your health literacy session discuss with community members what actions will be taken before the next session
- How will participants give feedback to others in the community on what they learned and decided at this meeting?
- What actions can participants take and report back on before the next session?
- Who will lead these actions? Who else will be involved to help?
- What will be the role of the health workers and the local council?
- What information or report-back will participants bring to the next meeting?

Ask the community members what else they want to know:
- Identify the topics that people want to know about in the next session.
- Are there issues that communities want to know about or to bring to the district attention?

Remember to plan your next session.

FACILITATOR'S PLAN

What topics will you implement in the next health literacy session?

What do communities want to hear about next?
- What new topics did the communities want to discuss at the next session?
- Which module(s) in the manual deal with these? How will you use them?
- Where and who else can you get information from?

What else do you want to include in the session?

- What other topics will you include in the next session?
- Which module(s) in the manual deal with these? How will you use them?
- What other information will you use and who else can you bring?

Module 5: Healthy life cycles

In this module we:
- discuss how we understand health at different stages in a person's life
- identify the changing health needs and priorities at different stages of a person's life
- identify community action in meeting those health needs

5.1 What do we mean by healthy life cycles?

The life cycle provides a powerful framework for understanding the vulnerabilities and opportunities in ensuring health from childbirth to old age and death. Human development is not a uniform process: critical periods exist during the life cycle. Health problems that occur during one period can affect later periods, or even the next generation. These periods also provide windows of opportunity to intervene to promote health.

If we think about promoting health at each step of the life cycle, we can:
- become aware of how health can be improved at all stages of life, giving attention to the different factors that affect health at the different stages;
- develop health at later ages on the improvements that we make in earlier ages;
- ensure that we have consistent promotion of health at all stages of life;
- prioritize interventions to improve health where they have an immediate and long-term effect.

While these stages are affected by health sector interventions, as we discussed earlier, many other social and economic factors affect health at each stage of life. Culture, traditions and norms for example, affect how people communicate, understand, and respond to health risks, information and services at different stages of life. The ability of health workers to understand and address these issues contributes to the effectiveness of health services. Healthcare professionals often have their own culture and language. Many adopt the "culture of medicine" and the language of their specialty as a result of their training and work environment. This can affect how health professionals communicate with the public.

The figure on the right shows the key stages in the life cycle, starting with birth and infancy, and the pre-school years, moving through the school-age years, adolescence, early adulthood and the reproductive years and periods of pregnancy in the case of women, and late adulthood, leading to old age.

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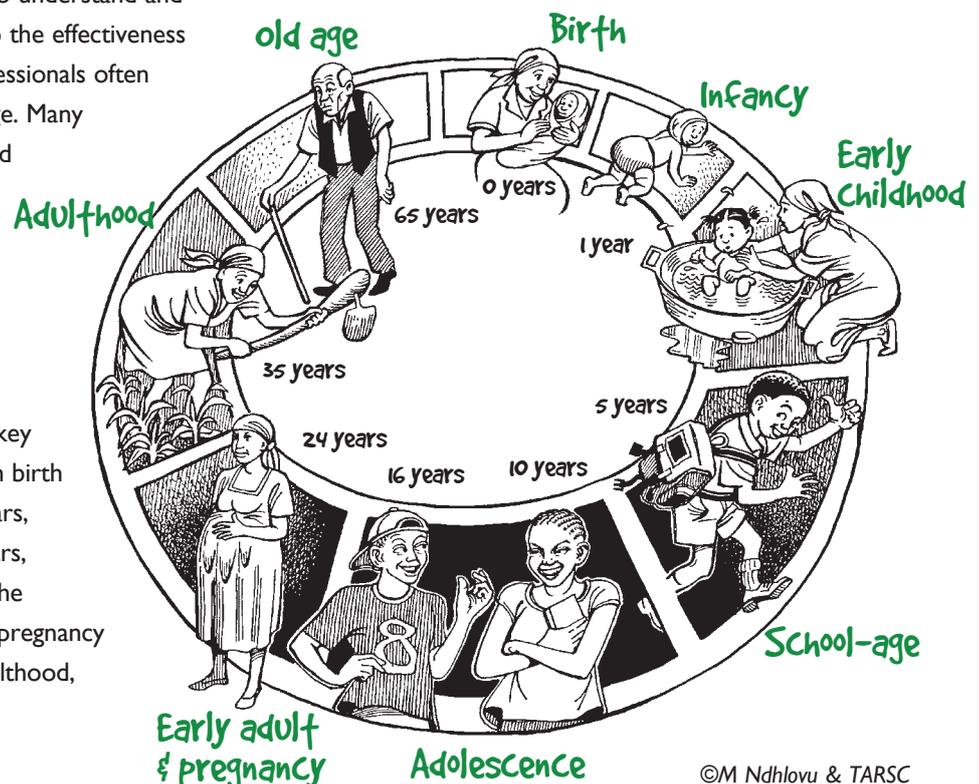
What affects our health at different times of our lives?

Method: Life-cycle mapping

Approximate time: 2 hours

Resources: Large cotton sheet or paper (about two square metres or the size of a single bedsheet) with the life-cycle map copied on to it. You will also need Stiki-Stuf™ or pins, marker pens, small pieces of paper in 3 different colours (or you can use three different coloured markers).

It's worth spending some time on both Part One and Part Two of this activity since understanding the different stages in a life cycle is the foundation of understanding how we can promote good health throughout a person's life. We will refer back to the life cycle map often during this module, so keep it somewhere where people can see it.

Procedure:

Stick the large sheet of the life-cycle map on to a wall, or place it on the floor so that everyone in the group can see it. Lead a short discussion on what people think the life-cycle map represents and how it can be used to explore the opportunities and vulnerabilities in ensuring health during the different stages in a person's life. Draw out examples of how health needs differ at different stages.

PART ONE

1. Divide participants into eight groups, each group taking one section of the life cycle from Childbirth to Old Age. Give each group a pile of small pieces of paper, preferably in three different colours. Otherwise, give them three different-coloured marker pens. Ask them to discuss their section of the cycle in relation to three questions. Note which colour to use for each question and tell each group to write its responses on a piece of paper using the agreed colour code, one response per card. The questions are:
   - What do people at this stage of their life cycle need to promote good health?
   - What can we do to prevent and manage ill health at this stage of their life cycle?

2. Give the groups enough time to discuss: about 30 minutes. When they are finished, ask each group to come up to the large sheet and either pin or stick their papers on the map in the relevant section.

3. Look at the map together and comment on these questions:
   - What are the most common things people need to promote good health across the different stages in the life cycle? What about common strategies for preventing and managing ill health?
   - Are there also many differences? If so, why is that the case?

End by pointing out that the information they have pinned on to the large life cycle map will help in identifying priority interventions and actions for health.
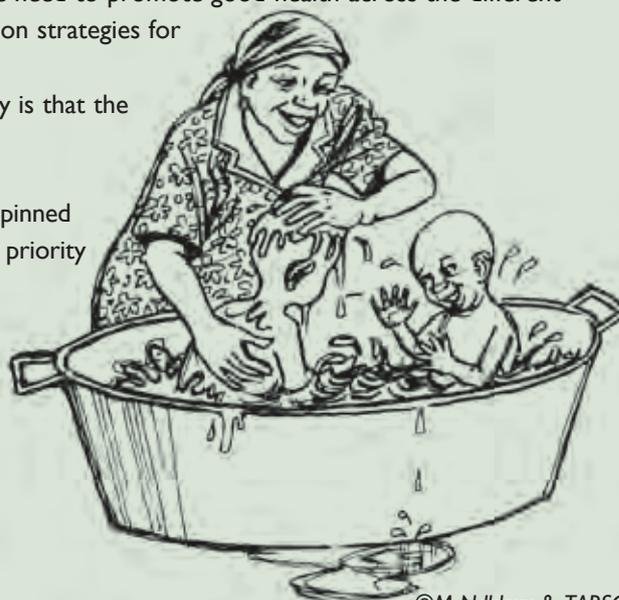
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1. Participants go back into their same groups. This time they must identify a single priority intervention – an action that they think is critical at this stage of the life cycle to promote health and prevent ill health. For example, if the group identified good nutrition as the key to maintaining good health during infancy, then they will work on an activity that ensures that the nutritional needs of 1–5-year-olds in their community are met.

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2. Let the groups work on their strategies for as long as they need (about 30 minutes) and then bring them back together again to discuss briefly the range of interventions discussed in each group.

3. Finally, discuss how an intervention at one stage in the life cycle affects later stages.

In this module we will explore some of the life-cycle stages to see what health issues arise and what we can do to promote health. You may identify others that are more important to your community. You can use the methods for some of the life-cycle stages we discuss to explore these, and you can bring in health workers or local organizations that support these groups as additional sources of information.

5.2 Protecting newborn babies

The birth of a baby is an exciting time. It is the beginning of a new life and the continuation of a family. Its also a time when the new person is very vulnerable.

Mortality in newborn babies

Young babies may die at birth or in the first month of life. The common cause of newborn deaths is prematurity or low birth weight; asphyxia (inability to breath at birth) and infections. There are several reasons that contribute to newborn deaths namely:

- Poor health of mothers for various reasons including poor child spacing
- Mothers not accessing or using antenatal care to identify complications early
- Poor nutrition during pregnancy
- Poor hygiene practices during delivery
- Poor newborn care at birth and in the first week of life, including ensuring breathing is started, starting breastfeeding in the first hour of life, drying the skin and keeping the baby warm and keeping the umbilical stump clean.

Children who have a birth weight below 2.5kg are at risk of illness and death. As discussed in Module 3, among the babies for whom birth weight information was obtained in the survey, 9 percent had a low birth weight (less than 2.5 kg). According to WHO (2012) the major causes of neonatal death in Zambia are pneumonia (14% deaths); malaria (13%); pre term delivery (11%) and HIV (10%) (WHO 2012).

Looking at the information given above, discuss (with a health worker present)
- What do you think are the causes of the causes of the deaths in these babies?
- What could have been done to prevent them?

Typically, the chances of dying in early childhood are much higher when children are born to mothers who are too young or too old, when children are born with less than a two-year birth interval, and when they are high-birth order children. Very young mothers may experience difficult pregnancies and deliveries because of their physical immaturity. Older women may also experience age related problems during pregnancy and delivery. A mother is considered to be too young if she is less than 18 years at the time of delivery. A short birth interval is a birth occurring within 24 months of a previous birth (UNZA, MoH, CSO Macro, 2007). Spacing children at least 36 months apart reduces risk of infant death. In Zambia, the average birth interval is 34 months. Infants born less than 2 years after a previous birth have particularly high infant mortality rates (129 deaths per 1,000 live births compared with 50 deaths per 1,000 live births for infants born 3 years after the previous birth). About one in seven infants in Zambia is born less than 2 years after a previous birth.

What infections do babies suffer from in their first year of life?

Method: Ranking and scoring
Approximate time: 30 minutes
Resources: Small pieces of paper, marker pens
Procedure:
1. If necessary, first divide the participants into small groups, and then get each group to make a list of all the possible illnesses that babies can get during the first year of their lives.
2. They should write each illness on a separate piece of paper and then, using the floor or a large table, work together to rank which illnesses are the most common in their community. They should move the pieces of paper around so that the most common illnesses are at the top and the least common are at the bottom of a "list".

If there was more than one group, compare the lists of the different groups.

We have already discussed some of these diseases in Modules 3 and 4. Can you think of some now? For example, malaria, diarrhoea and pneumonia can all cause children to die in their first year of life. Yet they can all be prevented by breastfeeding, improved nutrition, safe environments and care from adults.

Let's have a look at meningitis, for example. Infection of the blood or septicaemia is one cause of meningitis. Many newborns die of septicaemia and not all of them suffer from meningitis. Meningitis is an infection of the membranes that surround the brain and spinal cord. It is caused by bacteria or viruses. Bacterial meningitis is a rare but sometimes fatal disease, especially in infants and the elderly. Viral meningitis is rarely fatal in individuals with a healthy immune system. It is frequently not diagnosed because it is thought to be the flu (influenza). Individuals infected with viral meningitis usually recover without specific treatment within 7 to 10 days. However, meningitis can be very dangerous to small babies as their bodies are not as able to fight disease.

Meningitis in newborns and infants shows symptoms of fever, irritability and neck stiffness, but these may be hard to detect. Other signs in babies might be inactivity, irritability, vomiting and poor feeding.

stiff neck

back bent back, knees forward

soft spot bulges up (babies under 1 year)

fever

drowsy, sleepy, fits or jerks

sometimes vomiting

Symptoms get worse and worse until the child loses consciousness
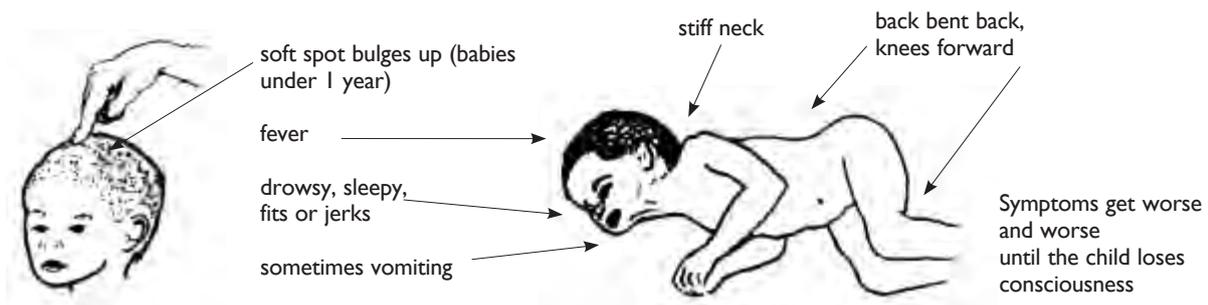
Signs of meningitis Source: http://www.dinf.ne.jp

Good personal hygiene reduces the risk of getting meningitis from an infected person: avoid sharing food, utensils, glasses and other objects with an infected person. People are advised to wash their hands often with soap and rinse them under running water. It is crucial to fight cases of bacterial meningitis quickly. If a child is diagnosed with (or strongly suspected to have) bacterial meningitis, he or she will be hospitalized and closely monitored, and doctors will start intravenous antibiotics as soon as possible. This means that people caring for infants should know the signs of the disease and be able to take a child to the nearest health facility or hospital as soon as possible if they are showing the signs..

For reflection or discussion:

Looking at the information given above on meningitis, discuss (with a health worker present in case you need information)
- How common is meningitis in your community?
- Why do you think babies and the elderly are more at risk of the disease?
- What do you think should be done if a baby shows signs of meningitis?

Discuss the same questions about other conditions that affect newborns in your area.

One of the biggest threats to newborn babies' health is HIV infection. Infants born to HIV-infected mothers in Zambia have a higher risk of dying compared to infants born to mothers who don't have HIV infection. We can reduce this by reducing mother-to-child transmission of HIV through antiretroviral therapy (ART), such as nevaripine, giving appropriate advice on breastfeeding, and providing cotrimoxazole prophylaxis and ART to children. ART is found at central and provincial hospitals, mission hospitals, and is prescribed by private practitioners. Some large employers may also provide it through their health services.

5.3 Health in the first year of life

One of the most important contributors to infants' health is the awareness and caring from their parents (mother and father), care-givers and grandparents. This relates not only to how quickly they can identify illness and respond to it but also to how they can prevent harm to their own health – and, even more importantly, how they stimulate and play with their infants. The development in this first year of life is important for the rest of a person's life, and the extent to which babies are stimulated and cared for affects the rest of their lives.

Method: Sipiwe's story

Approximate time: 40 minutes

Resources: 12 small pictures, on an A4 page shown on page 79.

Source: With thanks to Masithethe Project, Early Learning Resource Unit, South Africa, for permission to adapt their poster Sipiwe's story, for use in this manual.

Procedure:

Show the series of pictures on the next page to the group. Lead a discussion on what participants think Sipiwe's story is about. Use some or all of the following questions to help the discussion:

- What do you see happening in this story?
- Why do you think Sipiwe's baby got sick? (For each reason you think of, ask, "But why did this happen?" to get to the causes of the causes.)
- Do you think there was anything that Sipiwe could have done to change what happened?
- Sipiwe's life was hard but she also loved her child. What did she do to try to help her baby grow well?
- What resources and support did Sipiwe have in caring for her child? What additional support do you think she needed?
- How does this story reflect what's happening in your community?
- What support do parents in your community get in addressing the needs of babies and infants … at household level? … at community level? How can this be improved?

Additional activity: Cut out the 12 pictures and give a set to each group. Ask them to put the pictures into three piles: actions that promote good health in infants, actions that inhibit good health, and those actions that are neutral. Discuss what you've learned in the process.

Zambia has continued to experience high levels of under 5 year mortality in the past 5 years. In 2008, UNICEF rated Zambia as 14th out of 195 countries, in terms of high levels of Under 5 Mortality. Nevertheless, child mortality fell from 2002 to 2007, with rural: urban differences closing to almost parity with a marked improvement in rural child mortality (UNZA et al 2011). Currently one in every nine children in Zambia dies before his or her first birthday. The infant mortality rate for the five years before the 2007 Zambia Demographic Health Survey (2002 – 2007) was 70 deaths per 1,000 live births, as compared to 95 deaths per 1 000 live births in the period 1998-2002 (UNZA, MoH, CSO, ICFMacro 2007).

One of the most important measures that the health system and communities can take is to ensure that infants and children are immunized. Immunization protects children (and adults) against harmful infections. Nine potentially fatal diseases can be prevented by routine childhood immunization – against diphtheria, tetanus, pertussis (whooping cough), poliomyelitis (polio), measles, mumps, rubella, Haemophilus influenza type b (Hib) and hepatitis B. Immunization is given as an injection or, in the case of the polio vaccine, taken as drops by mouth. People are immunized at different ages throughout their lifetime – largely, though, between birth and 5 years of age.

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The schedule for Zambia is shown in the table below. Public and private health facilities throughout the country provide immunization and treatment services to avert the causes of illness and death in children.

Zambia Recommended Schedule for Childhood Immunization

Vaccine	Minimum Age at First Dose	Number of Doses	Minimum Interval between Doses
BCG	Birth	1	-
Polio (OPV-0)	Birth-13 days	1	-
Polio (OPV-1,2,3)	6 weeks	3	4 weeks
DPT-HepB-Hib (DPT-HepB-Hib-1,2,3)	6 weeks	3	4 weeks
Measles = OPV-4 if OPV-0 was missed	9 months	1	-
Rotavirus	6 weeks	2	4 weeks

Source: MOH 2009

Complementing the immunization program are interventions for three common childhood diseases:- Acute Respiratory Infection (ARI), fever (resulting mainly from malaria), and diarrhoea.

Disease	Treatment	Prevention
Diarrhoea.	Oral Rehydration Therapy (including increased fluids)	Hygienic sanitary practices and awareness creation on appropriate manner of disposing children's faecal matter
Malaria (Fever)	Antimalarial drugs	IRS, ITN
Acute Respiratory Infection (ARI)	Antibiotics	

For reflection or discussion:

Discuss the information given above on immunization
- What percentage of children in your community are immunized? Who does not get immunized? Why?
- What can your community do to promote child immunisation?

Go to other modules where there is information on newborn babies and infants. For example:
- The advantages of breastfeeding in Module 3.
- The way to manage diarrhoea using an oral rehydration solution in Module 4.

Now let's move further along on the life cycle to childhood.

5.4 Protecting children's health

A share of children who survive the first year of life do not live to their fifth birthday owing to malaria, malnutrition, intestinal infections, or pneumonia. These conditions are made worse by HIV and AIDS, malnutrition and tuberculosis. A number of organisations in Zambia support child health, including Zambia Civic Education Association (ZCEA) which promotes child rights, SOS children's village for orphans and Zambia Open Community Schools (ZOCS) which provide community open schools for under-privileged children, especially in rural areas.

We often look at the health of children between 1 and 5 years of age differently from that of children aged between 6 and 16. This is because the younger age groups are usually still at home, while the older ones go to school.

What differences do you think that going to classes at a school makes to children's health and their health risks?

You can do the exercises below for either of the two age groups or for both together

What affects children's health?

Methods: Body mapping, Broadcasting Game, and action planning
Approximate time: 90 minutes
Resources: Flipchart paper, marker pens, maize cobs or something of a similar size and shape, chair or table to stand on.

ONE: Body mapping (30 minutes)

Procedure:

1. Participants work in small groups, taking two sheets of flipchart paper each. On one, ask them to draw a healthy child (between 1 and 5 or between 6 and 16 years of age) in their community – putting labels or pictures to show both the healthy things about the child, and what contributes to why he or she is healthy. Then get them to do the same for an unhealthy child. We will call these "body maps".
2. Get the groups to display their pictures. Ask questions, and note differences between them. Use the pictures to probe. Possible questions to ask include:
    *   Look at the body map of the healthy child. What do you think are the reasons why this child is healthy? Are there causes behind the causes that explain this child's good health?
    *   Now look at the body map of the unhealthy child. Why do you think this child is unhealthy? Are there causes behind the causes that explain this child's ill health?
    *   What can community members and institutions do to promote good health?
    *   What support does the child and his or her family need when the child is ill? From whom?

Two: Broadcasting game and follow-up discussion

Timing: 60 minutes: 20 minutes to play the game, the remainder for discussion and developing action plans

This activity can be done with children, with adults, or with both together. The objective is to get some clear ideas on what children and/or adults think are the priority areas for action in supporting children's health needs. It may help to have the life cycle map easily available so that participants can refer to it while they are thinking about their message.

1. Before using this activity, ask participants to bring a maize cob each, or empty soda bottle or anything else that can be used as a "microphone" and also to think about an important message that they would like to communicate about a specified or unspecified child-health issue. They will be broadcasting to the community or to the country.

2. Participants (children and/or adults) sit in a circle, with a chair or table somewhere in the circle but looking like a special place. One by one, they stand on the chair or table, using their microphone, and broadcast their important message to the community/nation. (This part of the activity shouldn't take much longer than 20 minutes, depending on the size of the group. If the group is very large, let them work in threes to give one combined message.)

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3. One child, or adult, can write down the messages on a piece of flipchart paper for follow-up discussion and action.

4. Review the list of messages from the broadcasting game. See whether they can be clustered around the following topics:
   - Specific illnesses in children and their causes
   - Prevention of disease in children
   - Promotion of good health in children
   - Strengthening of child and community relations with health services

5. After clustering the messages, divide participants into four groups, each group taking the list from the 4 topics (and others) discussed above.

6. Ask each group to develop a plan of action dealing with at least one of the issues brought up during the broadcasting game. Don't forget to refer to Modules 3 and 4 for more information on the diseases discussed.

7. The groups can report back to the larger plenary. Decisions should be noted.

Note: these messages could also be put together as a letter (with the relevant children's and/or adults' signatures) and sent to whichever influential person or institution they choose.

