WEDC *Water and waste engineering for developing countries*

How Can an Extension Worker Bridge the Gap?

—Traditional vs. Modern Understanding of Disease, Water and Hygiene in Western Province, Zambia

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DRAFT

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INTRODUCTION

Health education has been taught in training institutions, schools, health services and local communities for several decades. The effort has been massive, while the effects on changes of behaviour are minimal. Why is this?

Let us examine the huge disparity between the traditional values and beliefs, and the western system of hygiene/health education. How can a goal be reached when the basic precepts of the people involved vary so greatly? Who is really teaching whom?

How can we bridge this gap of understanding? Is it possible to make our aim a participative, people centred health learning experience instead of continuing on the same 'health education' dead end road?

The main emphasis here will be on an area of Western Zambia, among the Lozi people, but reference will also be made to other areas of Zambia.

CHAPTER I. TRADITIONAL BELIEFS AND CUSTOMS

Traditional beliefs regarding health, disease, hygiene, food, water and sanitation vary from tribe to country to continent. Some beliefs are widely held, others are specific to an area. What is of interest here is not so much any specific belief, but the whole belief/culture/value system which influences how a traditional society views the important factors of their life. Beliefs grow out of a survival pattern for which the reasons may have been forgotten, but the tradition remains, and is not ignorance.

Information Gathering.

When looking at traditional beliefs we must remember who gathered the information and how. Conventional social surveys done by a westerner, or even indigenous people in the employ of a westerner, may produce the information which the villagers perceive is wanted, not what they really think. My experience is that people will tell you what they think when they want you to know, not when you ask.

If information is gathered as it is prefered by the local people, it often seems untidy and non-intelligible to the western mind. This is part of the whole problem, different cultures perceive information and ideas very differently, what is logical to me may seem entire nonsense to the local headman. To illustrate this point consider this conversation;

European asking: "All the cocks in Kasonbe Village are white. Lute Mirla saw a cock in Kasonbe village What colour was the cock she saw?

Villager answering: "Lute Mirla went to the Market yesterday to sell 2 chickens Lute Mirla has a sister she goes to see in Kasonbe Village. Ask Lute Mirla when she comes back."[1]

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1. Andreas Fuglesang, About Understanding, p. 15.

Where interpretation of this is logical? The villager is not being awkward, the answer is different from what the questioner expected, but the answer is correct.

The information which follows is partly from the literature, but mainly from the experience of myself and my Zambian colleagues.

Outline of Some Beliefs and Traditional Practices

WATER:

i) Considered "alive"
ii) Running water is always safe
iii) Cattle do not pollute water
iv) A still born child must be 'buried' in running water so that it remains 'alive' and the woman will produce live children in the future
v) Water in shallow wells - is not running, therefore is not alive and can only be used for washing and cooking, not for drinking.
vi) Must taste, smell and look good

SANITATION/HYGIENE: In many societys defecation is a sensitive subject and people do not like to talk about it much.

i) Babies stool is not harmful
ii) Faeces are used for witching purposes
iii) Men and women can not defecate in the same place
iv) A woman may become pregnant if she urinates where a man has done so.
v) Bilharzia is caught by urinating where someone with the disease has urinated.
vi) A man may not defecate where his mother in law does so.

DIARRHOEA: caused by

i) Diarrhoea is associated with bad food ie rotten sweet potatoes.
ii) Washing with cold water causes diarrhoea
iii) Someone else witching you
iv) offending of the ancestors/gods or taboos.
v) Breastfeeding while pregnant causes child to be witched.

Some examples of beliefs in their own context;

Diseases and health are often attributed to supernatural forces. Let me describe more fully some examples to show how important these forces are;

① In 1973 in Luapula Province, cholera killed many

people. The previous year the fish harvest had been so plentiful that some was wasted. The cholera outbreak was attributed as punishment from the gods to the people for being so ungrateful as to waste fish.[2]

(2) When a new traditional shallow well is dug, a furrow is made to the stream to let the water run away. If the water runs it is used for drinking it must be flowing, otherwise it is used for washing only. HOLOMBE (medicines) may be put into the well. If the people discover the medicines or see a snake in the water they no longer use the well as they feel it is now 'witched'. A new well has to be dug.