Early childhood centres provide a good place to reach children below 5 years of age, while schools play an important role in the health of children aged 6–16. Like younger children, the health of school-age children is affected by their diet, nutrition and environment, but this age group can also be affected by sexual and reproductive health issues, and by the use of hazardous products such as alcohol, drugs and tobacco. Children are in a social environment at this age, and their lives, bodies and social interaction changes rapidly.

How we can take health to where children are?

Method: Social map (revisited) and group discussion

Approximate time: 45 minutes

Resources: Your community social map, Information Sheet 5a, flipchart paper and marker pens

Procedure:

1. Refer back to your community social map. Make a note where children (both the 1–5 and 6–16 age groups) can be found on the map, e.g. at school, at the playground or sports field, at the clinic, etc. Ask: Is there a difference between where you would find girls and boys, especially in the older age group? If the answer is yes, discuss why.

2. Start by looking at schools. Ask: How are the health needs of children being met in a school setting?

3. Distribute copies of the Information Sheet below on Health in Schools. If necessary, divide participants into smaller groups to discuss the following questions:

   • Which of the health services exist in the schools in your community.
   • Which health needs are not being met and why?
   • What can communities do to improve health services in your schools?

   Bring participants back to plenary (if they worked in small groups) and ask for a summary of what they discussed. Focus mostly on the third question about what actions they can do to improve health in the schools.

4. Choose two more important settings and again get participants to discuss how children's health needs can be met.

5. End this session by asking: Why do you think it's important to take health care to where children are?

MCH outreach clinic, Makululu compound, Kabwe © R Zulu, 2011

INFORMATION SHEET 5a: Health in schools

With the involvement of parents, schools can significantly influence health behaviour and promote healthy choices in young people. School-based programmes support children in resisting negative influences and reinforce positive health behaviour. Although some risk factors are far beyond a school's control, others can be addressed directly and effectively through health education supported by collaborative efforts from parents, the school and the community.

For example, schools can:

- Promote health literacy.
- Develop positive health attitudes and behaviour through a wide range of learning styles, activities and teaching strategies to develop knowledge, skills, attitudes and behaviour for health.
- Provide physical education, exercise facilities and activities, promote healthy diets and provide school lunches.
- Provide school health checks, and health, psychological and counselling services.
- Ensure a safe and healthy school environment.
- Promote positive life skills in the youth through the involvement of staff, parents and the community.

Schools can also promote healthy behaviour and life skills, working with the community, and provide counselling. Schools are also a front line for emergencies, and all schools should have a first-aid box. A School Health Programme should identify and deal with a child's physical, psychological and emotional problems, and provide regular medical and environmental check-ups. The school health appraisal should involve health services, teachers, parents and the pupils.

Zambia has a comprehensive school health program implemented by Ministry of Health in partnership with Ministry of Education. Science and Vocational Training and Early Child Development. It starts with a school health record for each individual at enrolment. Pupils are required to provide copies of under five health cards for their immunisation record. Parents are also required to fill in special school health forms on their children's previous health complications, allergies and other conditions. The school health program aims at improving learning amongst children attending basic education through integrated health and nutrition interventions, in collaboration with the community and inter-sectoral partners. Activities in the school health program include

i.   school de-worming and general health and growth monitoring programme
ii.   physical examination
iii.   school environment, water and sanitation health inspection
iv.   general medical inspection
v.   dental checks, immunisation.
vi.   feeding programmes in some schools, including provision of micronutrient supplements to eligible learners
viii. health and nutrition education

In schools where school health programme has been implemented at intensive level, there is report of increased enrolments and improved daily class attendance; improved pupil performance and support for vulnerable children.

Source: LDHMT School Health Coordinator's Report, Lusaka

One challenge is how to reach the increasing numbers of children and young people who are not attending schools who do not access these services, and to explore – with them – what their health issues are and how they can best be addressed. Since some children do not report for classes because of hunger, for example, the School health programme offers nutritious food, which the pupils receive in their schools.

Empowering children means protecting them with services and adult support. It also means working with youth and children in a participatory way, so that they, too, can take some control over what affects their health. Doing this does not mean that adults are not responsible for children, or that children are blamed when things go wrong. Adults have an obligation to protect children, to make sure that no harm comes to them through their environment or behaviour. However, children can also play a role themselves.

There are a wide range of activities, strategies and youth-focused participatory materials that can be used to develop positive health attitudes in children and young people, and these can be adapted for any topic or issue. The activity below, adapted from a book called *Choices* by Gill Gordon, allows you to explore with children and young people how they want to go about making positive changes to their health. Doing it like a quiz or game makes it fun to do.

Working with young people to promote their role in health

Method: Snakes and ladders

Approximate time: As long as you enjoy playing!

Resources: Snakes and Ladders board for each group. Copy the one given overleaf on to a piece of flipchart paper, but get participants to complete the board before starting to play the game (see instructions below); a pair of dice, one per group; counters (e.g. pieces of paper), one per person.

Procedure:

This activity is as much fun to do with adults as it is to do with children.

1. Divide participants up into small groups of no more than 5 people according to age (for example: 6–10 years, 11–13 years, and 14–16 years and older). If there are children there under the age of 5, get their caretakers to take a lead in the game and let them decide on what goals they want to achieve for the under-5s.

2. Show them the snakes and ladders game. The idea of the game is to move through the squares from square no. 1 to square no. 75. using dice to determine how many squares they can move forward. If their counter lands on a ladder, they can climb up to a higher square; if their counter lands on the head of a snake, they have to slide down to a lower square. The person who gets to the end first is the winner.

3. Point out that, before they can play, they need to fill in the missing information as follows:
   • In the bottom right-hand square they need to decide what health action they want to get involved in. This could be a hope (e.g. wanting to improve communication between health workers and youth), a challenge (e.g. increasing attendance at antenatal clinics) or a specific activity (e.g. starting a preschool for working mothers). Make sure that the action is clearly defined, realistic and achievable.
   • In the top left-hand square they again write their health action down, followed by the words, 'a reality'.
   • On every ladder, the group should write down something that will help them achieve their shared goal. On each snake, they should put a barrier to reaching their goal.

   Let participants spend some time completing their gameboard. When they are finished, let them play!

4. Before the end of the session, ask all the groups to show their boards to each other. Compare the goals they each defined and the different ways they filled in their snakes and ladders (opportunities and barriers). End by asking everyone what they learnt from this game about how children promote their own health.
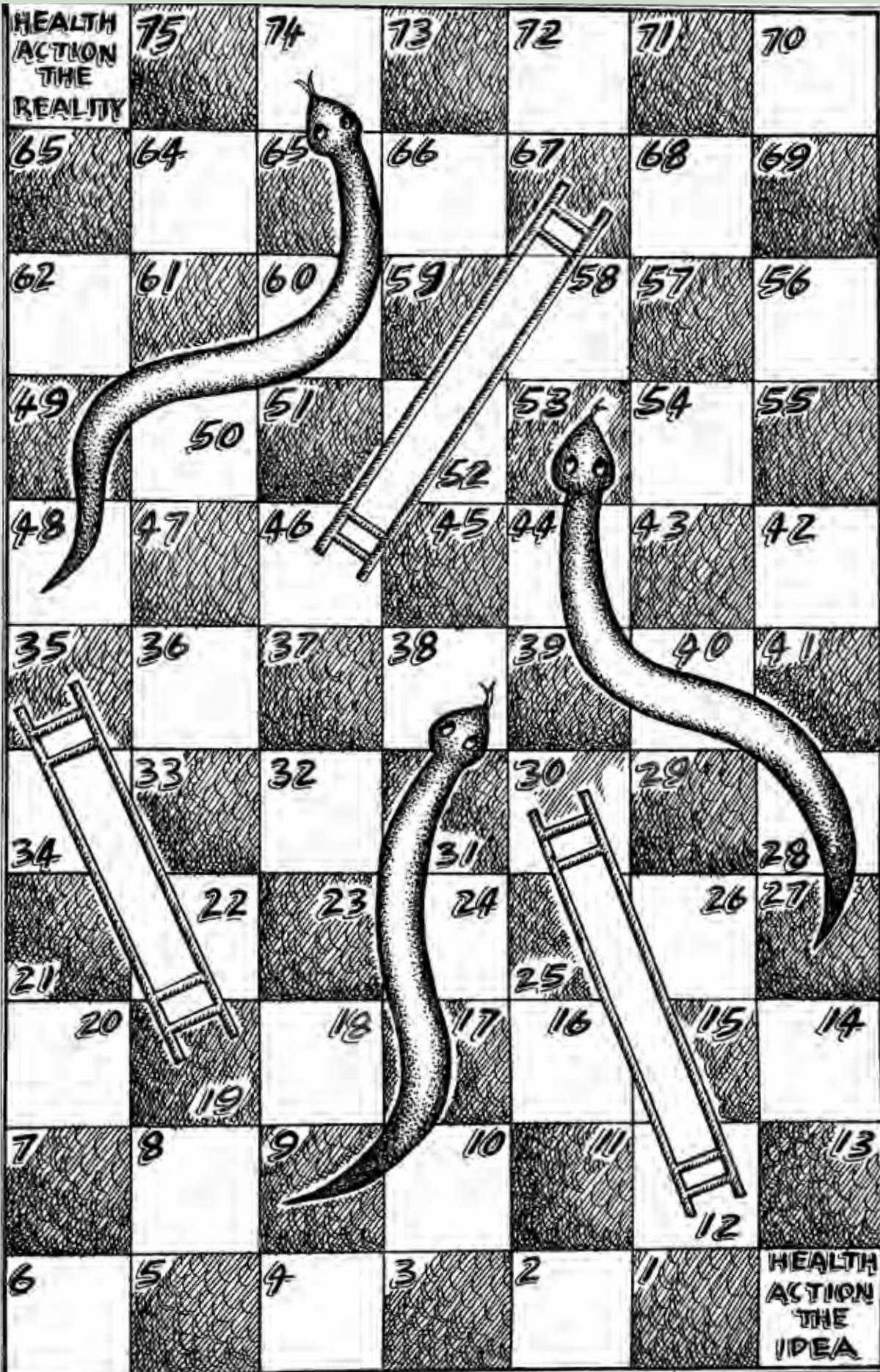
Source: Gordon 1999

Some children have even greater needs. In 2005, Zambia was estimated to have had 710,000 children under the age of 17 who had been orphaned by the death of one or both parents due to AIDS (MoH 2009). About 130,000 children were infected with HIV in 2005. There are many other children living in difficult circumstances, including children living in poverty, homeless children and children with disabilities. A number of non government organizations are providing interventions to support the shelter, nutrition, education, emotional and life skills needs of such children.

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For reflection or discussion:

Look at the general health needs you have identified for children. You can also refer to the life-cycle map you completed at the start of this module. Then discuss:

- Who are the most vulnerable children in your community?
- How do their health needs compare with those you have identified generally?
- What can be done to deal with their additional needs?
- What can be done to make sure that they access the services available?
- How can the community promote the health of these children?

5.5 Adolescent health – great opportunity and new risks

Everything we have discussed above for children is also true for adolescents aged 12 to 18, but new issues now affect their lives. Adolescents have increasing control over their lives, so one of the most important health actions is to understand – and inform – the way this age group sees their health, and the actions they can take to promote health. Adolescence can be broken down into two phases, an early phase from 12 to 15, and a more mature adolescence from 16 to 19 years of age.

Do adolescents see their health in the same way as adults do?

Method: Comparative surveys and ranking

Approximate time: 2–3 hours. Your survey: 30–40 minutes; youth survey: 60 minutes or more since you'll need to do an introductory exercise; final analysis: 30 minutes

Resources: Pieces of paper and marker pens, flipchart paper. Easy reference to your life-cycle map. You will also need to arrange to meet a group of youths to do this survey with. This tool has been adapted from *Training for Transformation Book 1* by Anne Hope and Sally Timmel (2001)

Procedure:

Your survey

1. Decide which group of adolescents you want to work with for this activity – Youth at school? Youth who have lost one or both parents? Youth at your church?

2. Then, still in plenary, brainstorm your ideas on the health needs and concerns of this defined group of young people in your community.

3. Divide participants into groups of 5–6 people and ask them to list these perceived health needs in the order that they think youth would prioritize them, from the most important to the least.

4. Put all the groups' lists up on the wall and, through discussion, try to arrive at a ranking that everyone agrees with. This should take about 20–30 minutes. Write this list down.

Youth survey

You could do this part of the activity between sessions and then report on the youth's findings the next time you meet. Alternatively, if a survey has been done recently, you could look at these results instead of meeting the youth face to face. Invite or visit a group of teenagers from the same social group that you identified (for example, school-going youth) and ask them to go through the same process in identifying and then ranking their health needs.

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Comparative analysis

1. You are now going to compare the two rankings – those done by adults on behalf of the adolescents and those done by the adolescents themselves. For each item that is the same, count how many points your answer is from the ranking the youth gave, and that is your score. It makes no difference whether you were below or above the correct answer; the distance is what counts. If you did not include the item at all, give yourself 5 points.

For example:

Health priority:	Your answer	Their answer	Your score
x	4	1	3
y	7	5	2
z	1	3	2
not mentioned	-	2	5

2. Add up your score. The **lower** your score, the more you understand the concerns and priorities of the adolescents.

3. Finally discuss in plenary what you learnt from doing this. In particular:
   - Where were the greatest differences between the perceived needs of the youth and of the adults? Why do you think this is the case?
   - What do you think that adults, working with the youth, can do about closing the gap? What role can the youth play in this process?

Note: If you met with the youth, make sure you either include them in this final discussion or get back to them with the results so they can also have some input into this survey.

The health issues you may have found to be important include those that are due to the changes in adolescent social roles, to changes in their bodies, or to other factors in their lives. Adolescents begin to take on new responsibilities and roles, some of which can incur risks as they begin to experiment with adult life.

This demanding emotional and physical phase is associated with behaviour that carries health risks, such as:

- Alcohol and substance abuse;
- Unprotected sex, sexual abuse and rape and unwanted pregnancy;
- Physical, sexual or emotional abuse (as a victim or as a perpetrator);
- Reckless driving or excessive risk-taking;
- Extreme eating habits; and.
- Excessive influence from advertising and the media.

Let's explore some of these further to see what actions we can take. Some of the information you need on this is provided here. You can obtain further information from local health workers.

How can we promote reproductive health in adolescents?

Method: Stop drama

Approximate time: About 2 hours, depending on how many dramas you work on

Resources: Flipchart paper and marker pens, WHO definition of reproductive health written on flipchart paper, copies of information sheets 5b and 5c.

Procedure:

1. Brainstorm the meaning of reproductive health and what it covers. After eliciting ideas from participants, show participants the WHO definition which is as follows:

   Reproductive health is defined by WHO as a state of physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this are the right of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and the right to appropriate health-care services that enable women to safely go through pregnancy and childbirth.

   Briefly compare this definition with the one generated by the group.

2. Explain that there are different kinds of barriers that prevent reproductive health in adolescents. Elicit or explain these, as shown below, and ask for other examples of each kind of barrier so that everyone is clear about what they mean.

   - Personal barriers, e.g. not being able to talk about sex or contraception with your partner.
   - Socio-cultural barriers, e.g. "good" girls are expected to be ignorant about sex, or the idea that a woman is not really respected unless she has a child, or the idea that a "real" man should have a number of sexual partners.
   - Environmental barriers, like inadequate numbers of staff for clinics, lack of policies to protect women against sexual violence.

3. Ask participants to break into three groups and assign one type of barrier – personal, socio-cultural or environmental – to each group.

4. Explain the task the groups must do: (a) make a list of the barriers that prevent people getting their full reproductive health rights; (b) develop a role play that shows some of the barriers you identified – and what causes them. The dramas should not take more than 5 minutes to perform.

5. Bring the groups back together to present their dramas. After each drama, let the group as a whole identify the barriers and underlying causes. The facilitator should write these down on a piece of flipchart paper.

6. After all the groups have presented their drama, introduce the concept of a STOP DRAMA. This is a process that allows participants to look at strategies for addressing the issues raised. (NOTE: there may only be enough time to do a stop drama with one or two of the dramas, so ask participants to choose which one(s) they would like to work on.)

A stop drama works in the following way:

- Participants reconvene in their groups for 10 minutes to develop concrete strategies for addressing the situation reflected in one of the dramas (this step is optional).

Youth using Auntie Stella   *Source: CWGH*

- Then the original group presents their drama again. During their performance any member of the audience who wants to intervene and become a character in the drama can do so by clapping his or her hands to stop the action. The new actor takes the place of someone in the drama or becomes a new character. The action then resumes.
- If someone feels that any response or action in the drama is unrealistic, he or she calls out "stop". This stops the drama and the person intervening must enter the scene and replay it in a more realistic manner.

7. At the end of the drama, discuss the following questions about the action(s) each one portrayed.

- Which of these actions can we take up with our own community resources?
- What steps do we need to take to implement these actions? Who do we need to help implement them?
- How can our health services help us?
- What other institutions or organizations can help us?

During this discussion refer to the information sheets below as appropriate, and to other sources from health workers to help with the planning process.

There are a number of important participatory tools available to health literacy workers to promote the reproductive health of youth. One of these tools is called 'Auntie Stella: Teenagers talk about sex, life and relationships'. 'Auntie Stella' is an interactive pack based on letters written to an 'agony aunt' (see www.tarsc. org or www.auntiestella.org). The pack is available in English, Shona, Ndebele, Chichewa, Portuguese and Swahili.

Zambia launched its National Youth Policy in 1994 to promote the welfare of youth and safeguard their rights. The policy seeks to improve the quality of life of youth, through environments that are conducive to their social, cultural, spiritual, political, economic and human development. For example the policy includes a focus on interventions to tackle youth unemployment through the promotion of self-employment enterprises and income generating ventures; and efforts to draw private sector, non state institutions, communities and individuals in support of youth programmes. This policy is implemented as a co-operation of many Ministries and organisations. The health services needed by adolescents are provided in the form of a package of "Adolescent Friendly Health Services (AFHS)". These services, while they aim to support the special needs of adolescents through adolescent friendly health facilities, face problems of inadequate resources and are too few.

The reproductive cycle in women – what really happens in those 28 days?

When a baby girl is born, she has all the eggs her body will ever use, and many more, perhaps as many as 450,000. They are stored in her ovaries, each inside its own sac called a follicle. As she matures into puberty, her body begins producing various hormones that cause the eggs to mature. This is the beginning of her first cycle; it's a cycle that will repeat itself throughout her life until the end of menopause. The cycle is usually about 28 days, but not always.

The egg is released from the ovary and is carried down the Fallopian tube towards the uterus. Fertilization occurs if sperm are present as the live egg reaches the uterus. [A tubal pregnancy (ectopic pregnancy) is a rare situation when the egg is fertilized inside the tube. It is a dangerous, life-threatening situation and demands surgery. The uterine lining becomes thickened. If the egg is fertilized, this provides the supportive environment for the foetus. If it is not, this thickening of the uterine lining is shed, forming the menstrual flow (period). Most periods last our to eight days but length of this varies over the course of a lifetime. Women can experience backache, nausea, diarrhoea, constipation, headaches, breast tenderness and mood changes. Women can also be invigorated and feel energy surges.

Many women have cramp during menstruation. To reduce cramp
- Try not using tampons.
- Avoid red meat, refined sugars, milk, coffee and fatty foods.
- Eat fresh vegetables, whole grains, nuts, seeds, fruit and cayenne pepper.
- Take hot drinks or use hot compresses
- Increase exercise.

Technically menopause is the last menstrual flow of a woman's life, although it now refers to the time before and after this event. For most women, menopause occurs between the ages of forty and sixty and takes place over six months to three years. The menstrual cycle usually goes through many changes, some slow and some sudden, before stopping altogether. A woman's periods may become erratic, closer together, or further apart. She may skip a period or two, or have blood spotting at other times in her cycle. A common experience is the loss of large amounts of blood with a period and the passage of large clots. When a woman nears the cessation of her periods, she may not ovulate for one cycle or several cycles. In this case, the endometrium doesn't receive the chemical message to stop thickening. It grows and grows until its heavy bulk causes a heavy flow. Signals of menopause include hot flushes, changes in sleep patterns, headaches or migraines, high energy, high creativity, and/or mood changes. These symptoms come from hormone imbalances and are also caused by poor nutrition.
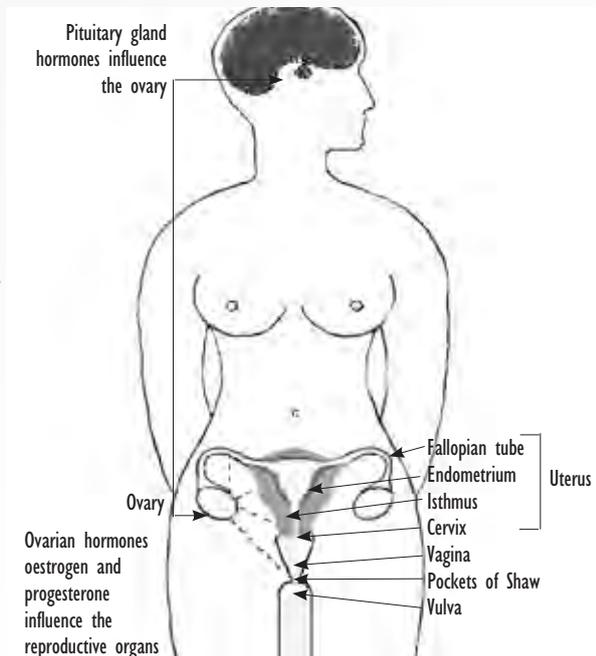
INFORMATION SHEET 5C: Sexually transmitted infections

Sexually transmitted infections (STIs) are infections that are spread from person to person by sexual contact. To avoid contracting an STI people should:

- Know about STIs and what their signs are.
- Not engage in sexual activity – the only 100% effective way to prevent contracting an STI.
- Avoid sexual activity that involves genital contact or fluid exchange. Hugging, kissing, cuddling, touching, fantasy, and using your hands are all safe practices.
- Use condoms.
- Limit the person they have sex with to one faithful partner.
- Talk to their partner to find out if he or she has ever had an STI, and ask about being tested before having sex.

The types of STIs, their symptoms and treatment are shown below. In all cases it is important for all exposed sexual partners to be treated or reinfection will take place.

Risks and myths

Type of ST	Symptoms	Treatment
Syphilis	A single firm, round, small and painless sore that appears at the spot where syphilis entered the body. If not treated, rough, reddish brown spots appear both on the palms of the hands and the bottom of the feet, there is fever, swollen lymph glands, sore throat, patchy hair loss, headaches, weight loss, muscle aches and fatigue. If still not treated it can damage the body and cause death.	Injection(s) prescribed by a doctor. There are no home remedies or over-the-counter drugs that will cure syphilis.
Herpes	Fever blisters in the genitals, which can disappear within 2 to 4 weeks. If untreated a second crop of sores, flu-like symptoms, fever and swollen glands occur. However, not everyone gets symptoms, while those who do may have several outbreaks a year.	There is no treatment that can cure herpes. Antiviral medications can, however, prevent or shorten outbreaks during the period of time the person takes the medicine.
Chancroid	Genital sores that rupture into painful ulcers after a few days. Can lead to swollen lymph nodes in the groin.	Can be treated by a medical practitioner. Home remedies or over-the-counter drugs will not cure chancroid.
Gonorrhoea	Fever, abdominal pain, pain on urination, and red, tender or itching genitals.	Can be treated by a medical practitioner. Home remedies or over-the-counter drugs will not cure gonorrhoea.
Trichomonas	Most males don't have symptoms. In females signs include a grey or greenish-yellow and frothy vaginal discharge, severe itching, redness, swelling and tenderness. Symptoms may last up to several months.	Can be treated by a medical practitioner.
Chlamydia	Unusual vaginal bleeding, penile discharge, fever, pain in the abdomen, burning sensation during urination, painful sexual intercourse.	Can be treated by a medical practitioner.

One of the key issues affecting the sexual health of adolescents is the imbalance of power between the sexes. Women's and girls' relative lack of power over their bodies and their sexual lives, supported and reinforced by their poverty and social and economic inequality, put them at risk of STIs and HIV. Adolescents find it particularly difficult to protect themselves against unwanted and unsafe sex from older people. Adolescents experience mood swings as a result of hormonal changes. They may feel moody or powerful, take excessive risks or feel suicidal. These mood swings can make adolescents vulnerable to unplanned behaviour and risks, including in their sexual behaviour.

There are many incorrect beliefs about how to treat a sexually transmitted infection. Some of these stop the signs of illness, but do not kill the infection. For example, you cannot cure an STI by having sex with a virgin. Some herbs can treat STIs, but they will not cure you. It's important that everyone on treatment finishes their medication, even if they are feeling better.

For reflection or discussion:

What can communities and health workers do to make sure that people
- use the existing laws and services affecting adolescent reproductive health,
- advocate improvements to these laws and to the community environments that affect reproductive health risks?

5.6 Early adulthood – and the challenges of AIDS

Early adulthood is usually a time for improved health and less risk of death. Young adults are usually classified as those between 20 and 34 years of age, and middle-aged adults as those from 34 to 64 years.

For reflection or discussion:

- Why is young adulthood classified as below 34 years of age?
- What strengths do young adults have?
- What risks do they face?

In Zambia, the biggest challenge to this age group has been HIV and AIDS, and early adulthood has become the period that poses the greatest risk to health and life. The Human Immunodeficiency Virus (HIV) is the virus that causes AIDS. HIV can be present in blood, breast milk, semen and vaginal fluids. It attacks the immune system, the body's defence against disease.

HIV is spread through sex, or from mother to child during pregnancy or childbirth, or through infected blood. Although babies are directly infected from their mothers, we refer to "parent-to-child transmission" instead of "mother-to-child" transmission to keep in focus the role of both parents in reducing the risk of infection in babies. For example, men should not expose pregnant or breastfeeding women to HIV through unprotected sex so that they reduce the viral load and risk to the baby. Both parents have a responsibility for the care of the child.

These are, however, just the biological ways in which HIV is spread. Environmental, social and economic factors that lead to this biological spread of HIV. Simply informing people about the causes of AIDS is not enough: it will not reduce people's risk unless we also address these underlying issues. For example, let's look at how gender affects the spread of HIV. Gender Based Violence (GBV) is a public health problem. Often the violence takes place between a man and woman in a relationship. It starts with tension and intimidation in the couple's relationship, and can then progress to physical assault with injury to the woman and sometimes also to the children. GBV is said to be more common where there is harmful use of alcohol and drugs (remember the earlier discussion on this?); where cultural norms, economic or social status make women subordinate and less able to respond to violence, or in situations of unemployment, poverty and homelessness. The common types of violence are physical or sexual. According to the 2007 Demographic and Health Survey, one in five Zambian women had experienced sexual violence at some point in their lives. For women over 15 years who experienced such violence, more than seven in every ten reported that the perpetrator was their current or past husband or partner (CSO et al 2009). Women who suffer from GBV can be supported by listening to them, by making clear that they are not to blame, by helping them assess and respond to their situation, especially to ensure their immediate safety, and to provide support from families, friends, local community or through non government organizations, shelters, social services, if available and legal support.

How do gender issues affect the spread of HIV in our community?

Method: Roleplays and discussion
Approximate time: 45 – 60 minutes
Materials: List of situations written up on flip chart paper
Source: Adapted from an activity in de Bruyn, M and N. France (2001)
Procedure:

1. Ask participants to divide up into groups of 3 or 4 people. Show them the following list and tell them to chose one of these situations.
   - Young wife wants to have a child; she knows her husband frequently has sex with other women.
   - Man wants to use a condom but fears loss of trust within his relationship if he suggests it
   - Young girl needs money to pay her school fees; a wealthy, older man tempts her with money or gifts
   - Sex worker wants to use a condom with her client, but he refuses
   - Couple have an argument; he uses his physical strength to force her to have sex with him
   - Girl drops out of school when she is 13 years old to help her mother sell fish at the market
   - OR any other situation relevant in your community that shows the relationship between gender and HIV

2. Ask each group to design a 3-minute roleplay using words, song, dance or body movement that describes how that situation could lead to the spread of HIV. Give participants 10 minutes to prepare their roleplay.

3. After 10 minutes, ask one group to present their roleplay.

4. At the end of the roleplay, ask participants one or all of the following questions:
   - What happened in this situation?
   - Describe the relationship between the various actors in the roleplay. Does one 'actor' have more power than the other/s? Why? What impact does that have on the situation?
   - How does this situation make the link between gender and the spread of HIV?

Ask for a few more groups to volunteer. Try to leave enough time for at least 3 groups to present. Each group should roleplay a different situation.

5. At the end, lead a discussion which gets participants to reflect on the following questions:
- How are gender relations connected to the spread of STIs and HIV? Do you think it's a major cause for the spread of HIV? Why or why not?
- What change does your community want to bring about in relation to gender? Who would they need to work with to achieve this?
- What institutions are already working to achieve the changes we want? What else can be done?

NOTE: An excellent training package, designed for communities in sub-Saharan Africa, that can be used to explore and bring about change in the area of HIV, communication and relationships, is *Stepping Stones* by Alice Welbourn. See the References and Resources section at the end of this manual for details.

Acquired Immune Deficiency Syndrome (AIDS) is the name given to group of illnesses in HIV-positive people. These are illnesses that arise when people living with HIV and AIDS (PLWHA) are no longer able to fight off infection because their immunity has been reduced.

When a person is infected with HIV, it takes between two and six weeks before the antibodies show up in the blood stream. As the test for HIV is for the antibodies, the person will test negative in this "window period". If a person is concerned about infection they should take the test after 6–12 weeks. When the antibodies are produced, they can lead to flu-like symptoms, but not always. Having HIV infection means that, despite the lack of symptoms of ill health, the virus is still present in the body. The infected person can infect others through sex, or through blood contact, or through breast milk. And the person will almost certainly gradually develop AIDS at some time in the future, often after 10 or 15 years. As the damage to the immune system grows, HIV-related illnesses begin to emerge. These are not necessarily life-threatening, but they become more serious as the immune system becomes weaker. AIDS is the final stage of HIV infection, when the virus has seriously weakened the body's defences against disease. The person becomes ill with life-threatening conditions, and may have only a year or two to live unless he or she can access the antiretroviral drugs that fight the virus directly. These drugs can extend life by many years. The time between HIV infection and its development into AIDS depends on the individual's circumstances and environment. It is never the same for every person.

HIV and AIDS in Zambia

DHS estimates show increasing HIV prevalence through the early 90s, peaking at about 17% of adults by 1995 and reducing thereafter to about 15% by 2006. HIV prevalence is higher in females aged 14 – 24 years, and males 25 – 49 years; and higher in urban than rural areas (CSO, MoH, Macro International, 2002, 2007, NAC 2008, 2009). There were higher HIV prevalence rates in Lusaka, Southern, Western and North - Western provinces.

Antiretroviral (ARV) therapy coverage began to improve after 2003, after an ARV programme was initiated in public health facilities. Condom distribution also rose steadily between 1998 and 2005, to cover about a third of 15 to 59 year olds. Since the launch of the treatment programme in 2003 there have been major improvements in universal access to prevention, treatment and care for HIV. People in need of ARVS has increased significantly to over 60%, while the coverage of PMTCT has doubled to 66%. VCT and HIV testing of pregnant women has also increased. to 2005. There are now almost 284 000 people receiving ARVs of an estimated 420 000 people in need, compared to 3000 people in 2003. By 2010 there were 939 sites or health facilities providing PMTCT against the national target of 1,500 sites.

HIV Prevalence, 1990-2006
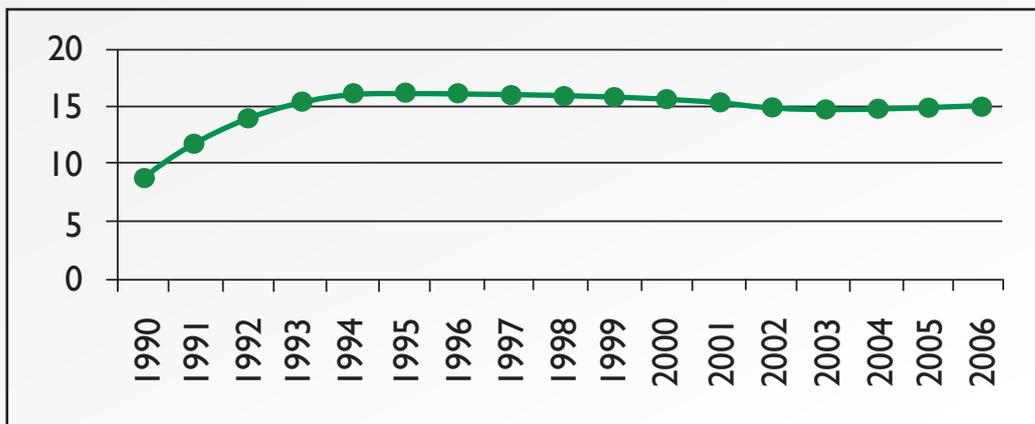
However, even as coverage has improved, differences in coverage have persisted or widened. For example, VCT and HIV testing improved more in urban areas than in rural areas. There are also regional differences in PMTCT coverage, with highest coverage in the Southern Province (89%) and lowest in Luapula Province (46%) and in three of the most rural provinces, Northern, North – Western and Luapula. While the rate of ARV coverage has shown an increase in adult uptake of about 60%, less than 40% of children under 14 years in need of ARVs are receiving the necessary medication.

UNZA et al 2011

HIV is different from many other reproductive health issues in that communities – and individuals within them – often do not have a good idea about how many people are infected or affected. Most people do not know their HIV status – and the majority do not want to know. As counselling and treatment is becoming more widely available, this is changing, but slowly. Taking action on AIDS thus often means starting a discussion on the issue in the community so as to identify where there are risks, problems and people that need support. While many people try to cope with AIDS, many others feel overwhelmed, and cannot manage the costs or deny the risks.

Some people facing the disease can experience stigma, being isolated and blocked from taking up the services and programmes that can help. Stigma refers to the shame that people can feel as a result of the negative attitudes and prejudice of the people around them.. It is often caused by fear and ignorance, when people blame individuals for problems that have social causes. Sometimes people use stigma to prevent others from accessing resources, as is the case when widows are victimized to prevent them inheriting from their deceased spouse.

We have learned lessons about stigma from the AIDS epidemic. Speaking openly about one's HIV status, for example, has helped to break stigma and discrimination and make people realize that stigma is a social problem. It is very important for people to know their HIV status, to better protect their own health, and their partner's health. HIV testing and counselling is an entry point to many services, including prevention of mother to child transmission and treatment. Where stigma or fear is a barrier to testing it is possible to take steps to overcome this. People can benefit from counselling, and community groups can offer support to people experiencing stigma. Most importantly, community and social leaders can discourage attitudes that discriminate and make sure that all groups access the health care they are entitled to.

How can we better identify how to act on AIDS as a community?

Method: Social map (revisited), group discussions and action planning, presentation of proposals

Approximate time: 2–3 hours. This is quite a complex activity, involving a number of issues. It's worth spending some time on it since it will, in the end, clarify many issues and help communities prioritize their actions.

Resources: Your community social maps. Copies of Information Sheets 5d – 5g below on Preventing HIV, Being Diagnosed with HIV, and Treating and Caring for AIDS, and marker pens or different-coloured beans.

Procedure:

1. Discuss the possibility of becoming an "HIV-free community" and what this might mean. Explain that this activity aims to assist communities in getting closer to realizing this.

2. Go back to the social maps and features from the transect walks. Identify areas on the social maps where there may be a high-risk environment for HIV and mark them with a red star. Identify areas where the risk is being reduced and mark them with a green star. (You can also put the maps on the ground and use different-coloured beans for this.)

3. Discuss the risk environments. Why were they chosen? What is different in the areas with the green star? Are the differences due to the people, the environment or the services in those areas?

4. Now divide into THREE groups, one each to discuss
   - Preventing infection
   - Knowing one's status
   - Treating and caring for AIDS

Give each group copies of the appropriate Information Sheet to use in their discussions.

5. Tell each group that they will be identifying actions to promote prevention/testing/treatment at
   - the level of individuals,
   - then in relation to the environment,
   - and finally in relation to services.

For each level, every person in the group should identify one thing that can be done to promote prevention/ testing/treatment. One person must record all the suggestions. Remind them to keep in mind the issues raised on the social maps.

6. When they have completed the listing, get each group to prioritize the actions at individual, environment and service levels to advance their area of focus. (Do you remember how to chose priorities with the beans? See Module 2.)

7. After the group work, ask each group to present its proposals at the three levels as though they were lobbying for support for it.
   - One group can argue as if they were talking to parliaments to raise and press for policies on these issues.
   - One group can argue as if they were talking to senior government officials to seek action.
   - One group can argue as if they were talking to international agencies and funders for financial support.

8. In each case the other participants can act as the target group, ask questions and make comments. Some of the questions they could ask include:
   - Which of these areas can we act on with our own community resources?
   - How will this help the most vulnerable groups?
   - What demands will this place on our institutions and organizations?
   - What evidence is there that it works?

9. At the end of each group presentation, ask the "target group", i.e. the other participants, what they would support and why? Discuss the outcomes. Were the target group persuaded by:
   - The content of the proposals?
   - The evidence to back the proposals?
   - The presenter or the style of presentation?
   - Or something else?
10. Finally, discuss what this tells us about putting forward community positions on health.

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INFORMATION SHEET 5d: Preventing HIV

The risk of getting HIV is reduced at an individual level by
- Abstaining from sex, and, in the case of young people, delaying sex until they are able to negotiate safe sex or are in a faithful relationship.
- Correctly and consistently using male or female condoms.
- Avoiding having multiple partners and /or casual sex.
- Being aware of the partner's HIV status and taking necessary precautions.
- Having non-penetrative sex with no fluid exchange (mutual masturbation, kissing, cuddling).
- Preventing mother (or parent)-to-child transmission (PMTCT) during pregnancy, childbirth or breast feeding, by preventing HIV in parents-to-be; preventing unwanted pregnancies in women with HIV; and preventing its spread from mothers to foetus or breastfeeding infants.

While people with HIV may appear healthy and symptom-free, and have good antibody response, they are more infectious when the viral load is high and when they start developing HIV-related diseases. Therefore maintaining health through good nutrition, positive living and treatment for infectious, opportunistic infections contributes to reducing HIV transmission and infectivity (although safe-sex practices remain essential). Likewise, people who are undernourished and unwell are likely to be more easily infected, to develop high viral loads faster, and to be highly infectious to others.

Voluntary HIV counselling and testing (VCT) is a form of HIV prevention. It helps people know their HIV status, and this helps prevent the spread of HIV. If the test is negative, individuals can learn about ways to protect themselves from HIV infection. If it is positive, they can learn how to live positively and how to avoid transmitting HIV to others or becoming reinfected. Pregnant women can seek advice at HIV counselling and testing centres on how to reduce the risk of transmitting HIV to their babies. By knowing their status, people can begin treatment if necessary and link to services such as support groups. The VCT service should provide competent counselling and support from a trained counsellor. Individuals thinking of taking an HIV test should make sure they are well informed about what the test result means for their lives. They need to decide who else they would want to know the result and how they would inform them. And they must consider who else the result will affect, such as their spouse or regular partner. It is often better for couples to discuss HIV and to go for counselling and testing together.

Confidentiality means that no one else will know about the person's results, or even that they came for an HIV test, unless the client gives their permission. Shared confidentiality means that information about a client cannot be shared with anyone other than the HIV care team staff. In shared confidentiality, information about the client can be shared only with those who are directly involved in that person's care – if that person has given his or her permission.

In Zambia, there are two types of HIV tests that are currently being used in the country. The first line test is Abbot Determine. The second line test, known as Uni-Gold test, is used to confirm the first test. If the earlier positive result turns negative, the third line test Bioline is done 6 weeks later. A person can get an HIV test done at a hospital or clinic. There are also many Non Governmental Organisations (NGOs) in the country that

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have HIV testing centres. For example, SFH Newstart HIV Counselling and Testing Centres and Comprehensive HIV/AIDS Management Programme (CHAMP) both offer mobile and on site VCT; Kara Counselling Center offers VCT and training in counselling at certificate and diploma level. A strategy that has worked well with young people has been the offer of arm bracelets to those who undergo VCT. This became fashionable and "cool" among young people, encouraging uptake of VCT.

HIV testing at Antenatal clinics has also become mandatory in Zambia as part of the Prevention of Mother to Child Transmission (PMTCT) programme. The programme no longer uses the "Opt-in" or "Opt-out" method where a pregnant woman after the Pre-test HIV counseling was given a chance to decide whether to test or not. HIV testing is now mandatory as part of ANC so that pregnant women can be included in the programme to provide ART for prevention of mother to child transmission.

Post-exposure prophylaxis

For people who have been raped, or for health workers who are exposed to HIV through a needle injury, post-exposure prophylaxis (PEP) is provided. This includes the administration of antiretroviral treatment to prevent infection. While PEP is clinically effective, it may not always be available, and there may be social and economic barriers to accessing support services after rape. There is also very little information on PEP available. People in this situation are advised to go to a doctor as soon as possible and to start taking medicines as soon as possible. If more than 72 hours (3 days) have passed since a rape or injury, it will be too late for these medicines to be able to reduce the risk of getting HIV.

Before treatment the person will receive counselling and an HIV test, and further counselling after receiving the results of the HIV. While waiting for the results of the HIV test, the doctor may give medicine to be taken immediately. This is called a starter pack. If the HIV test is positive, the specific course of medicines for PEP will be stopped and alternative support will be given to encourage the person to live positively and manage the HIV. If the test is negative, the medicines will still be given for 28 days. The starter pack of 3 days' medicine does not protect from HIV – the full 28-day course is needed. The medicines are strong and have side-effects like headaches, tiredness, skin rash, a runny tummy, nausea and others. Another HIV test is given after six weeks, again after three months, and again after six months. If the result is negative each time, it means there was no HIV infection from the event.

INFORMATION SHEET 5e: Being diagnosed with HIV

An HIV-positive diagnosis changes a person's life dramatically. People experience a wide range of emotions – fear, loss, grief, depression, denial, anger, anxiety. No matter how reassuring the doctor and loved ones are, how effective the drug therapies, how minimal the current physical impact of the infection, the need for support is great. The psychological issues faced by most people with HIV infection revolve around uncertainty. Future hopes and expectations, relationships and career require some adjustment to cope with HIV and lead a happy, productive life.

Partners are likely to suffer the consequences of HIV infection and disease as much as the infected person, albeit indirectly. Communication between the two partners, and between partners and professional counsellors, is important to foster understanding of the adjustments that will be needed. For example, adjustments in sexual behaviour are necessary to stop further infection.

Before an HIV test, and before learning the outcome, counselling is essential. Counselling is a structured conversation between two or more people that assists one of the participants to work through the particular problems he or she faces – for example, disclosure of HIV status. Counsellors encourage people to recognize their own capacity to cope so that they can deal more effectively with problems.

Good counsellors are able to understand the view of another person, are respectful, warm and discreet; they listen, and give time to people. There are techniques of counselling that are taught in formal counselling courses, and this health literacy programme does not cover these. But it is useful to know what these are for general communication skills and to be able to judge a good counsellor.

Counselling is …	Counselling is not …
Establishing helping relationships	Telling clients what to do
Having conversations that have purpose	Making decisions on behalf of a client
Listening attentively to what a client has to say	Judging or blaming
Giving correct and appropriate information	Interrogating or looking for faults
Helping clients tell their story	Preaching or lecturing
Helping recognize and build strengths	Making promises you can not keep
Helping develop a positive attitude	Imposing your own beliefs
Helping make informed decisions	Arguing with clients

In the context of HIV and AIDS, counselling helps people cope with the emotions and challenges they face when they (or their partners) are diagnosed with HIV. It prepares and supports people in relation to taking ART. It helps clients make choices about how to avoid becoming reinfected or transmitting HIV to others. And it helps people make decisions about how to prolong and improve their quality of life.

Children affected by HIV and AIDS also require support through counselling, and have similar "dos and don'ts" in relation to this support:

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Counselling for children includes …	Counselling for children does not include
Establishing helping relationships with children	Making decisions on behalf of children
Helping children tell their story	Judging children
Listening attentively to children	Interrogating children
Giving children appropriate information	Blaming children
Helping children recognize and build strengths and a positive attitude towards life	Making promises you can not keep
	Imposing your own beliefs on children
Helping children make informed decisions	Preaching and/or arguing with children

The post-test counselling session may be the last opportunity for any counselling, particularly if the client is not receiving any medical treatment or does not need medical monitoring on a regular basis. Where rapid tests are used, the post-test counselling follows closely on the pre-test counselling and the test itself, so counsellors need to take even more care that clients really are ready for their results.

INFORMATION SHEET 5f: Treating and caring for AIDS patients

People who are diagnosed as HIV-positive are treated with antiretroviral medicines (ARVs). These are medicines that fight HIV and enable people to live a healthier life. They do not cure HIV or AIDS, but they do reduce the amount of HIV in the blood. As a result, the immune system gets stronger and can fight the disease better. ARVs can give people with HIV a much longer, healthier life when they are taken correctly. The correct provision of ARVs with adherence support and all the appropriate care is called antiretroviral therapy (ART). ART greatly reduces infectivity by reducing the viral load to very low levels, although it is important that people receiving ART still always use condoms.

It is also essential that they take the right pills every day at similar times, for the rest of their life. And they should also enhance their positive living in other ways, such as ensuring good nutrition. People must take ONLY the ARVs the doctor prescribes. Information on treatment literacy is found at local clinics around the country, at private doctors' rooms, private clinics, and referral hospitals, and can be obtained from civil-society organizations that deal with issues of treatment literacy, HIV and AIDS, and ART.

The various services for preventing and managing AIDS all need to be available to and used by all groups, including young people. This means we need to be sure that there are no barriers to prevent people accessing these services. For example:

- Health workers may not go for testing if they think they will lose their professional roles by being found HIV-positive.
- Young people may not use treatment services if they fear a negative attitude.
- People may not use counselling and treatment services if they can't afford the transport to get to them.
- Men may not use condoms if they are distributed at places they do not go to, or if there are social or cultural barriers that will stop them using them.

Likewise, in caring for AIDS, the wider impact on communities needs to be managed. For example, women take on a greater share of the burden of AIDS. As the male partner is often the first to become ill, women divert household resources to care for them, often at the expense of their own or their children's needs. Children, especially girls, may be taken out of school because of a lack of funds or so

that they can assist with care. Once the spouse dies, women may not inherit anything, may be abandoned by their husband's family (particularly if he was known to be HIV-positive), and may face an uncertain and impoverished future.

In Zambia an estimated 16,658 new HIV infections in 2009 occurred in children. Over 21, 000 children living with HIV in Zambia were on treatment at the end of 2009 (MOH, 2009; NAC 2009). Both HIV-infected babies and those whose HIV status has yet to be determined, require special care and attention during the first years of life. For children at risk it is important to confirm their HIV status as early as possible; monitor their growth and development, ensure that immunisations are started and completed according to the recommended schedule, and actively look for and treat infections early. Parents and especially mothers need counseling and support, and information to help them ensure that babies are well fed, have good personal and food hygiene to prevent common infections, to seek prompt treatment for any infections or other health related problems and to ensure adherence to ART.

For reflection or discussion:

Looking at the impacts of AIDS you have identified in this discussion
- Where in the life cycle do you think that HIV can be prevented?
- Where in the life cycle do you think that AIDS has an impact?

Taking your findings into account, where would you prioritize acting as a community that would have greatest effect in preventing HIV or managing AIDS?

5.7 The challenges of adulthood and ageing

Now that we have discussed some stages in the life cycle, you can work with your local health workers to explore the issues that arise at other stages. For example:
- For many people, adulthood is not only a time for self-development but one taken up by the demands of families and children. Adults are increasingly taking action to plan the number of children they will have and when they have them. Who in the community is more or less able to do this? What resources and services are available to help them make these decisions? How can the MHEN support people – men and women – to make decisions on this and act on them?
- Men and women experience changes at later stages of their lives. Women go through menopause between the ages 45 and 55, when the production of female hormones begins to decline. At this time women will stop having their periods, and can experience mood swings, physical changes (weight changes, adult acne) and vaginal dryness. Men experience "andropause", which is also due to a reduction in hormones, with changes in mood and energy.
- Over time, the effect of poor diets, environments or lifestyles can cause health problems to accumulate and lead to chronic problems, like high blood pressure, heart disease or digestive problems. All of these can be avoided. We can discuss as a community how they occur, how to monitor these areas of health, and what we can do to avoid them.
- Later in adulthood, or as elderly people, men and women have a higher chance of developing cancer. Normally, cells grow and divide to form new cells as the body needs them. When cells grow old, they die, and new cells take their place. Sometimes, this orderly process goes wrong. New cells form when the body does not need them, and old cells do not die when they should. These extra cells can form a mass of tissue called a tumour. Malignant tumours are generally more serious than benign tumours and are called cancer. They may be life-threatening. They often can be removed but sometimes grow back. Cells from malignant tumours can invade and damage nearby tissues and organs, and they can spread to other parts of the body.

Communities need to know how to detect these problems early, so that they can be diagnosed and treated, and need to know what to do to care for those with cancer. For example, breast cancer and cervical cancer are very common, but both can be avoided as discussed below. Men suffer from prostate cancer, especially when they are over 50 years of age. The prostate is a male reproductive organ, and the cancer can be screened by medical checks and treated if found early enough.

In Zambia cervical cancer ranks as the first most frequently reported cancer amongst women between 15 and 44 years of age. Cervical cancer in Zambia occurs over 2.5 times more often than breast cancer, which is the second most common cancer in Zambia. Many women seek medical care when these disease are in their late stages, leading to higher levels of death from the cancers. However both cervical and breast cancer can be detected if women are screened early, and cervical and breast cancer screening through mammography and pap smear tests can now done at a number of provincial clinics and hospitals. If cases are found then the Cancer Diseases Hospital, located within the University Teaching Hospital, provides mammography, ultrasound and blood tests to screen for cancers; radiotherapy to treat cancer with high energy X Rays; and chemotherapy, which is treatment of cancer using drugs.

What health issues do elderly people face?

Method: Picture code

Approximate time: 30 minutes to work through the picture code; another 30 minutes to develop an action plan

Resources: Picture of the elderly man and woman blown up to poster size.

Procedure:

1. In plenary, show the picture of the old man and woman in a rural home and then facilitate a discussion about the picture, focusing on these questions. Note that as you progress through these questions you will increasingly move away from looking at the picture to reflecting on people's own experiences and plans for action.

   - What do you see happening? What is the elderly man doing? And the elderly woman? What do you think they are feeling?
   - Is this scene typical of older men and women in your community?
   - What are their health needs? Other needs? Make a list.
   - What services exist in your community to meet those needs?
   - What services are lacking and what actions do you think need to be taken to fill the gap?

2. End by developing an action plan.

In summary

In this module we have
- Introduced a life-cycle approach to exploring health.
- Explored the risks to, and opportunities for, health at different stages of life and how they can be managed.
- Taken a closer look at specific problems of infants, children, adolescents and young adults, who make up the largest share of our communities.
- Encouraged discussion of health issues in older adults and the elderly.
- Explored the actions that communities can take around these issues.

Remember to review all the issues you discussed in the session so you can draw up your community plan on what communities can do to improve health at different stages of life. How will participants identify and make contact with local organizations that can provide support to health needs at particular stages of life? How will participants reach and involve youth, children and elderly people in their health activities?

COMMUNITY PLAN

What will we do next?

At the end of your literacy session discuss with community members what actions will be taken before the next health literacy session
How will participants give feedback to others in the community from discussions at this meeting?
- What actions can participants take and report back on before the next session?
- Who will lead these actions? Who else will be involved to help?
- What will be the role of the health workers and the local council?
- What information or report-back will participants bring to the next meeting?

Ask the community members what else they want to know about
- Identify the topics that people want to know about in the next session.
- Are there issues that communities want to know about or to bring to the district's attention.

Remember to plan your next session:

FACILITATOR'S PLAN

What topics will you implement in the next health literacy session?

What do communities want to hear about next?

- What new topics did the communities want to discuss at the next session?
- Which module(s) in the manual deal with these? How will you use them?
- Where and who else can you get information from?

What else do you want to include in the session?

- What other topics will you include in the next session?
- Which module(s) in the manual deal with these? How will you use them?
- What other information will you use and who else can you bring?

Module 6: Understanding health systems

In this module we
- explain what a health system is
- discuss how primary health care promotes people-centred health systems
- discuss traditional health services and youth-friendly services
- explore the way that different approaches to financing health and to the roles of health workers affect health systems

6.1 What do we mean by people centred health systems?

A health system includes all the people, institutions and resources that take actions with the main aim of improving health. This includes the actions taken by communities, health workers, schools and others.

Health systems:
- protect and promote a population's health and prevent disease, for example, by making clean water available
- provide health services to care for major diseases
- look after people who have long-term illnesses or who have disabilities

When we talk about health systems we often think about the curative health services – the hospitals and clinics that cure disease. The health facility is a focal point at the community level; the district hospital co-ordinates health services in the district, including those at the district hospital itself. At the next level provincial hospitals provide hospital care to clients referred from district hospitals. Central hospitals and special referral hospitals provide specialized services.

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Many people also think that health care is the same as seeing a doctor and getting medicine. Medicines are important because:

- They save lives and improve health.
- They promote trust in health services.
- They are costly.
- They are different from other consumer products.
- If they are used effectively and efficiently, huge resources can be saved for use in other parts of the health system.

The vast majority of health problems that most members of the population suffer from can be treated with a small, carefully selected number of medicines. These need to be available at a price that the health services and the community can afford. However, making the medicines available is not enough. People need to know when they need to use health services, how to take medicines, what to do if they have side effects, and other issues relating to the use of medicines. So the resources we provide in health services are best used when people are well informed about their health and health care.

But are these curative services what health systems are about?

> What is the point of treating people if you send them back to the conditions that made them sick? We need to do more!

INFORMATION SHEET 6a: Zambia's state health institutions

Zambia has a health system that is structured as below (excluding private and other state and non-state facilities). The main providers of health care services in Zambia include: Public health facilities under Ministry of Health; facilities under Ministry of Defence, clinics under Ministry of Home Affairs; Mine hospitals and clinics; Mission hospitals and clinics which are coordinated by Churches Health Association of Zambia (CHAZ); Private hospitals and clinics; Non-Governmental Organisations (NGOs) and traditional healers.

In Zambia, the management and control of health services and facilities fall under Ministry of Health (MoH), through the Provincial and District Health Offices. To promote community participation in health services, neighbourhood health committees were set up in the 1990's. The facilities at different levels are:

A health post caters for 500 households (3,500 people) in rural areas and 1, 000 households (7,000 people) in the urban areas.

Health Centres in urban areas serve a catchment population of 30,000 to 50, 000 people, and in rural areas serve an area of 29Km radius or a population of 10,000.

Referral Hospitals - 1st Level Hospitals found in most of the 72 districts and intended to cater for 80,000 to 200,000 people with medical, surgical, obstetric and diagnostic services, including all clinical services to support health centre referrals.

General Hospitals – 2nd Level Hospitals - at provincial level and intended to cater for 200,000 to 300,000 people, with a range of referral services

Tertiary Hospitals Serving a population of 800 000 and above with a range of specialized referral services

The number of these Health Facilities by ownership are shown below:

Facility Type		Number of Health Facilities by Ownership				
		Government	Private	Mission	Total No. of health facilities	
					No.	%
Level 3 Hospitals		6	0	0	6	0.3
Level 2 Hospitals		13	5	3	21	1.0
Level 1 Hospitals		39	4	29	72	5.0
Health Centres	Rural HC	930	22	77	1,029	66.0
	Urban HC	206	53	6	265	17.0
Health Posts		161	8	2	171	11.0
Total Health Facilities		**1,355**	**92**	**117**	**1,564**	**100.0**

Source: MOH, 2008

District health systems are managed through the District Health Office (DHO) by a District Health Management Team (DHMT) headed by a District Medical Officer (DMO). The DMO is supported by a range of specialized health Program Managers and Officers responsible for: Planning Clinical care services; Pharmacy; Dental; Laboratory; Mother and Child Health (MCH); Environmental Health; Nursing Care; Nutrition; Community Partnership; Information, Education and Communication (IEC) and Health Management Information System (HMIS). Under Administration, the DMO is backed up by Accounting; Human Resource; Stores and purchasing; Transport; Security and Secretarial staff. DHMT staff backstop the entire health system in the district according to their specialization. The district health office facilitates ongoing capacity building and professional development of health workers in all health facilities in the district. The staff in administration equally provide administration related support to health workers, thus overall contributing to an effective and efficient district health services.

The Ministry of Health retains the responsibility for health policy development, professional/technical guidance and supervision of health care irrespective of the provider or institution.

In 1996, the Ministry of Health developed a Basic Health Care Package (BHCP) to address the health problems that make the greatest contribution to the burden of disability and lost years of life. The BHCP outlines the package of interventions to be provided for this, to guide the allocation of resources and to make clear to Zambians what health benefits government prioritises and would seek to provide free of charge. The 1996 BHCP was revised in 2008, with new interventions such as ART, radiotherapy, and other new technologies added.

Health worker client interaction at a health centre
© B Goddard EQUINET/TARSC

For reflection or discussion:

Looking at the different services above
- Are all these health services curative?
- What other types of health-related services are covered in the health system?
- What other kinds of institutions play a role in health?
- What are the gaps in service provision in your district?

What makes a health system people-centred?

Method: Human sculpture
Approximate time: 90 minutes
Resources: A large space, pen, small pieces of paper to use as labels and as cards, a flipchart, pins, a camera (if possible)

Procedure:

You need at least 15 people for this activity. Participants will position themselves in ways that express power relations among major actors – in this case, the major actors in the health system. The result is a human sculpture that represents the group's understanding and knowledge of what is going on in their health system.

1. To start with, set the scene or ask one of the participants to describe a common situation at a clinic, noting the person and the problem they come with.
   For example, a 16-year-old girl in her third trimester of pregnancy comes to a clinic in a poor rural area. She arrives on a day when the clinic is busy with its usual line of patients for treatment.

2. Before beginning the human sculpture, get participants to name the major actors that would be found in this situation. One facilitator writes the names of the actors on the flip-chart; another facilitator writes the names on small slips of paper.

3. Ask participants to place the actors as they are named. Start with the person who comes to the clinic and whoever comes with her or him. Then add the clinic personnel and others named (family members, people in the community and in the health services, the state and international players, and so on).

Human Sculpture Tanzania 2006   *Photo: TARSC*

4. If you use the example of the pregnant teenager, it would go like this: Ask one of the participants to take her role and stick a label on her shirt. The group discusses how the teenager should be positioned in the middle of the room. Then invite the rest of her family to come forward one at a time and, again, the group decides how they should be positioned in relation to the girl, keeping in mind that we are sculpting the power relations between each actor. Participants indicate the different power relations by placing people at different heights or distances from each other, using gestures, body movements, and so on).

5. The group continues to identify and place the other actors, leaving the national and international actors until last. Keep asking whether everyone agrees that the way people are placed reflects their status and links. This will ensure that the sculpture is an agreed outcome of the group.

6. When all the actors are in place, discuss what this sculpture is saying about power relations:
   - Are the teenage girl's needs being met? How or why not?
   - What role is each "level" of the health system playing?
   - Who has the power? Who does not?
   - Who is connected? Who is not?
   - Is this how things are in your health systems generally?
   - Is this how you think things should be?

7. If you have a camera, take a photograph of the sculpture. Now ask the participants to move the actors into different positions so that they deal with the problems they raised, or so that they show things they want to change to make the system more people-oriented.

8. Discuss the difference between this sculpture and the one before.
   - What has changed about the power relations?
   - What has changed about the relations between the people and the health workers?
   - What has changed within the community? And within the health services?
   - What is different about the local–national–international relations?
   - What do you think the characteristics are of a people-centred health system?

9. Give the participants small pieces of paper to use as cards. Ask them to write down the features they see or hear as the discussion is taking place – about how the sculpture looks now and the features of a people-centred health system (for example, supporting the patient, better links between local and national health authorities, and so on).

10. Take a photograph of this sculpture for comparison and then tell everyone to sit down.

11. Lay the cards down on the floor in the middle of the circle and group them into common features. What are the common features that people have identified of a people-centred health system? Write these as a summary on a flipchart. Does everyone agree with this?

12. Discuss in plenary how it is possible to move from the current to the desired situation. Note the changes suggested and that this is a process of transformation.

13. Stick the flipchart of features on the wall as a reference point for other discussions.

6.2 Primary health care

From mid-1970 the WHO started a new approach to health care aimed at the most disadvantaged part of the population. Primary health care (PHC) is a comprehensive health systems approach that is developed in partnership with the communities themselves. It involves all sectors and activities that influence health, and includes prevention, health promotion, cure and rehabilitation. Inspired by the Alma Ata Declaration in 1978, country after country the world over embraced

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PHC as an explicit priority. This has resulted in significant improvements in people's health. Since the adoption of the PHC approach, the worldwide infant-mortality rate has decreased from 90 per 1000 live births in 1975 to 59 in 1995, while immunization coverage for children under one year of age has risen from 20% to 80% between 1980 and 1990. In the mid-1970s, only 38% of the people in developing countries had access to safe drinking water and 32% to adequate sanitation, whereas those figures had risen to 66% and 53%, respectively, by 1990.

Primary health care services generally include:
- Prevention and treatment of common diseases and injuries
- Basic emergency services
- Referrals to/co-ordination with other levels of care (such as hospitals and specialist care)
- Primary mental health care
- Palliative and end-of-life care
- Health promotion
- Healthy child development
- Primary maternity care
- Rehabilitation services

For reflection or discussion:

Looking at the features of PHC above
- How do you understand these? Ask a health worker to describe how they organize these services.
- Which features exist in your community? Which do not?

Primary Health Care (PHC) services in Zambia are provided in communities, at health centres (HC), health posts, hospital affiliated health centres (HAHC) and 1st Level Hospitals and managed by the District Health Offices through District Health Management Teams (DHMTs). These may be public, private or non-governmental organization institutions. Primary Health Care in Zambia includes and goes beyond curative services at primary and first level care, and covers preventative and promotive health, for children and women, for reproductive and adolescent health; for common diseases such as malaria, HIV/AIDS, TB, for improved nutrition, for epidemics preparedness, for environmental health and social and intersectoral action in health.

PHC is not only an issue for rural and urban residential communities, but should also extend to workplaces. The tripartite institutions – government, unions and employers – should co-operate to ensure that workers access workplace health services and safe work environments with the full participation of those at the workplace.

Katangwe Health Centre, Mansa © A Katambala

What does PHC mean to health workers and communities?

Method: Interview
Approximate time: Half a day
Resources: Health worker from the local health facility, or a district nursing officer; a community member involved in health

Procedure:
1. Arrange for the community to invite a health worker from the local health facility or a district nursing officer, and a community member involved in health, such as a community health worker, to come to a discussion about PHC.

Before the guests arrive:

2. Organize participants into two groups, one group to interview the health worker, the other to interview the community member Make sure that the interviewing groups include people from marginalized or vulnerable groups, women and youth.

3. Discuss with the two groups of interviewers the purpose of the interviews. Ask them to prepare and discuss within the group some questions that will help to understand how the PHC system works and how it supports community roles in health. Some suggested questions appear below as examples, but it will be better if you use those that come from the community.

Suggested questions:

- Tell us about what you do in the health system please.
- Can you explain to us what PHC means?
- How does your work fit into the primary health care system and approach?
- What areas of primary health care are you focusing on now? How? For whom? Are there any groups you don't reach?
- In what ways does your work involve the community?
- What works well in PHC? Why?
- What doesn't work, or what difficulties do you have?
- How do you think the PHC approach can be strengthened in our area?

4. Ask each group to arrange beforehand who will introduce the group and why they are interested in this topic, and who will thank the guest at the end.

After the two interviews:

5. Meet as a group and discuss what came out of the interviews:
   - Anything they learnt about PHC.
   - Anything they disagreed with or would change (but didn't say during the interview).

6. Discuss the differences between the community member and health worker interviews. How do the two groups see the PHC system? Where do they see things in the same way? Where do they differ?

7. What actions do you think the Ministry of Health can take locally or nationally to strengthen PHC?

6.3 Health systems reflect society and respond to social groups

Health systems reflect the societies we live in. The cultural practices and behaviour in society affect the way in which services are provided and used. Health systems can, however, go beyond this and provide additional opportunities for groups who may be more vulnerable or more disadvantaged in society. In this way they can even produce change in society. In this manual we explore some of these different health-care providers. There are many others, including faith-based healers and services, and homeopathic approaches, which use extremely small doses of natural materials to stimulate the body's own immune system. It would be useful to find out what is being practised in your communities and what people know about and think of these different approaches.

How do health systems respond to social differences?

Method:	Role play of a talk show
Approximate time:	60–90 minutes: talk show – 30 minutes; discussions – 30–60 minutes, depending on how you choose to do this.
Resources:	Any props you think the actors may like to wear/use e.g. caps for the two young people, walking stick, nurses uniform, etc.; copies of Information Sheets 6b and 6c for two of the actors, copies of the talk show "script" (below) for all the actors.

Procedure:

1. Ask for six volunteers to participate in a role play. The situation is a radio talk show with the following actors taking part:
   - a talk show host
   - Two young people who don't feel comfortable using clinic services (give the role players information sheet 6b on youth health services)
   - An elderly lady who prefers using traditional healers (give the role player Information Sheet 6c on traditional health services)
   - A woman who has small children
   - A nurse
2. Give the actors time to prepare their roles (approx. 15 minutes). They can do this while other participants are involved in another activity or energizer.

The talk show

1. The talk show host begins the role play by telling the audience that the focus of the talk show this week is how people deal with health issues in their area.
2. Let the host start by asking the young people where they go when they have a health issue or question that they would like answered. (In preparing this role play, the "teenagers" should discuss what these health issues are.) Let them talk about why they don't go to the clinic and where they go instead – e.g. some get advice from their older siblings, others get information from school, from what they read in magazines, etc. – but they acknowledge that there are gaps in their knowledge and in the support they get.
3. After 5 minutes (the talk show host must make sure that the conversations don't go on for too long!), the talk show host asks the elderly lady who uses traditional healers why she prefers them.
4. Then the host turns to the woman with small children and asks how she meets her children's health needs. What does she do when the children are ill? Where does she take them for treatment? Who looks after her children when she is at work?
5. The host then asks the nurse for her comments. How are health services taking these different views into account?
6. The host can then open to questions from the floor. Participants can ask the characters questions such as:
   - Why do you choose or avoid traditional health services?
   - What do you think the health services can do to respond better to your needs and concerns?
   - Who else in the community do you go to when you have health problems?
   - What barriers do you have to using the clinic or hospital?
7. After a while the host will wrap up the show.

DISCUSSION:

1. At the end of the role play, let participants discuss the questions below. You can do this in plenary, or you can break participants into two groups. If participants work in small groups, they should discuss and report back on all five questions, but your final discussion should focus particularly on the last two, related to actions.
   - What social or cultural aspects influenced the way in which people responded to health or used health services differently?
   - How do the different institutions that promote health respond to these social and cultural issues? Are our health services effective at responding to differences between people?
   - Do our health systems CHANGE social views or culture? Can you give an example of where this has happened?

2. Then, groups can go on to discuss and agree on
   - an action that you think should be taken in your area by health systems to respond better to local culture or social beliefs and practices; and
   - an action that you think should be taken in your area by heath systems to change social norms or behaviours

How will they implement these?

3. If participants worked in two groups, they now need to report back to the plenary. Look for the similarities and differences between the two groups and try to come up with one agreed action for each of the two last questions.

INFORMATION SHEET 6b: Traditional health systems

Although Western medicine is generally accepted throughout Africa, it has not replaced but rather augmented indigenous or traditional health approaches. The World Health Organization (WHO) estimates that 80 per cent of people in Africa regularly seek the services of traditional healers, which means that they are often the first and last line of defence against the most contagious and debilitating diseases that plague our lives. Leaving traditional healers on the sidelines can have serious consequences. Some patients, preferring the healers, may disregard their doctor's advice or take herbal medicines that could have dangerous interactions with pharmaceuticals. By contrast, if they work with healers, doctors gain allies who live in the patient's community.

Traditional healing is linked to wider belief systems and remains integral to the lives of most Africans. Doctors trained in the Western sciences focus largely on the biomedical causes of disease, while traditional beliefs take a more holistic approach. Some traditional healers are reputed to be able to divine the cause of a person's illness or social problems. Many have in-depth knowledge of plant materials and their various curative powers. They use leaves, seeds, stems, bark or roots to treat symptoms. Animal parts and minerals are also employed, but to a lesser extent. Most traditional healers are both herbalists and diviners, but some specialize in one aspect.

In the past, the gulf between modern and traditional practitioners was enormous, but it has narrowed somewhat in the past decade. WHO advocates incorporating safe and effective traditional medicine into primary health-care systems. Traditional medicine in Zambia has remained part of the health care system. In both rural and peri-urban areas a traditional medicine person (healer/herbalist) is often the first point of contact when people are ill. The Traditional Healers Practitioners' Association of Zambia (THAPZ) registers all traditional practitioners and they are included within the Primary Health Care (PHC) approach. The current THAPZ president is a member of the National AIDS Council. Through THAPZ traditional healers and herbalists have been encouraged to submit medicines

Traditional Healer (N'ganga), Lusaka © A Zulu, 2012

for clinical trials and register medicines with the Registrar of Patents to protect local property. There have been several publicly funded trials of traditional herbal medicines in Zambia.

There is a growing realization that it is possible for traditional and Western practitioners to work together to improve patients' well-being, especially when it comes to developing new medications, reporting new cases of contagious diseases, and finding ways to ensure that patients stick to their prescribed treatments. Traditional healers are already a trusted source of health information and treatment, and using this trust and the healers' accessibility can create a win-win situation for everyone involved.

INFORMATION SHEET 6C: Youth-friendly health services

There is a growing recognition that "youth-friendly" services are needed if young people are to be adequately provided with reproductive health care. Such services are able to attract young people effectively and meet their needs comfortably. Whether services are provided in a clinical setting, in a youth centre or at a workplace, or through outreach to informal venues, certain youth-friendly characteristics are essential to effective programmes. Basic components include specially trained providers, privacy, confidentiality and accessibility.

Given that young people tend not to use existing reproductive health services, specialized approaches must be established to attract, serve and retain young clients. From their point of view, young people face many barriers to service use, including laws and policies that may restrict their access to affordable services and useful information, embarrassment at being seen at clinics, fear that confidentiality will not be honoured, and concern that staff members will be hostile and judgemental. Operational barriers also exist, such as inconvenient operating times, lack of transportation, and high cost of services. Many of these barriers can be addressed by specific programmes that serve young people. Perhaps the single most important action that any reproductive health programme for young adults can implement is the selection, training and supervision of staff members to work with adolescents. There must be an emphasis on attitude, respect for young people, and the development of interpersonal skills to promote good provider–client communication. Other provider characteristics that programmes should consider include an emphasis on privacy and confidentiality, allowing adequate time for discussion, and the availability of trained peers as a counselling option.
Facilities can provide
- A separate space or special times for teenage clients only, convenient hours, accessible location.
- Adequate space with sufficient privacy, and comfortable surroundings.
- Allowing clients to receive services without appointments (as "drop-ins").
- Reducing overcrowding and waiting times, setting affordable fee schedules, developing publicity.
- Recruitment activities that inform potential youth clients effectively, ensuring that the most-needed services are available on site and that good referrals are available for services needed but not offered.

Given the rapid changes that adolescents experience, a need exists for education and counselling services, especially related to development and maturation, boy–girl relationships, decision-making about sex, gender issues, sexual abuse and exploitation, sexual and contraceptive negotiation, adoption of contraceptive methods, and pregnancy options should pregnancy occur.

Counselling services are also important for the mental health and social issues described in Module 5, including those to deal with mood swings, depression, and suicidal feelings. Health services needed cover prevention, treatment, and follow-up care, including:

- sexual and reproductive health education and counselling (as noted above)
- physical examinations, including pelvic and breast examinations for females and testicular examinations for males
- screening, counselling and treatment for cervical cancer, STIs and HIV
- contraceptive method choice, adoption and follow-up
- pregnancy testing and options counselling
- abortion services (where legal) and post-abortion care
- antenatal, post-partum and well-baby care, and
- nutritional services

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When heath systems make an effort to respond to social practices they perform better for the community. Have a look at the information on youth oriented health activities in Zambia below. Use this information in your community meetings to generate discussion on the relationship between the youth, as a community, their own networks, and the health system. You can read the information out loud, or make copies and distribute it. Use the questions below the box to help in your discussions.

Youth oriented health interventions in Zambia

Currently, in Zambia, there are two categories of health services available to the adolescents, namely: those offering specialized Adolescent Friendly Health Services (AFHS) through the Youth Friendly Corners (YFCs); and health facilities offering healthcare services to the general public.

The AFHS through the Youth Friendly Corners (YFCs) seek to provide adolescents with access to essential health services in an adolescent friendly environment, providing for appropriate location of health facilities, appropriate standards of care, privacy and confidentiality, cost effectiveness and affordability of services, flexibility, availability of appropriate IEC materials, effective partnerships and involvement of the adolescents in policy formulation, planning and implementation of adolescent health programmes.

Youth Friendly Health Corners in Zambia, though not fully established throughout the country, provide health services that focus on the priority needs of youth. Services offered by health facilities that have introduced YFCs include: general healthcare services; peer counselling and education; Voluntary Counselling and Testing (VCT); Family Planning (FP) services; life-long skills programmes, Edu-sport and drama activities within the communities and schools; and health promotion and information.

Source: MoH 2009

6.4 The way health systems are financed affects communities

As we have seen in all our discussions, health systems need a range of resources, including personnel, materials, drugs, finance, infrastructure and equipment. These resources come from government, donors, communities and the private sector. At present while we need about $60 per person for a decent health services, our countries spend less than this. African governments promised in Abuja in 2003 to spend 15% of total government spending on health.

Do we spend 15% of government spending on health? If not what can we do?

In 2001, the Zambian government, like many other African governments, committed itself to the Abuja Commitment of increasing the share of government domestic spending on health to 15%. The commitment aimed at ensuring health as a priority in the budget and the use of domestic public resources to strengthen public spending for achieving population health and protecting the poorest from financial shocks. Before 2001, Zambian government health spending, as a share of total spending, ranged from 5% to 7.7%. After 2001 this percentage shifted very little, ranging from 4.7% to 7% in subsequent years. However, while Zambia is still far from achieving the Abuja Commitment, it has begun to make improvements. From a share of 6.8% government spending on health in 2006, the level rose to 9.8% by 2009. Zambia increased its real total health spending between 2003 and 2006 to US$56 per capita, close to the $60 per capita minimum for health systems to meet MDG targets in health (UNZA et al 2011)

One of the goals of the health reforms of the early 1990s in the Zambian health care system was to direct more resources from secondary and tertiary hospitals towards the district level.Zambia made progress in realizing this goal by devoting a larger percentage of health resources to primary level of care, with the total to the district and primary care level combined rising above 50% in 2005, as shown in the table below.

MOH Expenditure by Level of Care, 2003-2006

	2003		2005		2006	
	ZK million	%	ZK million	%	ZK million	%
Tertiary	88,197	14.3	98,506	10.9	97,665	10.8
Secondary (district)	45,320	7.3	95,408	10.5	71,578	7.9
Primary health care	261,531	42.4	438,278	48.4	397,235	43.8
Mission facilities	0	0	4,788	0.5	7,534	0.8
Central administration	159,087	25.8	106,072	11.7	152,696	16.8
Other (*)	62,883	10.2	167,355	18.5	187,323	20.7
Total	617,018	100	905,618	100	906,497	100

Source: MOH (2009)

A growing issue in Zambia is the amount of money people have to pay in cash at the point of care (called out-of-pocket payments). In 2007, 42% of all health spending in Zambia came from private sources, and two thirds of this from direct out-of-pocket payments. This is in a context where very few people are covered by health insurance in Zambia, with low-income employees often excluded from private insurance schemes because they cannot afford the required contribution.

User fees or cost sharing was introduced in Zambia as a means of promoting community participation in health, encouraging health workers to provide better services through performance bonuses and raising additional funds to improve quality of care at the point of collection. The majority of the funds collected through user fees were supposed to be returned to the health centre where they were collected and to be spent on improving the quality of care in health centres and the community. The funds could also be used to purchase drugs, to pay a cleaner or a guard, to buy medical or cleaning supplies, as well as to support community based agents such as Traditional Birth Attendants (TBAs) and Community Health Workers (CHW). However, the Government has since abolished user fees. The decision was taken on the premises that user fees constituted a barrier to the poor to access health services and that the contribution of user fees to the overall health budget was insignificant. It was also felt that the fees were not used for the purpose it was established for but instead used for administrative activities at the District Health Office (MOH 2009).

How do user fees affect our communities?

Method: Two-sided spider diagram

Approximate time: 30 minutes

Resources: Flipchart paper and pens, small pieces of paper in three different colours or labelled F/C, D and N

Procedure:

1. Participants work in groups of 5–6 people. On a piece of flipchart paper they draw the following diagram:

2. Participants then spend some time writing down on cards or pieces of paper, each response on one card, the ways in which user fees have a positive impact on health. Put each card at the end of one of the legs of the spider with the + sign in its body. If some cards are saying the same thing in different ways, put them together on the spider's leg.

3. Then do the same for the ways in which user fees have a negative impact, putting the cards at the end of the legs of the spider with the – sign in its body.

4. When they've completed the spider, give each group a pile of beans. Ask people to put a bean on each card where the impact is felt by more by the community (individuals and families). Encourage discussion among group members.

5. Let the groups come together to compare their spiders and then lead a discussion based on the following questions:
   - What does this activity say about the use of user fees?
   - Which side of the spider is more weighted – the positive or negative impacts of user fees?
   - Where are the most beans – on the positive or negative side? What does this say about the impact of user fees?
   - Who benefits when user fees are removed? Who does not benefit?
   - How can any negative impacts be managed?

If user fees can prevent the poorest from using services, either we need to find other sources of funds or we must make choices about where to put the funds we have.

In general, it is preferable that health services are funded by pooling the contributions from rich and poor into one fund, like an insurance fund, so that richer people can help to pay for the services for poorer people. The bigger the pool for this, the better it is for all, as the costs can be shared more widely. This is why national health insurance has been developed in some countries, and progressive taxes are a fair way of funding health services. In contrast, fees charged to the users of the services often make up a bigger share of the income of poor people than they do of that of the rich. This can mean that health care becomes unaffordable for the poorest people, and can prevent people from using services when they need to. User fees and health care payments for unexpected illness – catastrophic payments- can lead to households going into deeper into poverty as a result of health care costs. This provides a strong reason for pooled funds such as social health insurance.

For reflection or discussion:

Invite someone from the council or district health team to give information on what was spent on health in the district and to explain how health services are financed:
Looking at the country information on health financing in Zambia in this section
- Are the funds enough to cover PHC? Are they enough to cover all services? If there are shortfalls, which services should be funded first?
- Is the money mainly coming from the wealthy?
- Are there sources that might lead to poor people not using services?

Why not let the private sector run health services?

At no time in history have the major elements of health systems been organized or secured through the market. While the private sector has played a role in health systems in the region, especially through not-for-profit private providers like churches, for-profit providers have generally been reported to contribute less to the care of poor communities and to public health objectives. If you are interested in knowing more about health financing in the region, read the publications on the EQUINET Website at www.equinetafrica.org and especially the review of health financing in Africa that is EQUINET Discussion paper 27.

Urban primary care health services are often delivered by private individuals for fees, and there can be problems of widespread unlicensed practice, purchase of drugs, including antibiotics, without prescription, self-medication and high charges that discourage effective use of services. It can also cause health workers to leave public services for private arrangements where they can make more money, sometimes through informal and untaxed routes. (Remember the discussions on privatized water services?)

Who uses private health services?

Method:	Picture code
Approximate time:	30 minutes
Resources:	3 or 4 copies of the picture below, enlarged to A3 size

Procedure:

1. Ask all the participants to form a circle and put the copies of the picture code on the floor so that everyone can see a copy. Then lead a discussion using some or all of the following questions:
   • What do you thinks is happening in this picture?
   • Who is being served at the clinic? Who is not?
   • What is good about private health care?
   • What is not good about private health care?
   • Does this picture reflect what is happening in your communities?
   • Why do we have two parallel systems of health care? What can we do about this?

2. At the end of the discussion, summarize what participants have said and what conclusions and decisions they have come to.

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The structural adjustment programmes in the 1980s and wider forms of liberalization and privatization have greatly affected health systems. They

- reduced the role of the state;
- introduced user charges for government health services;
- reduced health financing levels from public funds; and
- led to declining access to basic public services.

They have led to parallel worlds, where those with wealth and connections can have access to the highest technology while many poor people cannot get or afford secure access to TB drugs or to safe water supplies.

6.5 Relationships with health workers

The categories of Health workers in Zambia include doctors, clinical officers, dentists, nutritionists, radiographers, physiotherapists, midwives (both registered and enrolled), nurses (both registered and enrolled), environmental health technologists, pharmacists, lab-technologists and other categories that include casual daily employees. The table below shows the actual number of health staff employed against the recommended numbers as approved in 2010.

Number of health staff employed versus the required number, Zambia.

Staff Category	Actual Staff 2010	Approved MoH establishment 2010
Clinical Officer	1,535	4,000
Dentists	257	633
Doctors*	911	2,391
Nutritionists	139	209
Lab Technicians	639	1,560
Pharmacists	371	425
Physiotherapist	239	300
Radiographers	259	233
Midwives	2,671	5,600
Nurses	7,669	16,732
Environmental Health Technicians (EHTs)	1,203	1,640
Other health workers (clerical officers, drivers, classified daily employees, security duards)	363	5,865
Total	**16,256**	**39,588**

*Source: MoH 2010 * number of doctors excludes doctors in positions at MoH headquarters*

Their roles are shown below:

Staff Category	Role
Clinical Officer	First line health staff - responsible for screening patients, diagnosing ailments, prescribing treatment, treat and refer patients for further investigations. They act as In-Charge of health centres.
Dentists	Advisors on dental hygiene - screening people with dental related health problems, diagnose, prescribe treatment , extract tooth, fills in tooth, replace tooth with artificial ones

Staff Category	Role
Doctors	Take in referred cases from Clinical Officers, they screen patients, diagnose ailments, prescribe treatment.
Nutritionists	Identify nutrition related concerns and recommend different foods to be taken by patients diagnosed with deficiencies.
Lab Technicians	In charge of laboratory department – they examine medical specimens in order to identify and confirm causes of ailments.
Pharmacists	Dispense and advise clinicians on available medicines, prepare records/ stocks, initiate orders, identify essential medicines.
Physiotherapist	Take care of the physically infirm (lack mobility of certain parts of the body) to gain full functioning of their body parts.
Radiographers	In charge of radiography (X-ray/Scanning). They identify and confirm diagnosis of injuries, ailments and disorders.
Midwives	Provide reproductive health services, counseling, antenatal care, assist in deliveries, refer complicated antenatal and post-natal cases, immunize newborns, infants, children. Provide general nursing care.
Nurses	Care for patients, screen, diagnose and prescribe medication. Some are in-charge of health centres.
Environmental Health Technicians	Enforce public health and inspect public places like restaurants etc.
Other health workers	Help health workers in maintaining and running of health facilities/services.

Health workers desire better salaries and living conditions, and want to be able to provide for their family needs. However, they also need to be able to carry out their work in a professional way, to be recognized, and have a career path that satisfies them.

For reflection or discussion:

What makes health workers stay or leave our district?

- Get people into groups of 3 or 4 and brainstorm reasons why health workers stay or leave your district.
- Discuss what can be done to keep health workers in your area – what incentives can communities give them?
- What incentives should they get from the health services? What else would make them stay?

Zambia's policy commitment to address the health worker crisis is expressed in its Fifth National Development Plan 2006-2010, 2006-2010 National Health Strategic Plan, and the 2006-2010 Human Resources for Health Strategic Plan (HRHSP) (MOH, 2005a; MOH, 2005b). The five year HRHSP has been costed and seeks to ensure an adequate and equitable distribution of an appropriately skilled and motivated health workforce through effective planning, increased health workforce production, improved health workforce productivity and stronger management and governance structures (MOH, 2005b).

By 2006, there was evidence that health worker dissatisfaction was higher at hospital level and in urban health centres (See Figure) Working conditions and resources were poorer in rural services and at primary care level.

Difficulties within health systems can lead to health workers feeling that their contribution is not recognized, or they lack job satisfaction, creating a push for migration. While many factors that create this situation lie beyond the health sector, there are some within the health sector that can act as incentives for health workers to stay in the system.

Level of clinical health worker satisfaction by level of care 2006

Level	Highly satisfied	Satisfied	Indifferent	Disatisfied	Highly disatisfied
RCH	7	49	9	32	3
UHC	3	38	15	34	10
Hospitals	2	31	13	45	9
All	4	40	12	36	7
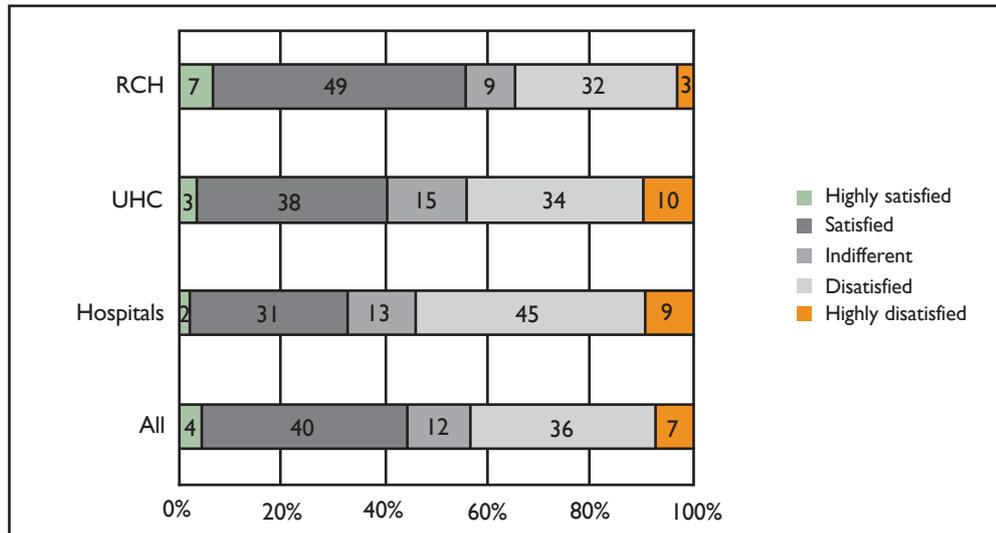
Source: Picazo and Kagulula 2008

Nb: RHC= Rural Health Centre UHC – Urban Health Centre

For discussion in the health facility committee meeting:

Report on what the community feels are the reasons that health workers stay or leave the district
- What can be done within the district to encourage health workers to stay?
- Are any of the incentives above being used? If so, for which health workers? How successful are they?

The Zambian Government and several external funders have supported initiatives to provide non-financial incentives to cadres of health workers in Zambia, such as building or renovating housing for staff in Luapula province, one of the Zambia's poorest rural provinces; import duty exemptions for medical doctors importing a motor vehicle, staff training, housing and transportation services and upgrading health facilities and equipment. The Zambia Health Workers Retention Scheme was expanded to include tutors, lecturers, Zambia Enrolled Nurses (ZEN), Zambia Enrolled Midwives (ZEM), Environmental Health Technologists (EHT) and Clinical Officers (UNZA et al 2011)

Recognising the role of health workers in PHC
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However, it's not just the number of health workers that are important. It is how the health workers relate to the community, and vice versa.

Method: Press cuttings

Approximate time: 30–40 minutes

Resources: Copies of the following newspaper clipping, one for each group.

NURSES GET INCREMENT

By Kondwani Munyeka   **Fri 06 Apr. 2012**

GOVERNMENT has awarded health workers salary increments ranging between K852,000 to K2,200,000 depending on an individual nurse's salary scale. Zambia Union of Nurses Organisation president Thom Yungana said following negotiations with government, nurses and midwives had been awarded the highest salary increment in comparison to other professionals. He said these increments could easily be explained in block figure terms and not in the usual traditional 'percentage across the board'.

"We have seen our members going away with additional cash ranging from K852,000 to K2,200,000 depending on an individual nurse's salary scale," said Yungana during a briefing in Lusaka yesterday. He also thanked government for making allowances flexible and not fixed with housing allowance on 20 per cent, newly introduced transport allowance at 10 per cent and commuted night duty allowance at five per cent of the basic salary. "This means that every time the basic salary shall be adjusted upwards, allowances shall also automatically increase upwards," said Yungana. He commended government for putting up a comprehensive and elaborate public service pay policy.

Yungana highlighted the 2012-2021 collective bargaining guiding principles as equal pay for equal work, life cycle of conditions of service, graded salary increase, introduction of compulsory health and funeral and life assurance schemes, retention of duty facilitating allowances, maintenance of housing and commuted night duty allowances and introduction of transport allowances as a percentage of basic salary to eligible employees.

Divide participants into groups of about 8–10 people. Give each group a copy of the newspaper cutting and a list of the questions below. Give them 20–30 minutes to discuss these questions, and then lead a short summary discussion in plenary to find out what the overall opinions are in relation to health worker issues and communication between health workers and the community.

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- What is this article saying about health worker concerns?
- What do you think it means for health worker – community interaction when health workers are unhappy with their conditions? How will things change when their conditions improve?
- What do you think can be done to improve communication both ways between health workers and communities?

In many communities, community health workers play an important role in bridging the divide between communities and the health workers at the clinic. Do you think community health workers can play this role in your community? If so, how?

How can we strengthen our communication with health workers?

Method: Margolis Wheel
Approximate time: 45 minutes
Resources: Group of health workers and a group of community members; drum/ plate and spoon
                       – something to make a noise; chairs (optional)

Procedure:

1. The health workers stand (or sit on chairs) in a circle, facing outward, not too close together. Community members make another circle around them, facing them, so that each health worker has a "partner". If there are more community people than health workers, each health worker can have two or even three partners, but space out the circle so that each pair can have a conversation comfortably. (You can also do this with people standing or sitting in two lines; when people move, the one on the end goes to the beginning of the line.)

2. Explain what they are going to do. The health workers must describe one or more of the problems they have in their job; and the people in the outer circle – the advisers or consultants – will suggest possible solutions.

3. Tell them that, when they start, they will have three minutes to discuss the problem(s) and potential solution(s); then – when you give the signal – the health workers will move one place to the left and talk to the next adviser about the same problem(s). (You bang a drum or plate etc, to show when it's time to move.)

4. The health workers will raise the same problem(s) with 5 or 6 advisers, so they get a range of different advice.

5. Start the first round – allow a bit longer the first time if everyone is deep in conversation – then give the signal for everyone to go on to the next adviser. Do 5 or 6 rounds – tell them when you signal the last one.

6. Everyone sits down – in one big circle this time. Give a couple of minutes for the health workers to write down the best of the advice they heard, and for the advisers to write down the problems they heard. Which were the most common?

7. Volunteers from both groups share their feedback after asking people from their group what they learnt. Health workers summarize the problems and the most useful advice they received; community members can share anything they learnt about being a health worker.

Community health workers (CHWs) provide outreach services, helping in case management, referral and follow-up home visiting. They support the promotion of health and health education, and they inform communities and mobilize them for health action. They create a bridge between the services and the community, especially to those who are hard to reach.

In Zambia

- **CHWs** disseminate health related information to the community
- **Trained Traditional Birth Attendants (tTBAs)** – refer pregnant women to health facilities for deliveries.
- **Safe Motherhood Action Groups (SMAGs)** promote safe motherhood in communities by encouraging expecting mothers to attend ante-natal health services and deliver at the health facilities.
- **Community Health Assistant** – A carer that is receiving a one year training earmarked to work at health posts especially in rural areas. The first in take graduated in 2012.
- **Community Distributors** promote good health life styles and distribute health commodities such as ITNs, contraceptives, chlorine and condoms.

Communities support community health workers by selecting them, by mobilizing social and financial resources to support their work, by providing social support, and by attending meetings. They give community health workers information about their health needs, and support their efforts to communicate those needs to the health services so that they can be addressed.

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In summary

In this module we have
- Explained what we mean by a people-centred health system, and shown that its main focus must be on primary health care
- Given voice both to health workers and to community members to discuss what they understand to be the role, services and attributes of primary health care
- Looked at how health systems can respond to differences in society and culture, as well as play a role in changing social norms and culture when this is needed to promote health
- Looked at how health services are funded and how user fees affect households and their use of services
- Discussed how private health services affect the health system
- Examined what makes health workers want to stay or leave work, and
- Explored the relationship between communities and health workers and considered how this can be improved

First, discuss what was done after the last session

Discuss with community members the actions that people took after the last session, using the questions used in previous modules.

What will we do next?

- What actions can participants take and report back on before the next session?
- Who will lead these actions? Who else will be involved to help?

Ask the community members what else they want to know about
- Identify the topics that people want to know about in the next sessions.

Remember that making changes in health systems is not a one-off action. It takes time, issues need to be raised in the Health Facility Committee, and trust needs to be built between health workers and communities.

FACILITATOR'S PLAN

Think about the topics you will need to plan before the next health literacy session.

What do communities want to hear about next?

- What new topics did communities want to hear about for the next session?
- Which module(s) in the manual deal with these? How will you use them?
- What other information will you need to bring?
- Who else will you need to invite to help you with this session?

What else do you want to include in the session?

- What other topics will you include in the next session?
- Which module(s) in the manual deal with these? How will you use them?
- What other information and who else can you bring?

Module 7: Community roles in people-centred health systems

In this module we:
- explore community roles in health
- discuss how health systems listen to and include community views
- discuss who else communities can engage in health issues

7.1 What roles do communities play in health systems?

In Module 6 we talked about the various ways in which health systems work and how they are taking steps to become more people-centred. However, this often happens in a very limited way, which raises a problem: we don't have many examples of health systems that are strongly people-centred, yet that is what we are trying to achieve. The gap between the reality and the ideal we are striving for is often large. But we need to have a vision and implement it. What would this health system look like? What role would you be playing to make it that way? What role would people in the community be playing, whether they are health practitioners, community leaders, teachers, parents, young people or children?

How do health systems involve communities?

Method: 'Where's Mapalo?' (inspired by the *Where's Waldo?* children's book)
Approximate time: Part one: 45 minutes; Part two: 45 minutes for group work and discussion
Resources: Full-size poster of 'Where's Mapalo?': you can find it at the back of this manual; photos, if you have any, from the human sculpture activity in Module 6; flipchart paper and marker pens.

Procedure:

PART ONE:

1. Working in groups of about 8–10 people (hopefully no more than 2 or 3 groups), get participants to look at the picture. Tell them that their task is to describe what they see happening in this community. Who is doing what? What are different people doing to meet their own health needs and those of the community?

2. Encourage each group to find as many things as possible; and to share what they see. While they are looking, they should also try to find Mapalo. She is wearing a funny pointed hat and is in a lot of different situations. She's in this picture to make it more enjoyable for everyone while they are looking at the different situations described in this picture.

3. After about 10 minutes, show participants this list of Health Action Areas that can be undertaken by communities within the larger health system:
   - providing health services
   - promoting health
   - making policies

- mobilizing and allocating resources for health
- monitoring quality of care and responsiveness

Make sure everyone understands what is meant by each of these action areas. Point out that each action area represents a particular function, or role, of the health system. (There is more information on this in the next few pages of this manual).

4. Participants must then go back to the "Where's Mapalo?" picture and look at who is doing what in each Action Area to meet this community's health needs. Here we are particularly looking at who is doing what action to strengthen the development of a people-centred health system. Get each group to make a list or table as shown below. Add any other Health Action Areas you think are important.

Health System function: Area of action	Who is doing it?	What action is being taken?
providing health services		
promoting health		
mobilizing and allocating resources for health		
monitoring quality of care and responsiveness		

5. When the groups have completed their tables, put all of them up on the wall and ask for feedback on what they learnt from the poster and from completing the tables.

PART Two:

6. Put participants into 2 or 3 groups, either the same groups as before or you can break them up in to new groups by similar geographic or work areas if you want. Tell them that they are now going to discuss what is happening in their own communities, drawing on what they learnt from Part One of this activity. Give them the following questions, written out on a piece of flipchart paper. Each group should discuss all four questions.

   Questions:
   In relation to your own communities:
   - Which of these Health Action Areas are being well covered? Discuss how they are being fulfilled, and by whom. Are these activities making a difference to the health of people in your community?
   - Which activities are being partly done but need improving? How can they be improved?
   - Which of these Action Areas are not happening in your community? Why aren't they? Do you think it would be good if they were happening?
   - What would need to happen for people in the community to start doing things to cover these Action Areas? Which existing institutions would it be good for them to partner with? What obstacles might they face, and how can these be overcome?

   While answering these questions, reflect on the Human Sculptures you did earlier (Module 6), when you were looking at what you think an ideal health system would be like. Look at the photographs, if you took some; otherwise just remind each other of how you envisioned a people-centred health system. Then as a group summarise the issues you have raised in the discussion and chose the three main issues you want to report back to the plenary.

7. Bring the groups back to plenary and get them to report on their discussions. Make sure that the report backs don't drag on for too long. If you predict that there will be a lot of repetition from one group to the next, get each group to report back on only one question and then the others can add their own ideas at the end. So, for example, Group 1 reports on the first question, followed by

comments and further input from the other participants; then Group 2 reports back on the second question, etc. This will work well as long as you, the facilitator, make sure that differing opinions from the different groups are taken into account.

8. Finally (and most importantly!) discuss how you can plan to put these ideas into action. See the Community Plan at the end of this module.

As you saw in the picture activity, "Where's Mapalo?", communities have important roles to play in many aspects of health systems. Go through the ideas below, and see which you have already discussed, and if any are new.

- People stay healthy as a result of their understanding and awareness of health – parents are responsible for the health of their children, partners for each other's health, and communities should care for the elderly and poor in their communities.
- People share information with health services about the conditions in their community and about preventing and treating disease.
- People have local health knowledge to contribute to their health systems, including knowledge about healthy foods and local health risks
- People play a role in implementing health actions, including outreach, caring for people who are ill, and supporting health services
- People contribute resources to the health system, including giving up their time, even building clinics, waiting mother shelters, and other services.
- People set priorities and make decisions on how health problems should be addressed, and on how resources should be allocated
- Communities also monitor their services and make sure that they are functioning in the way they expect, and provide feedback to health authorities and discuss issues with health workers

Communities contribute a significant amount to the health sector through out-of-pocket payments (fees), taxes, and in other ways. Communities mobilize their own resources to implement community-based health improvement initiatives through village funds, revenue collection, selective exemptions from local levies, private-sector funds, commodity sales and some cost-sharing. These resources are complemented by the contribution of labour, time and other inputs, particularly in enabling villagers to become directly involved in health-improvement activities in ways that they can afford.

Health System function: Area of action	Examples of community roles
Health Service provision	Providing services; Supporting the use of the services; Distributing health resources such as bed nets, or cement for toilets; Supporting the morale of health workers.
Health promotion and information exchange	Obtaining and distributing health information; Giving people information to enable them to make choices about health; Implementing and using health research; Helping to change social attitudes; Mobilizing and organizing for health.
Setting policy	Representing public and community interests in policy; Promoting fair policies that support disadvantaged people; Negotiating public health standards and approaches; Building agreement and sharing information on policies; and Mobilizing public support for policies.

Health System function: Area of action	Examples of community roles
Resource mobilization and allocation	Paying for health services; Informing health services about community needs; Ensuring that funds for health reach those who need them; Building public accountability and transparency in the use of funds for health.
Monitoring quality of care and responsiveness	Monitoring the quality of health services; Giving voice to disadvantaged groups, promoting their needs; Representing the rights of patients; Channelling and negotiating patients' complaints and claims

Do these contributions give communities any say in decisions made about health services?

Community roles in people-centred health systems go beyond simple "participation" to empowering people to improve and control their health. This means that people can take informed decisions and act on their priorities and needs. Community participation does not mean that people "do it alone", but that they have effective partnership with authorities that influence health. The principle of partnership is one we should always stress and remember.

7.2 How do health service personnel listen to people's views?

Effective participatory local planning requires that health planners
- Include, consult and listen to people.
- Involve representatives of all groups in communities, and have representatives who communicate with their community members.
- Make connections between communities and the organizations that are authorized to make decisions and manage resources.

There are various practical ways in which health services share information with communities
- Health services can gather information on public needs and preferences through surveys on facts and opinions, competitions to generate ideas, input from people who work in relevant services or agencies, and by using print and electronic media, as well as participatory approaches.
- Health services can communicate information to the public on health profiles, policies and activities through "White Papers" (draft proposals from government"), charts and posters in health and public facilities, discussion documents, and mass publicity programmes. They can allow citizens access to official information, agendas and minutes, encourage the public to listen to budget discussions, provide accessible summaries of policies and budgets to citizen groups. They can hold meetings, lectures, discussion sessions, joint committees, and can use local and national newspapers, radio and television.
- The public can assist in giving feedback to health planners by making sure that people are aware of the procedures for lodging objections to proposals, by holding public hearings and meetings, lectures and discussion sessions.
- Communities can make sure that their proposals are considered in health planning through committees, hearings, meetings, and by the use of suggestion boxes.
- Communities can use drama as a way of raising their issues and concerns.

Looking at the options used to communicate with communities,

- In what ways do health services listen to communities in your area? Are these adequate?
- What other ways could they use in your area?

How well do health systems listen to people's views?

Method: Wheel chart

Approximate time: 50 minutes

Resources: Large copy of a wheel chart with 6 segments on flipchart paper; flipchart paper and marker pens

Procedure

1. Participants work in groups of 8–10 people.
2. Get them to copy the wheel chart on to their flipchart paper, and mark each "spoke" on the wheel with points from 1 to 5, with 1 nearest the centre.
3. Then get them to label each segment, as shown in the diagram above.
4. Participants are now ready to assess how well their health system is listening to people's views. For each segment of the wheel, they must first discuss what the situation is now and then decide on a scale from 1 to 5 (1 is very bad and 5 is very good) the extent to which the health system takes into account the views or actions of communities.
5. Once they've decided, they shade the area of the segment to show this. Then they decide what the situation should be, and mark that in each segment with a squiggly line. The space between the two markings creates a clear visual picture of the gap between what the situation should be (squiggly line) and what it is now (shaded area).

Health system gathers information on public needs and preferences

Health facility committee used regularly to exchange information

Health system communicates information to the public

Health system uses community i,nformation in allocating resources

Public gives feedback to health planners

Community participates in health planning

KEY
~~~~ should be
is now

6. After about 20 minutes, ask each group to put their wheel chart on the wall. Lead a discussion on the differences and similarities between each of the wheel charts.

7. Finally, ask the everyone these questions:
   - In which aspect does the health system listen best to people? Why is this?
   - In which aspect does the health system least listen to people? Why is this?
   - How can areas of communication gaps be improved?
   - Do community groups have a role to play in this? If so, what?
   - What is the role of health workers?

NOTE: the wheel chart can also be used to measure progress over time. So, the shaded area would reflect the situation at the start of the health literacy programme. Future squiggly lines (say, for example, every 3 months) would document any changes. Remember to facilitate a discussion to explain the changes – why have things improved? Why not? What else can be done? By whom? etc

Health Committees are one way through which health services and communities communicate. Zambia has neighbourhood health committees that bring health workers, community members and other stakeholders together to plan and implement health actions.

For reflection or discussion:

If not already involved in the health literacy programme, invite members of the local Health Committee (Neighbourhood or other Health committee) in your area to this discussion. Other stakeholders like churches and clubs may also be brought in if not already involved. Information sheet 7a provides further information for this discussion.
- How have Health Committees helped services listen to communities in your area?
- Which of the areas of the wheel chart that you developed have they played a role in?
- What difficulties do they face?

There was very limited space for participation in the Zambian health system in the early 1980s. The decentralisation policy included in the revised National Health Services Act (1995) ushered in the District and Hospital Management Boards, and Neighbourhood Health Committees. Neighbourhood Health Committees were developed to enhance accountability and community participation in planning, budgeting and implementation of health activities. Capacity development programmes were initiated and guidelines developed to orient them in their expected roles. Survey evidence in 2006 suggested that most communities were involved in the planning and budgeting of health activities on an annual basis, but that there was little or no incorporation and implementation of these community plans by health centres. Communities were not well informed of the available resources or their disbursement and utilisation at health centre and community levels, leading to tensions and misunderstandings between health workers and the local communities they served (Lusaka Health Board, Equity Gauge Zambia 2006). Clear guidance, support, communication and information exchange were identified as essential, but sometimes missing contributors to partnership. In 2006, the Ministry of Health abolished all autonomous structures in the sector that were charged with responsibilities for health care provision and support i.e. DHBs, HMBs and the CBoH, with the exception of the NHCs. The 2006 [(Health Services (Repeal)] Act moved to dissolve the District Health Boards, Hospital Management Boards and the Central Board of Health. The role of the Neighbourhood Health Committees was reconstituted into the Neighbourhood Advisory Committees. Their roles were redefined as "advisory" (UNZA et al 2011).

INFORMATION SHEET 7a: Health committees at local and facility level

Health Committees provide joint mechanisms for the health services and communities to identify the priority health problems in communities, plan how to raise their own resources, organize and manage community contributions, and tap available resources for community health activities. A Committee at health facility level is a joint community–health service structure, linked to the clinic and covering the catchment area of a clinic. Membership of such a committee usually includes both community and health worker representatives. The Committee:

- helps people in the area identify their priority health problems and what they think can be done about them;
- assists communities plan how to raise their own resources, and how to organize and manage community contributions for community health activities;
- uses information from the health information system and from communities in planning and evaluating their work (they should be trained to do this);
- assesses whether the health interventions in the area are making a difference to people's health, using the health information system and community information;
- is a channel for information flow to and from the community and local government and district assemblies;
- is informed about the activities of different public and private health providers in the area;
- raises and discusses aspects of patient care, and represents communities on issues they raise about services offered, to see how these can be addressed;
- obtains information from the health services on budget allocations for health, on Ward-level allocations, and provides input and feedback to the services on budget planning, and keeps communities informed about health budget issues, particularly where these relate to the mobilization of local resources.
- works with local government to motivate and implement public health standards, such as those for water supply and sanitation.

In Zambia, the Neighborhood Health Committee (NHC) is a non-political mechanism that acts as a link between the Health Centre and the Community and that co-ordinates health related community based groups at grass roots level.

Members of the NHC identify health problems in the community in conjunction with other stakeholders, bring the identified health problems and other community evidence to the attention of the Health Centres, and identify possible actions to address the problems. The NHCs facilitate and guide community based health activities and inform and mobilise community members on health outreach activities like immunization and growth monitoring. The NHCs also mobilise community resources for health and ensure accountability in the use of health resources.

NHCs include non- partisan community members elected from the community on the basis of their interest in the health of their communities. They should have some health related skills and knowledge. Members are elected by communities in a procedure that involves campaigns for at least 14 days before day of elections. The members should have a gender balance. The NHC is composed of 10 elected members who include: Chairperson, Vice Chairperson, Secretary, Vice Secretary, Treasurer, Vice Treasurer, Publicity, Vice Publicity and two committee members. NHCs are guided by their constitutions and by government policies on health. After NHC members are elected they should receive an orientation from health personnel to under their roles and responsibilities.

How can we use health committees more effectively for dialogue with health workers and employers?
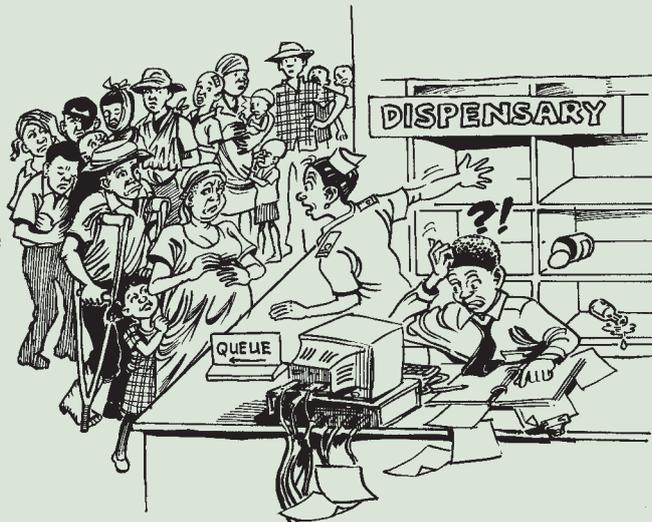
Method: Picture code
Approximate time: 30 minutes
Resources: 3 or 4 copies of the picture code provided
Procedure:

Ask all the participants to form a circle. Put copies of the picture code on the floor so that everyone can see it. Then lead a discussion using some or all of the following questions:

- Who do you see in the picture?
- What problems are the different people experiencing? Why? (Use the 'But why?' approach to get as deeply into the causes as possible: see Module 2.)
- Do any of these problems exist in your community, workplace or health service?
- How can you best communicate and partner with the health service to respond to these problems?
- At what levels can you act to address the problems?
- What support do you need?
- How can you partner with your health-service providers to improve the situation?
- Who else is already engaged in working with these issues and how can you work with them?

For summary discussion:

What actions have we identified
- to strengthen our voice in health decisions?
- to strengthen our dialogue with health workers?
- to improve the functioning of our health committees?
- to make sure that our representatives on these mechanisms consult us and give us feedback?

7.3 Who else can communities engage in health issues?

There are a wide range of institutions, groups and individuals involved with health issues who can be engaged to ensure that their community's health needs are fully met. As well as clinics and other institutions that provide health services directly, there are other organizations within the community that also provide for health.

- Schools and other child- and family-service organizations are a critical point for promoting health, providing education, and promoting the appropriate use of health services.
- Shopkeepers sell products that can help or harm health and can thus have a positive or negative impact on health. For example, shopkeepers sell malaria prophylactics and other drugs, and can ensure their safe use. They can also promote healthy foods, or they could promote those that harm health if used inappropriately, like breast-milk substitutes.
- Agricultural extension officers can support community food production and healthy diets.

Examples of the role of other sectors are shown in the Table below:

Other Ministries and Institutions	Their roles in Health Provision
Ministry of Education, Science, Vocational, Training and Early Education	Promotes school health education.
Ministry of Community Development, Mother and Child Health	Responsible for mother and child health promotion.
Ministry of Local Government and Housing	Promotes Environmental Health and Sanitation. It is also responsible for water and sanitation provision.
Ministries of Defence and Home Affairs	Run some hospitals and health centres catering for their security personnel and at times open to their surrounding communities.
Parliament	Pass laws that support quality health services Advocate for improved health facilities for their constituencies

In Zambia the Ministry of Local Government is comprised of city councils, municipal councils, district councils, and ward development committees (WDC). The Ministry of Local Government receives a yearly Grant from the Ministry of Finance and National Planning. The councils submit budget proposals to the Ministry of Local Government where they are reviewed. Those found wanting are sent back to individual councils while those deemed feasible are given grants. Each Parliamentary Constituency obtains a grant from a fund called the "Constituency Development Fund" (CDF). WDCs apply for funding to implement development projects prioritized by the community. The WDCs are made up of community members living in a given ward. They elect representatives at a community meeting or "Insaka", a Bemba word that stands for a community coming together to share ideas. Members of WDC collect information about problems in their communities and the WDC analyses this information and draws up a budget for actions. This is submitted to the Ward Chairperson, then to the area councillor, and the Member of Parliament for the area. The council holds its meeting in the Council Chamber presided over by the head councilor (usually a Mayor or Chairperson) where all submissions by the different wards are discussed. If they are feasible they get approved and may receive a grant from the CDF.

Parliaments are important for health, especially at national level. They

- pass laws;
- review national budgets;
- monitor the performance of government;
- raise and debate issues relevant to the people.

There is evidence from existing experience that, when parliamentarians are given adequate information and technical support, they are able to carry out their responsibilities effectively, with a positive impact on health. Despite this, professionals

Community Planning meeting, Matero, Lusaka © A Zulu 2012

and civil-society organizations working in health often do not understand parliamentary processes sufficiently well to be able to support or work with them effectively. And parliaments may not be linked adequately with professionals and networks working on health equity.

Civil-society organizations (CSOs) play a major role in the delivery of health services. Religious organizations have had a long history of service provision, while other organizations have become more involved in recent years. CSOs mobilize effective demand for services, building awareness of community needs, and experimenting in innovative approaches to service delivery. CSOs have raised community preferences in health services. CSOs lobby for equity and pro-poor health policies. CSOs promote public understanding and attitudes about health, promote healthy public choices, build more effective interactions between health services and clients, and enhance community control over and commitment to health interventions.

CSOs have participated in global policy areas such as trade agreements and health, prices of and access to drugs, international conventions and treaties on health-related subjects – such as landmines, the environment, breast-milk substitutes and tobacco – and in debates around policies and public-health standards.

For discussion:

Invite the CSOs in the area to present information about the work they are doing in health

- Where do they operate in the social map?
- Which groups do they work with?
- Which health priorities do they work on?
- In what way can the Ministry of Health work more closely with CSOs?

7.4 Civil-society alliances in health systems

The role of civil society in health is not only related to local action. Civil-society alliances can influence national, or even international, policies in health. Have a look at the priorities adopted by health civil-society groups at the Southern African Social Forum in Zimbabwe in October 2005.

RESOLUTIONS OF HEALTH CIVIL SOCIETY IN EAST AND SOUTHERN AFRICA

Southern African Social Forum, October 14 2005

Health civil society groups in Zimbabwe and east and southern Africa, recognising the initiative of health civil society in the region met in Harare on the 13th of October 2005 to discuss our struggles for health. We agreed on the following resolutions. We are united, together with health civil society in the region, around the core principles and values of:

i.   the fundamental right to health and life

ii. equity and social justice

iii. people-led and people-centred health systems

iv. public over commercial interests in health (health before profits)

v. people-led and grassroots-driven regional integration.

To take these values forward we are reclaiming the state in health and have identified the following priorities:

1. Building a national people's health system

2. Organising people's power for health

3. Having adequate fairly treated health workers

4. Sufficient and equitable funding of our health systems

5. Global solidarity for economic and trade justice.

Within these areas we resolve that:

BUILDING A NATIONAL PEOPLE'S HEALTH SYSTEM

1   We are struggling to build an integrated health systems underpinned by the principles of equity that addresses our lives, not just our illnesses and that keeps us healthy.

2   We will link, network and foster strategic alliances with partners, inside and outside the health sector, to develop a unified voice.

ORGANISING PEOPLE'S POWER FOR HEALTH

3   We are organising people's power to amplify our voice, claim our right to health and control our resources for health.

HAVING ADEQUATE, FAIRLY TREATED HEALTH WORKERS

4   Our health systems need adequate, well-trained and fairly distributed health workers at all levels of our health systems in places where people need them most.

5   Health workers in the public sector need to be motivated through decent conditions, training, incentives, living wages and safe work environments, in a way that promotes gender-equity.

SUFFICIENT AND EQUITABLE FUNDING OF OUR HEALTH SYSTEMS

6   We demand sustained increased investments in the public sector in health. We expect our governments to meet their Abuja commitment to spend at least 15% of government spending in health.

7   We demand an end to African wealth unfairly flowing out of the continent so that we have the resources for our health.

8   We demand an end to unfair charges on poor people for health.

GLOBAL SOLIDARITY FOR ECONOMIC AND TRADE JUSTICE

9   We expect our parliamentarians to ensure our countries have the independence and sovereignty to protect our right to health.

10   We remind those who go to the World Trade Organisation (WTO) that: "No deal is better than a bad deal."

We as health civil society, together with all other progressive forces in society in the region, are taking forward the struggle. We call on our global partners to support us in this struggle!

For discussion:

Look at the five priority areas for reclaiming the state and building a people-centred health system. In your own community or district, do you think that some of these five priority areas are more important than others? If so, which ones and why?

Choose one or two of these priority areas to work on. Divide up into groups of about 6–8 people and in each of your groups discuss the following:

- What is already happening in relation to meeting this priority? Which organizations and people are involved?
- What still need to be done? Who will do it?
- What should the organisations in your own area do? What concrete action would you want to take in your area to build a people-centred health system.

In this module we have
- Looked at the different roles that communities can play in a people-centred health system and discussed how we implement these roles locally.
- Discussed the way in which health systems listen to people's views, as well as the mechanisms for this, such as Health Committees.
- Discussed the role of other institutions, groups and individuals in supporting community action for health.
- Identified options for strengthening community roles in health, and strengthening people-centred health systems.

Remember to go back on all the issues you discussed in the session before drawing up your community plan on what communities can do to improve their voice and input in health systems. These actions may include, for example, following up with the different mechanisms that do exist for this to see who is on them and how well they are functioning; or taking steps to set up a local health committee. You can also follow up on actions taken after previous sessions to see how well they are working and how to strengthen community involvement.

Queuing up for Child Health Week, Makeni, Lusaka © A Zulu 2010

As with making changes in health systems, strengthening community roles in health is not a one-off action. It takes time, issues need to be raised in the relevant Health Committee, and trust needs to be built between health workers and communities.

COMMUNITY PLAN

What will we do next?

At the end of your session discuss with community members what actions will be taken before the next health literacy session
- How will participants give feedback to others in the community on what they learned and decided at this meeting?
- What actions can participants take and report back on before the next session?
- Who will lead these actions? Who else will be involved to help?
- What will be the role of the health workers and the local council?
- What information or report-back will participants bring to the next meeting?

Ask the community members what else they want to know about
- Identify the topics that people want to know about in the next session.
- Are there issues that communities want to know about or to bring to the district health team's attention.

FACILITATOR'S PLAN

What topics will you implement in the next health literacy session?

What do communities want to hear about next?
- What new topics did the communities want to discuss at the next session?
- Which module(s) in the manual deal with these? How will you use them?
- Where and who else can you get information from?

What else do you want to include in the session?
- What other topics will you include in the next session?
- Which module(s) in the manual deal with these? How will you use them?
- What other information will you use and who else can you bring?

Module 8: Organising for health in Zambia

In this module we:
- how we can improve our ability to organise for health, and
- the methods and organisations that can support this.

Building organizing skills and strengthening our organizations to advance health is not something that can be summarized in a few pages of a manual! For some organisations, the tasks relate to building the skills of the members to produce the changes they seek. For others, at various times, the main task is to audit the strengths and weaknesses of the organization to identify what areas need strengthening. Because the demands are different at different times, this module introduces some of the issues and skills involved. We also understand that we are building skills in facilitation, listening, asking the right questions, making and presenting collectively agreed summaries throughout the different activities and processes in the programme, and not just in this module.

It is demanding to work with everybody that is involved throughout all stages of implementation of a health programme or activity. Different parts of the programme will involve different people in the community. This poses a number of challenges for health literacy facilitators, who will need to
- ensure that all members of communities have the opportunity to participate and have their voices heard, making sure that there is no bias in favour of one social group over another,
- enable everyone's views to be listened to and discussed, and ensure the widest participation in discussions and decisions, and
- work with different groups at each stage in the process, while ensuring that the powerless or most affected are given a voice.

For example, during the introduction, awareness, creation and sensitization of a health activity, all community members should be involved. But it is not possible to have all community members present in a planning meeting, so meetings will involve representatives of social groups in a community.

If equity in health demands that people have greater power or control over their resources for health, then the processes we use to address health need to ensure that those with least power are not excluded, and that they strengthen the voice and influence of all social groups in health. That includes the way we build and work within our own organizations.

For reflection or discussion:

Think about a health programme or activity you have been involved in.
- What was the health issue involved?
- Which social groups were affected by this health issue?
- Which social groups were included in the activity?
- Who led the activity? Which social group did they come from?
- Which of those affected were left out and why?
- Do you think the health activity would have been more effective if those excluded from the programme had been included?

Looking at the information given above,
- Do you know of any social groups that have networked across areas to make their needs more visible? Which groups? What did they do?

8.1 Organizing for health

Working within organizations like LDHMT or the Ministry of Health offers opportunities to reach communities through organized structures and people. People who hold positions in these structures, or who have a role in the organization, have a responsibility to speak for or serve all social groups, and particularly those with greatest health needs.

This raises the challenge of how to select representatives to participate in activities or structures, or to take a role in the organization.

Let's take the example of participation in activities like health literacy training.

Health meeting at Chipata Clinic Lusaka © A Zulu 2011

How can we make sure that participants come from and can represent various social groups?

Method: Story with a gap
Approximate time: 30 – 40 minutes
Resources: Two pictures (overleaf), enlarged to A3 size

In a 'story with a gap' the facilitator uses two pictures to raise debate about problems and possible solutions. The first picture shows the problem, and the second shows a desirable situation or solution. The discussion focuses on the events that may have occurred in order for the solution to come about ie what happened in the 'gap'?

For example, in this activity the problem is that young people do not feel comfortable going to their community clinic; in the second picture, youth representatives from a number of youth groups have organised to meet with the clinic staff to talk about ways in which to make the clinic more youth-friendly. The 'gap' is to explore how the two youth representatives were chosen by the youth groups to represent their interests at the clinic.

When facilitating a 'story with a gap' it is best if the group is given time to study the first picture and to volunteer information on the possible causes of the problem. They then focus on the solution shown in the second picture and discuss what happened to get from Picture 1 to Picture 2.

Procedure:
Show the two pictures to all participants (either by putting the pictures on the floor or on the wall, as long as everyone can see them) and facilitate a session using some or all of the following questions:
Picture 1:
- What do you see happening in the first picture? (Spend some time exploring this: What is the problem? What are the youth feeling – at the beginning of the cartoon? At the end? Why do you think there is a change in mood? And so on.)

Picture 2:
- What do you see happening in the second picture? (Again, explore a little further: Who are those two youths? Who are they hoping to meet? And so on.)

©M Ndhlovu & TARSC

Source: Loewenson et l 2006; ©M Ndhlovu & TARSC

The 'gap':
- What do you think happened to get the youth from Picture One to Picture Two – the 'gap' in the story? (It's like when you heard the beginning and the end of a story and you're trying to guess what happened in the middle.)
- How do you think the youth representatives in Picture Two were chosen by the larger group of youths? What criteria do you think they used to choose those two representatives?
- What do you think happened at the meeting in Picture Two? And what happened afterwards? How do you think the two youth representatives reported back to the larger group?

To conclude
- What lessons can you draw from this story in relation to group participation and representation?
- Discuss further who you think should be involved in the health literacy programmes in your area. How will you include them?

Making sure that different social groups are brought into activities, listened to, participate in decision-making, and are given information on how decisions are being implemented are fundamental to building a membership organization. The strength of any organization is a reflection of the participation, capabilities, organization and solidarity of its members. To start with lets share the basic information about your district health team.

But we also need structures and procedures so that people know what to do in the organization

8.2 Acting on health

The structures and mechanisms for participation and decision-making in the organization provide an important basis for being effective in health. Equally important is the way in which the organization and its members act.

At various times in the health literacy programme, participants have discussed actions that communities can take in health, both directly and in co-operation with allies such as health workers and local leaders.

What does a district health team do?

Procedure: Wall art, panel discussion or group work

Approximate time: 90 minutes

Resources: A wide range of materials from organisations working in health in the district – reports, IEC and training materials, strategic plans, annual reports, etc. (i.e. enough material to give participants a sense of the range of activities underway); flipchart paper, marker pens; copies of Information Sheet 8a, one for each group.

Procedure:

1. Put the materials on a large table on one side of the room. Put three pieces of flipchart paper on the wall next to the table, far apart so that it is not too crowded. Place marker pens next to each piece of flipchart paper. Label each piece of flipchart paper as follows: "Actions at Community Level", "Actions at District level", "Actions at National Level".

2. Give participants enough time (about 20 minutes) to walk around the table looking at all the materials, writing a list of actions on the relevant piece of paper as they see them in the materials. They can also add to the lists from their own experiences.

3. When the participants feel that these lists are complete, bring them back to plenary and spend a short time reflecting on the three lists. Is there a lot of overlap? Are the actions clear?

4. Then, divide the participants into three groups, each group taking one of the lists so that they are each focusing on a different level of action. Make sure that every group has at least one informed member of the district health team in the group (either from the secretariat or a cadre from district level). Their role in the group is to answer any questions and provide any additional information the group may need. They should also take a copy of Information Sheet 8b for reference.

5. Each group then develops a table with the following columns:

ACTION	WHO WILL SUPPORT THIS ACTION	PROGRAMMES TO SUPPORT THIS ACTION	STRENGTHS OF THIS ACTION	WEAKNESSES OF THIS ACTION

6. When the groups have completed their tables, ask them to put them on the wall. Look at the tables and lead a discussion on what can be done to be more effective in action at COMMUNITY level and also at NATIONAL level. Note all decisions arising out of this discussion.

INFORMATION SHEET 8a: Actions and programmes on health by the district health team

District health systems are managed through the District Health Office (DHO) by a District Health Management Team (DHMT), which is headed by a District Medical Officer (DMO). The DMO is supported by a number of other cadres and departments that make up the DHMT. The specialists in particular areas ensure that health workers in the district are trained and kept up to date to deliver services at all health facilities in the district. The staff in administration provide administrative support to health workers. DHMTs have an overall responsibility for health care delivery in their respective districts. They offer the range of services discussed in Module 6 and other sections of the manual.

District health systems are managed through the District Health Office (DHO) by a District Health Management Team (DHMT) headed by a District Medical Officer (DMO). The DMO is supported by specialized personnel already discussed in Module 6. The DHMT staff backstop the entire health system in the district according to their specialization. Take for example the Lusaka District Health Management Team (LDHMT) under Ministry of Health. It has a responsibility to provide quality health care for its residents through provision of an integral Basic Health Care Package, by a competent workforce, working in partnership with other public and private stakeholders, to improve the health status of the residents of Lusaka district. It is supported in this by other public and private partners and the neighbourhood health committees.
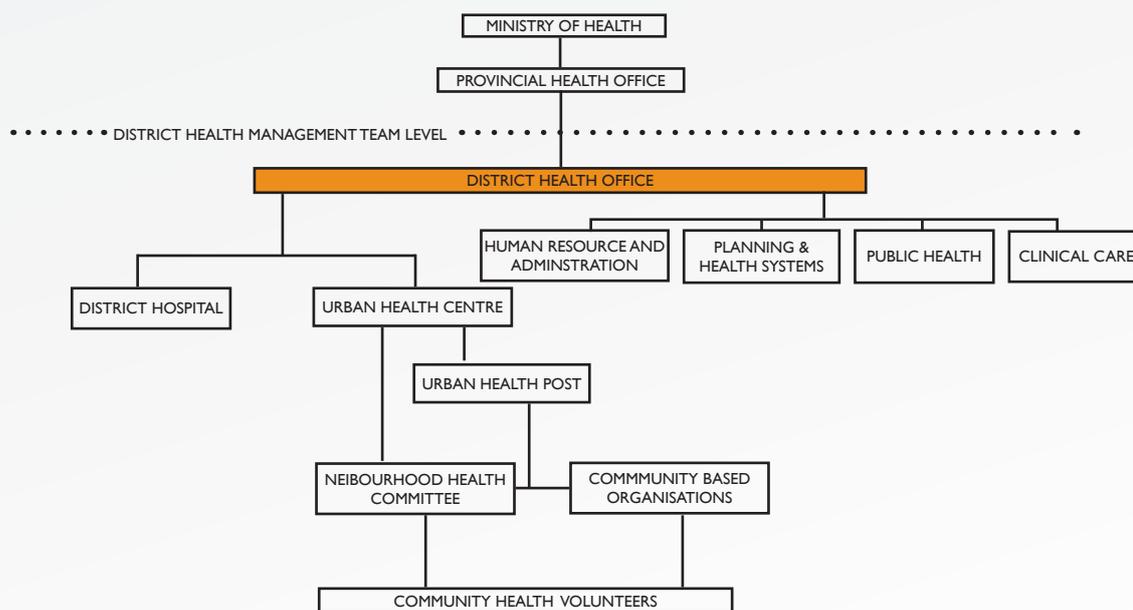
INFORMATION SHEET 8b: Government agencies that support the district health team

As the previous sections indicate, many ministries have a role to play in health and PHC. Some of the most important Ministries are introduced below:

The Ministry of Health is constitutionally charged with the health of Zambians. The Ministry of Health seeks to "provide equity of access to cost effective, affordable and quality health services that are as close to the family as possible." It has its headquarters at Ndeke House in Lusaka, health facilities namely health posts, health centres, hospitals and training institutions. All these institutions are run through provincial and district health offices. It has Statutory Boards that ensure that national policies are implemented in various areas. These include the Zambia Flying Doctors Services (ZFDS), Radiation Protection Authority (RPA), Pharmaceutical Regulatory Authority (PRA), Medical Council of Zambia (MCZ), General Nursing Council (GNC), Occupational Health (OH), Tropical Diseases Research Council (TDRC), National Food and Nutrition Commission (NFNC), Medical Stores Limited (MSL), National AIDS Council (NAC) and the Food and Drugs Laboratory (FDL). The cadres of the Ministry of Health were discussed in Module 6. The structure is shown on the next page:

The Ministry of Community Development, Mother and Child Health (MCDMCH) was renamed in September 2011 and now incorporates Mother and Child Health, with staff dealing with maternal and child health transferred from the Ministry of Health to the MCDMCH. The restructuring and realignment in the two ministries is still in process. Once this process is complete the ministry will have a key role in contributing to poverty reduction; including through improving living standards and promoting health, particularly of mothers and children. Its broad mandate is to facilitate socio-economic empowerment, social assistance support to vulnerable people, and to promote maternal and child health. The MCDMCH seeks to provide an enabling environment for active participation of communities, individuals and the private sector in community development, social welfare and maternal and child health services. It facilitate the provision of community development, social welfare services, the registration and coordination of non-government organisations and the promotion of mother and child health to ensure that services reach people at the grass root level, countrywide. The Ministry is responsible for policies on community and women's development; disability issues; NGOs; and social welfare. It facilitates non-formal education, community development and skills training. Support to self-help initiatives and for juvenile correction and probation services; rehabilitation of persons with disabilities; social safety nets; child welfare, adoption and social welfare service and for co-ordination of counselling organisations; food programmes; group housing and for maternal and child health.

MINISTRY OF HEALTH ZAMBIA ORGANIZATIONAL STRUCTURE

The Ministry of Local Government and Housing is charged with the administration of local government and ensuring that Zambians are provided with the necessary municipal services. It has a mandate to promote a decentralized and democratic local government system and facilitate the provision of efficient and effective delivery of quality housing, infrastructure and social services by local authorities and other stakeholders. It oversees the implementation of social, economic and political functions and responsibilities delegated to local authorities, in areas of:

- Co-ordination of Local Government Administration.
- Regulation and provision of social amenities.
- Urban Planning and Regional Planning.
- Valuation of property.
- Water Supply and Sanitation.
- Provision of housing.
- Provision of municipal infrastructure services and support services.
- Co-ordination of the implementation of the National Decentralization Policy.
- Provision of rural feeder, community and urban roads.

The Ministry of Education also plays a big role as a partner with MoH and District Health Management teams in school health programmes such as School Health and Nutrition.

For reflection or discussion:

A wide range of skills are needed to advance health
- What skills are needed in your work to advance health?
- Which of these are found locally? Which are not? Where else can they be found?
- What role can the DHMT play in supporting these skills?
- How can you strengthen actions by tapping skills found inside and beyond the district health team, including from other Ministries?

Sometimes technical agencies can provide support to skills for health. For example TARSC, a co-producer of this manual works regionally to strengthen community and public capacities in health.

INFORMATION SHEET 8C: TARSC programmes for health

Training and Research Support Centre (TARSC) Zimbabwe is a non-profit company registered in 1994. TARSC provides training, research and capacity, and technical support to develop social and organizational capacities within public organizations in the state and civil society on areas of social policy and social development.

TARSC does this through
- Implementing and training in research, particularly analytic and participatory research, to inform social and economic policies and programmes
- Compiling, analysing and providing technical information and analysis on social and economic development
- Training, skills development and mentoring of organizations working in areas of social and economic development

TARSC has a number of programmes and resources that can be found at www.tarsc.org.

Participatory action research has been the cornerstone of much of the work undertaken by TARSC, covering areas of child sexual abuse, workplace health, community perceptions of health priorities, local government and community roles and health, distribution of resources for health versus the distribution of health needs in districts, planning within districts on the equitable allocation of health resources, and participatory mechanisms for community involvement in health. The Community-Based Research and Training programme includes the Community Monitoring programme, which compiles quarterly information from about 160 sentinel sites on key areas of social and economic progress, as well as courses and programmes to provide research skills and support to community-based organizations.

TARSC is the secretariat for the Network for Equity in Health in East and Southern Africa (EQUINET) that networks people in state, academic, civil-society and other public institutions to carry out research, training and exchange of information and experience to promote equity in health in the region (See www.equinetafrica.org). The CWGH is a member of the steering committee of EQUINET.

TARSC has developed a range of participatory materials on health, including materials on AIDS and occupational health for trade unions in the region, an adolescent reproductive health pack, called "Auntie Stella: Teenagers talk about sex, life and relationships", a toolkit on participatory methods for a people-centred health system, and the health literacy materials that you are reading now!

Over the years TARSC has carried out many capacity-building programmes, particularly on health, at national and regional level. Recent examples include the Public Health Winter School run by TARSC with the University of Zimbabwe, Department of Community Medicine (UZ-DCM). This programme aims to build capacities in health for people who are working particularly at district level in health-related work, but who may not have had the benefit of formal training in health. In addition, TARSC has carried out regional training in areas such as trade and health, participation in health systems, writing skills and Web-based courses on health and social policy.

The institution has a library with publications on major areas of social and economic policy, provides searchable Web-based databases of materials on various topics, and has TARSC publications on its website (www.tarsc.org).

8.3 Taking local action

Over the course of the health literacy programme we have been building local capabilities in various ways, for example:

- Knowledge about health, and analysing the causes of problems,
- Taking actions, reflecting on these and learning from experience, and
- Making contact with authorities and resource people to strengthen understanding and action

For reflection or discussion:

During the process, participants have undertaken a range of actions on health
- Which were easy to do? Why?
- Which seemed difficult, but, after trying them, are now easier? Why?
- Which are still difficult to implement?
- What can we do about these?

Organising to take local action demands some basic organizational skills, such as those required to hold meetings, negotiate with authorities or advocate positions. It also involves some specific facilitation skills. Some of the roles and characteristics of a PRA facilitator have already been discussed in the first module of this manual; this section looks at additional skills needed to be an effective health literacy facilitator:

As already mentioned, the more knowledgeable you are on issues related to health, the causes of health problems and the role of people-centred health systems, the better you will be at sharing this information at community level.

At the same time, an effective HL facilitator has to know how to facilitate! This involves everything from workshop planning and preparation, setting a clear programme with clearly laid out objectives, knowing how to listen, ask the right questions, respond to difficult situations, reflect on and synthesize the discussion, and assist participants in action planning. These are not easy skills to acquire and are usually learnt through reading, talking to other trainers and, most importantly, from direct experience, including the many mistakes we all make over time! An excellent book that will help you learn these skills in the context of PRA training is called 'Participatory Learning and Action: A trainer's guide' by Pretty, et al (2005). The full reference is available at the back of this manual. The book is available through IIED in the United Kingdom.

Community action for Health Matero Lusaka © A Zulu 2012

Another aspect of effective facilitation lies in the way organizations support and integrate the HL facilitators and community workers into the HL programme and strengthen links between the various network partners from district to community level.

To assist in strengthening facilitator skills, the following pages provide an activity that allows HL facilitators to identify and then practice key skills you will need to facilitate this programme. This activity is supported by Information Sheet 8d which gives you some tips on how to hold a meeting, Information Sheet 8e on the roles and tasks in team work, and Information Sheet 8f on how to communicate with health authorities.

How can we improve our organizing for health?

Procedure: Discussing and Prioritizing; Participant/Observer Exercise

Approximate time: 2–3 hours

Resources: PART ONE: flipchart paper, marker pens, three counters (e.g. seeds, small pieces of paper) per person

PART TWO: Paper, pencils, copies of Information Sheets 8d–8f, one for each 3 or 4 people. The group should be about 16–24 people. Chairs.

Procedure:

PART ONE: Buzz groups

1. Distribute copies of Information Sheets 8c–8e. Ask participants to get into buzz groups (of about 3–4 people) to go through the three information sheets. While they go through them they will list where they feel they need support to improve their organizational skills (for example, in facilitating meetings, negotiating, etc.)

2. After about 10–15 minutes ask the participants to come up to the front of the room to write a list of these skills on the flipchart. People come up randomly and each writes one. If their contribution is already on the list, they place a tick next to it.

3. When they are finished, review the list. If it is long, ask participants to prioritize the three most important skills where they feel they need support. You can do this by giving each person three counters; then they all come forward and "vote".

4. Identify the three most important skills and discuss what support the groups feel they need. Discuss HOW they propose to improve these skills and what support local organizations can provide in this process.

PART TWO: (The fishbowl)

This exercise can be used to practise shared leadership and gain insight into the needs of a group through observation

1. Start by explaining to the group that there are two important aspects in every discussion:
   a. What the group is talking about – the content
   b. How the group talks about the subject – the process

Process is a means of discussing content in the most fruitful way possible. The role of a facilitator is to provide a process which will help the group to discuss the content. Explain that the following exercise will help improve these two skills, focusing on the task and relationship needs discussed in Information Sheet 8c.

2. Divide the participants into two equal groups, Groups A and B. Each group will have one turn working in the fishbowl and one turn observing.

3. Group A is asked to go into the fishbowl (a circle of chairs in the middle of the room). Each member of Group B is assigned a partner to observe. Group A will discuss a topic and Group B will observe the discussion.

4. Suggest an interesting topic for discussion, one that involves both the sharing of ideas and decision-making. For example: What do you feel are the main health problems in your area? OR List the three most important organizational skills that this group needs and discuss what you can do to improve on these skills (this is a good topic if you feel the discussion in PART ONE needs further review).

5. It is better if the group does not choose a chairperson or facilitator, but that each member of the group tries to fulfill the task and relationship needs as they arise. However, you can also choose one member of the group to take a lead in facilitating the discussion. At the end of the discussion, everyone can comment on the strengths and weaknesses of their facilitation process and how it could be improved in the future.

6. The observers (Group B) are asked to take notes on the needs they see in Group A , and the responses of the person they are observing. They can refer to Information Sheet 8e to assist them. Ask them to make a note each time they see a person fulfilling one of these needs.
7. Stop the discussion after 10–15 minutes. Each observer from Group B will meet with his or her partner (from Group A) for 5 minutes to discuss and provide feedback on the process.
8. Group A returns to the fishbowl to try to make their decision in another 10–15 minutes.
9. Both groups evaluate together how effectively Group A arrived at its decisions, and what else would have helped the group to work more effectively. It is important at this point to keep the discussion on the process and not on the content of the discussion.
10. Time allowing, the two groups now reverse roles: Group B goes into the middle and Group A are observers. A different, but comparable, task is given to Group B and the same steps are followed.

Note: This type of concentrated observation is important training in helping people to become much more aware of group processes. It is usually not possible for us to do this when we are actively involved in discussing content. This is also a useful activity for facilitators to use in improving their facilitation skills.

Source: Hope and Timmel (2001)

INFORMATION SHEET 8d: Holding meetings

Holding a successful meeting is an art! It is also a necessity if the meeting is to be useful and produce outcomes that move things forward. This means that meetings need to be prepared for. Some of the issues to keep in mind in organizing meetings include:

1. Know what you want to achieve in the meeting and what needs to be discussed to achieve it.
2. Have an agenda, preferably written, that is shared in advance of the meeting so that people are clear on the purpose and expected outcomes before they arrive.
3. Be clear about whom to invite and why. Send invitations in good time and follow up to confirm who is coming.
4. Make sure you have identified who will chair the meeting, and who will take notes (minutes) before the meeting begins, and that they are properly briefed about what they are expected to do.
5. Check that you have all the items that you are supposed to bring to the meeting well before the meeting begins.
6. Circulate or prepare papers for the meeting well in advance.
7. Make sure that the meeting room and supplies (e.g. water to drink) are organized beforehand.
8. Keep the meeting to time, and summarize the agreed outcomes, actions and responsibilities for each agenda item.
9. Make sure the minutes report on what was discussed, what was agreed, what actions were proposed, who will take them and when.
10. Distribute minutes of meeting soon afterwards, including the action items and responsibilities.
11. Check in with those responsible for action items to keep the process moving.

INFORMATION SHEET 8e: Roles and tasks in team work

In every group someone is needed to play each of the following roles if it is to accomplish its task and maintain good relationships among its members.

TASK NEEDS	RELATIONSHIP NEEDS
Starting the discussion or helping the group begin a job **Asking for information.** Asking group members what information they have and/or where information can be found on the topic being discussed. **Giving information** when group members do not have particular facts that are relevant to the topic. **Asking** what people think. Getting group members' opinions is essential for good decision-making. It is also important for people to be willing to share what they think. **Explaining.** Giving practical examples to make a point clear. **Summing up.** Repeating what has been said clearly in few words. **Checking** to see if everyone agrees. **Analysing** the problem under discussion. **Making creative suggestions** to resolve the problems. **Having a clear process** for making each decision. **Evaluating.** Looking at the strengths and weaknesses of the group's work and seeing how it can be improved.	**Encouraging.** Being friendly, responding to and building on suggestions made by others. Showing acceptance and appreciation of others and their ideas. **Giving** everyone a chance to speak. **Asking** what people feel. Sharing what one feels and checking the group's feelings (e.g. are people tired?). **Encouraging** shy members, especially young women or those less formally schooled. **Resolving** arguments. **Encouraging** creativity. **Sharing** responsibilities. **Developing the confidence and skills** of all members **Setting standards** (e.g. Shall we agree that nobody speaks more than twice?) **Diagnosing difficulties** (e.g. Maybe some of us are afraid of the consequences of this decision.) **Relieving tension.** By bringing it out into the open, putting a problem in a wider context, or making a well-timed joke.

The chairperson or facilitator will fulfil some of the roles, but it is difficult for any one person to fulfil them all. It is good if the group can share responsibility for leadership by observing carefully which needs are not being attended to and calling attention to these needs, e.g. "Perhaps we need more information before we can make a decision", or "Perhaps we need a summary of the main points which have been made so far." Think about how a bicycle works and see how this relates to task and relationship needs. A bicycle is driven forward by the back wheel, to which the pedals and chain are attached. The back wheel represents the task needs, which push the group towards its goals. The front wheel controls the steering and balance of the bicycle, so this wheel represents the relationship needs of the group.

Source: Hope and Timmel (2001)

INFORMATION SHEET 8f: Communicating with authorities

Steps for negotiating with authorities can't be prescribed – it depends on the authority, the relationship, the issue and the situation. Some tips include:

Be Prepared. Preparation is the single most important element in successful negotiations. In negotiations, information is power. The more relevant information you have, the better your position is. Allow yourself adequate time to prepare prior entering any negotiation.

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Understand the needs of the other party in the negotiation. Put yourself in their shoes. What would they like to gain from the negotiation? What can you discuss that they want to hear and what is non-negotiable.

Know what you need out of the negotiations. Make a list of the outcomes you want from the negotiations. Identify the items you are willing to negotiate and those items which are non-negotiable. Most negotiations concern parties involved in a long-term relationship. Always be sensitive to the potential impact of your negotiations on these relationships.

Where your case is weak, work to strengthen it. Plan how to handle areas that remain vulnerable, should they arise.

Be fair. Negotiation means "to bring about by mutual agreement" – not to win! The best negotiators create "win-win" situations. Negotiation frequently involves compromise. Look for creative solutions and make trade-offs in less important areas in order to gain the more important ones. While it may be possible to bludgeon your adversary into agreeing to your terms, this does not create the "mutual agreement" that makes for a truly successful negotiation.

Quit while you are ahead. The best negotiations are brief and to the point. Get agreement on your major points and stop. Additional items can be addressed in subsequent negotiations.

8.4 Mobilizing for health

Of the skills needed to take health actions forward, perhaps the most important is that of social mobilization, to bring all the people needed together to organize action to reach a common goal. Read the following story and then discuss the questions below.

The Treatment Advocacy and Literacy Campaign (TALC)

TALC was formed in 2005 to lobby for equitable, affordable, and sustainable access to treatment, care, and support for PLWHA in Zambia. Based in Lusaka, but with over 100 affiliates throughout the country, TALC is a movement that works with nongovernment, faith, and community-based organizations in seven of Zambia's nine provinces. With a special emphasis on poorly managed rural clinics and the inconsistent availability of antiretroviral drugs, TALC has been able to focus

Advocacy for adequate medicines for HIV and TB, © TALC Zambia 2008

national attention on the plight of PLWHA. On the ground, TALC mobilizes its network to monitor the delivery of health services and to keep the public informed on new developments in the fight against HIV/AIDS. As a well respected and highly motivated grassroots advocacy organization, TALC is a regional leader in raising awareness about the epidemic in Africa.

During the 2006 election cycle, TALC challenged politicians to bring HIV/AIDS to the forefront of the national debate. TALC Director Felix Mwanza told the IRIN News Agency, "All election candidates should… tell us what they will do about the pandemic if we elect them to office, because they should recognize that HIV is as much an election issue as a better economy or improved education." TALC distributed questionnaires among the candidates for the office of president, seats in parliament, and local government positions, asking each to answer a set of questions about their commitment to supporting PLWHA. "It will not be a case of waiting until after the election – we are able to tell someone's commitment easily from their answers in these questionnaires," said Mwanza. "HIV is a national issue and every voter… has been affected by it in some way."

By making HIV/AIDS a political issue, TALC is ensuring that the problem receives the attention it deserves. TALC has kept the pressure on policymakers in recent years by mobilizing many different constituencies in support of PLWHA. To commemorate World AIDS Day in 2010, TALC organized a rally in the Eastern provincial capital of Chipata. The march for "Universal Access and Human Rights" caught the attention of the local media, which began to publish some disturbing discoveries made by TALC. The previous year had been difficult for PLWHIV, as the global economic crisis threatened public investment in the health sector and decreased the availability of some essential antiretroviral drugs (ARVs). The Global Fund to Fight AIDS, Tuberculosis, and Malaria also had frozen payments to the Zambian Ministry of Health after audits revealed US$8 million were missing. In the private market, ARVs cost as much as US$70 a month, making the drugs far too expensive for most Zambians to afford without government assistance. The Zambia Post published an article about how some residents of Lusaka had developed resistance to a second stage of ARVs. The newspaper reported that "transmitted drug resistance in eleven countries increased by 38 percent for each year that a country had been scaling up ARV treatment." TALC estimated that approximately 160 people in Zambia were in need of expensive third stage ARVs to continue their treatment. In response to the shortage of third line ARVs, TALC petitioned the then Zambian Minister of Health, Kapembwa Simbao, to distribute medicine to those who had developed resistance to other medications. TALC dubbed the petition "Life for Two Weeks Not Enough," reflecting how dire the situation had become for those whose conditions were quickly deteriorating. The government initially resisted the demands of the campaign, but after months of lobbying, it finally agreed to provide third stage ARVs to PLWHA.

Source TALC 2012

Look at the action described above,

- In what aspects was it successful? Why? Where did it work less well? Why?
- What lessons did you learn about how to mobilize for or campaign on health issues?

How can we take advocacy forward on our health priorities?

Method: Group work and presentations

Approximate time: 90 minutes (maybe more, depending on the size of the group)

Resources: Flipchart paper and marker pens, questions for group discussion copied on to a piece of flipchart paper

Procedure:

1. Use one of the issues you have identified earlier in the health literacy programme. Agree with participants on
   - What the problem is and who is affected
   - What your goal or position is
   - What change you want to see
   - Who is responsible for bringing about this change or has influence on it

2. Divide participants into groups of about 8 people and give them 30 minutes to draw up an advocacy plan. Give guiding questions for the plan:
   - What will your key message(s) be?
   - How will you communicate your messages? Through what media?
   - What evidence, information or stories will you collect and how will you present them?
   - What will the goals of your advocacy plan be?
   - Who do you want to target?
   - What do you want them to do?
   - What will you do? With what resources and people?
   - Who will you ally or partner with? How will you build these alliances? To do what?
   - Who will oppose you? How will you manage this?
   - How will you test whether you are succeeding?

3. After 30 minutes, bring all the groups together. Let each group present their advocacy plan to the other participants. After each presentation, lead a discussion with everyone on some or all of the following questions:
   - Were the messages clear? If not, why not?
   - Were the goals feasible?
   - Did people agree on who is the target to lobby? If not, why not?
   - Did the plans include many targets to lobby? What effect will this have on the strategy? And on the organization?
   - Did the groups find it easy to identify allies at community level? At national level? At global level? What effect would this have?
   - Did choosing some allies mean that you would lose others?
   - Did people agree on the strategies? What choices did you have to make in deciding on one strategy over another?

   If there isn't enough time for all groups to present, discuss with them whether they want to present on a different day, or find a way of combining groups that have chosen similar issues to address.

4. End by summarizing some of the main points arising from the presentations.

What did different people say? There are some differences in approach to strategy. What differences can you see in the dialogue below?

> I think it means getting key messages in press releases, speeches, one-to-one dialogue and meetings. We can also use discussion forums, seminars and courses to exchange relevant and interesting information with the public, and build allies, as long as we have the right speakers!

> Yes, but we need to choose individuals who are well known and respected and who can bring positive attention to the issue. Then we can prepare speeches, fact sheets, videos, press releases and other media to support these people. We also need to meet media people periodically and invite them to meetings and activities.

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It is also important to evaluate the progress made, reflect on obstacles and identify strategies for how to overcome them. An easy way of doing this is to use the Wheel chart described in Module 7 to assess progress. Each segment may be one of the aims set for action and the line on the chart how far we have come in achieving it. This can open discussion if we ask "why" when we find that things are progressing well or not.

Another way that has been used in Zambia is through mapping the outcomes on Progress Markers set. This has been adapted from the Outcome Mapping approach by Earl et al. (2001). Progress markers are selected at the time of identifying action plans in terms of what participants would:
- 'Expect to see' (usual situation)
- 'Like to see' (higher level or improved situation)
- 'Love to see' (more ideal situation) progress markers.

These progress markers are then used to monitor progress towards the desired outcomes on these actions, and regular meetings held to assess progress, and discuss what obstacles need to be overcome or opportunities tapped. An example of progress markers used in work by LDHMT on the communication between health workers and communities in planning is shown overleaf.

Lusaka Progress Markers and their status in 2006

	What we Expect To See	Done?
1	HC receive formats and guidelines on next year's plan	Yes
2	HC Management Committees give HCCs and departments feedback on planning guidelines	Yes
3	HC & community hold planning meetings together for next year's plan	Yes
4	Participants present able to explain planning format to others	Underway
	What we would Like To See	
1	Agree on priority activities for next year's plan	Yes
2	Draft Action Plan done together with community	Underway
3	Feedback on planning through regular meetings between HWs and CMs	Yes
4	HCC & departments receive a quarterly financial report	No
5	Participants present able to write a plan as per format	Underway

In summary

IIn this module we have
- Discussed how to organize for health, in communities and with the DHMT
- Identified ways to improve our own skills for community organization
- Discussed an advocacy strategy for one of the issues we identified as important

COMMUNITY PLAN

What will we do next?

Discuss with community members so that you agree on what actions will be taken after this health literacy session.
- What local actions will be taken to inform, organise and mobilise people on health?
- Who will lead these actions? Who else will be involved?
- How will participants report back on these actions?
- What else do people want to know for the next session?

FACILITATOR'S PLAN

Think about the next steps for the health literacy work.

What will you do next?

- Ask people what information or skills they still need. Make a list of the answers and discuss them. Which can be followed up locally? Where else is support needed?

What will you communicate to MoH?

- What issues do you need to report back to your district health team to act on?
- What feedback do you want to share with other facilitators?

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Abbreviations

AIDS	acquired immune seficiency syndrome
ART	antiretroviral therapy
ARV	antiretrovirals
BCG	Bacillus Calmette-Guérin (vaccine against tuberculosis)
CATF	Community AIDS Task Force
CBD	Community Based Distributing Agents
CESCR	Convention on Economic, Social and Cultural Rights
CHBC	Community Home Based care
CSO	civil society organization
CSH	Communication Support for Health
CT	Counselling and Testing
DACA	District AIDS Coordinating Adviser
DHMT	District Health management Team
DMO	District Medical Officer
DHO	District Health Officer
DOTS	directly observed treatment
EHT	Environmental Health Technician
EPI	Expanded Programme of Immunization
EQUINET	Regional Network for Equity in Health in East and Southern Africa
FDC	Fixed Dose Combinations
FP	Family Planning
GMO	Genetically Modified Organisms
HAHC	Hospital Affiliated Health Centres
HC	Health Centres
HCC	Health Centre Committee
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
ILO	International Labor Organization
IMCI	integrated management of childhood infections
IRIN	Intergrated Regional Information Networks
LPCB	Local Partnership Capacity Building
LDHMT	Lusaka District Health Management Team
MCH	Mother and Child Health

MoFNP	Ministry of Finance and National Planning
MoH	Ministry of Health
MUAC	mid upper-arm circumference
NAC	National AIDS Council
NHC	Neighborhood Health Committee
NGO	Non-Governmental Organisation
NZP+	Network of Zambian People living with HIV/AIDS
OVCs	Orphans and Vulnerable Children
PACA	Provincial AIDS Coordinating Adviser
PATF	Provincial AIDS Task Force
PEP	post-exposure prophylaxis
PHC	primary health care
PLWHA	people living with HIV and AIDS
PMTCT	prevention of mother-to-child transmission
PRA	participatory reflection and action
PPAZ	Planned Parenthood Association of Zambia
SADC	Southern African Development Community
SANASO	Southern African Network of AIDS Service Organizations
SFH	Society for Family Health
SMAGS	Safe Motherhood Action Groups
SRH	Sexual Reproductive Health
SSS	salt and sugar solution
STI	sexually transmitted infection
TARSC	Training and Research Support Centre
TALC	Treatment Advocacy and Literacy Campaign
TB	tuberculosis
UCZ	United Church of Zambia
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's' Fund
VCT	Voluntary Counseling and Testing
VIP	Ventilated Improved Pit latrine
WDC	Ward Development Committees.
WHO	World Health Organization
ZCTU	Zambia Congress of Trade Union
ZCCP	Zambia Centre for Communication Programmes
ZESCO	Zambia Electricity Supply Company
ZNBC	Zambia National Broadcasting Cooperation
ZNYC	Zambia National Youth Council

Glossary

In this glossary we provide the terms that you may have found difficult to understand in the text, with simple explanations. If there are other terms that you don't understand please let us know at admin@tarsc.org so that we can include them in future revisions of the manual. Please also ask a local health worker for help in understanding health terms.

adherence support	Support given to patients to ensure that they take their drugs correctly. It involves supporting the patient in taking the right drug in the right dose, with the right frequency (number of times per day) at the right time. It also includes encouraging and reminding patients to attend all scheduled clinical visits/procedures, including clinic appointments, lab tests and prescription refills.
adherence counselling	Counselling people who are on treatment to overcome their fears, physical responses, social problems, in relation to a medical procedure or treatment
allergy	An adverse physical reaction to a substance when it is breathed in, eaten, or brought into contact with the skin
andropause	The male menopause, involving a reduction in hormones, with changes in mood and energy.
antenatal clinic	A clinic that specializes in attending to pregnant women
antibody	A substance that is produced by the immune system in the body in response to a foreign substance (antigen).(See also immune system)
antiretroviral drugs	Medicines that stop the HIV virus from multiplying and enable people to live a healthier life. They do not cure HIV or AIDS, but they do reduce the amount of HIV in the blood.
catchment area	In this manual this refers to the area served by health services.
disease	An illness with recognizable signs and medically significant symptoms, often having a known cause. It is different from an infection, which means that a person has a virus or bacteria in their body but may not have symptoms. A person has a disease when there are visible symptoms.
efficacy	The ability to produce the desired results.
food security	Access to good-quality food, sufficient amounts of food, and a regular supply of healthy food that is affordable to people.
food sovereignty	Local control by the people over food production, marketing and supply.
health service	Services for promoting health, preventing disease, monitoring, diagnosing and treating disease, and for rehabilitating and caring for those affected by ill health.
health literacy	People's ability to obtain, interpret and understand health information and to use and act on it in ways that promote their health
health literacy facilitator	A person who organises, guides and supports the participatory exchange, reflection and action that takes in health literacy
health system	All the people, institutions and resources that take actions with the main aim of improving health.
HIV prevalence rate	The share of the total population that is infected with the HIV virus at a particular point in time. In adults, this is usually estimated from the share of pregnant women at antenatal clinics who test positive in the HIV test, and is usually expressed as a percentage (the number per 100 people).

immune system	The defence system for the body. It consists of different kinds of fighter cells found in the blood stream that recognize and destroy or control foreign bodies or organisms that may cause disease.
immunize	To make a person resistant to a particular disease, usually by vaccination. (See also vaccination.)
infection	The presence of a virus or bacteria in someone's body, even though they may not show any symptoms. It is different from an illness or disease, which mean they have symptoms and are affected by it.
menopause	Technically, the last menstrual flow of a woman's life, although it now refers to the time preceding and following this event. For most women, it occurs between the ages of 40 and 60 and takes place over six months to three years.
oral rehydration solution	A mix of sugar, salt and water used to replace body fluids lost though diarrhoea. It is best produced by households using a mix of sugar, salt and water, as described in the manual. It might also be available for purchase commercially.
palliative	Alleviating pain and symptoms without eliminating the cause
post-partum	Occurring in or relating to the period immediately after childbirth.
primary health care	A strategy for organizing health systems to promote health. It encompasses essential health care made available to all individuals and families by a means acceptable to them and at a cost that the society can afford. It covers actions in and outside the health sector, working across sectors. It is the nucleus of a country's health system and contributes to national socio-economic development. It includes political action to address the causes of ill health, and involves empowering communities to act on their health.
prophylactic	A drug that prevents the development of a disease.
prophylaxis	Treatment to prevent the development of a disease.
referral hospital	A hospital that provides specialist care and treatment, to which patients will be referred from a hospital or clinic that does not have the facilities to treat them.
sentinel sites	A geographical area or community that can be used to find out the extent of an indicator in an area, for example, the prevalence of HIV or the share of households with safe water. Going back to the same site to measure the indicator allows people to see how things are changing over time.
traditional health providers	Health services that are provided by people and institutions that are founded in the indigenous local culture of a country or community and that use the culture and spiritual systems to explain and organize a response to health problems.
treatment literacy	A person's awareness, organization and readiness to claim, begin and adhere to treatment.
vaccination	The injection of a vaccine so that the body's immune system produces a response and defence against any future exposure. (See also vaccine, immunize.)
vaccine	A preparation containing weakened or dead microbes of the kind that cause a particular disease, administered to stimulate the immune system to produce antibodies against that disease
viral load	The amount of virus in the blood.
well-baby care	A form of health promotion providing ongoing monitoring and care to support the development of babies who are not ill and to keep them healthy. It includes growth monitoring, immunization, early child development, promotion of breast-feeding, and advice to mothers.