A HOLOMBE is a snake in a persons image. First the person making the HOLOMBE cuts his finger, the blood is then mixed with other things and put in a small pot in the bedroom. It has to be given food and then starts growing until it eventually gets a face like the owners. Now it has to be kept somewhere such as

i) a well
ii) or abandoned woodpeckers nest
iii) if the owner is brave enough, he/she will keep it in the house

Hulombe is suspected if people start being ill. Then the witchfinders are called to find the Hulombe.[3] (See Diagram

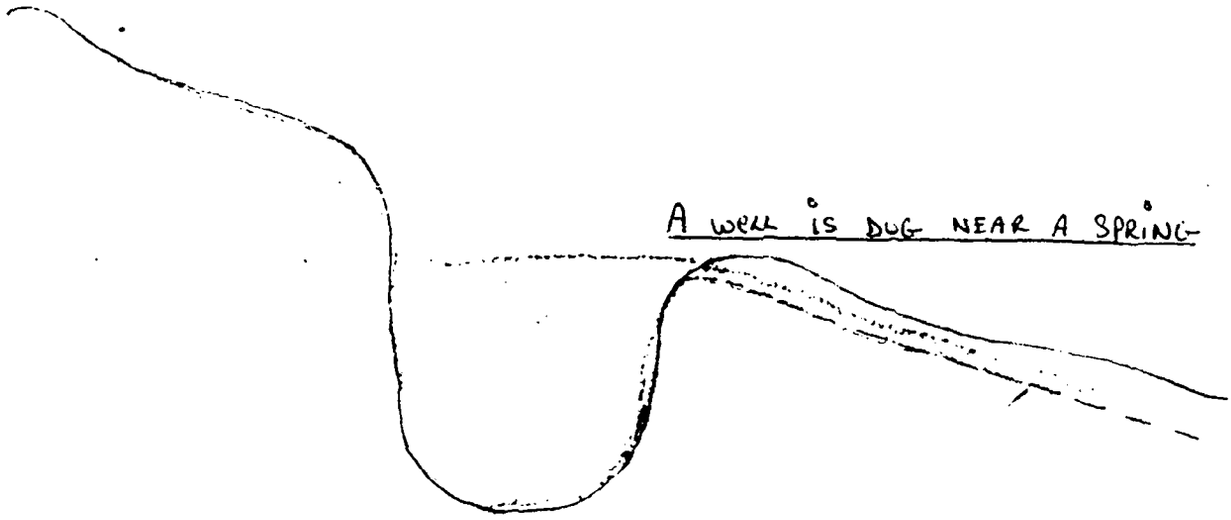
(3) After a funeral, when the mourning is over, everyone is called by a senior member of the family. Questions such as these are asked:

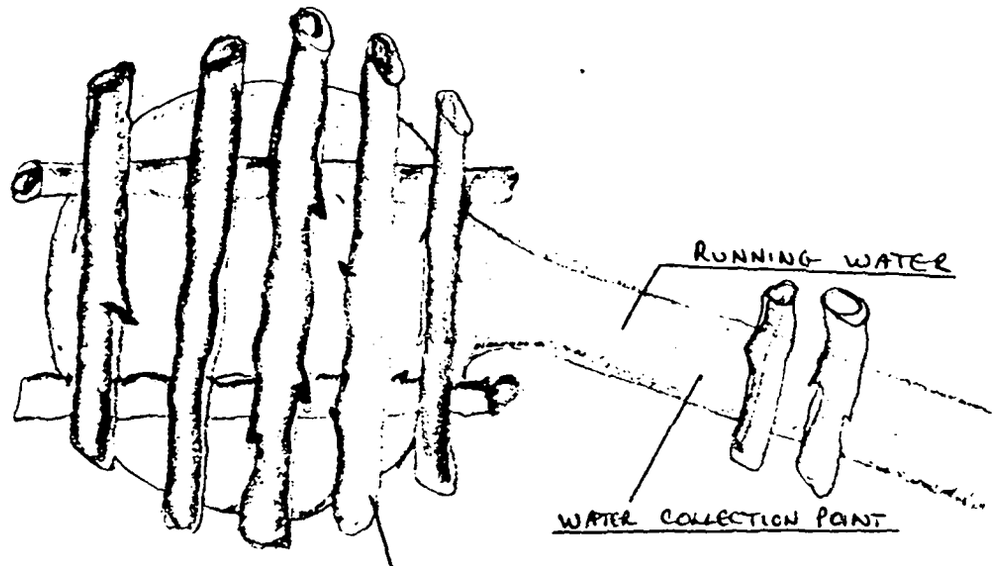
Why did he die?
was it his wife's responsibility?
Did he bring it on himself?
Who has caused this?

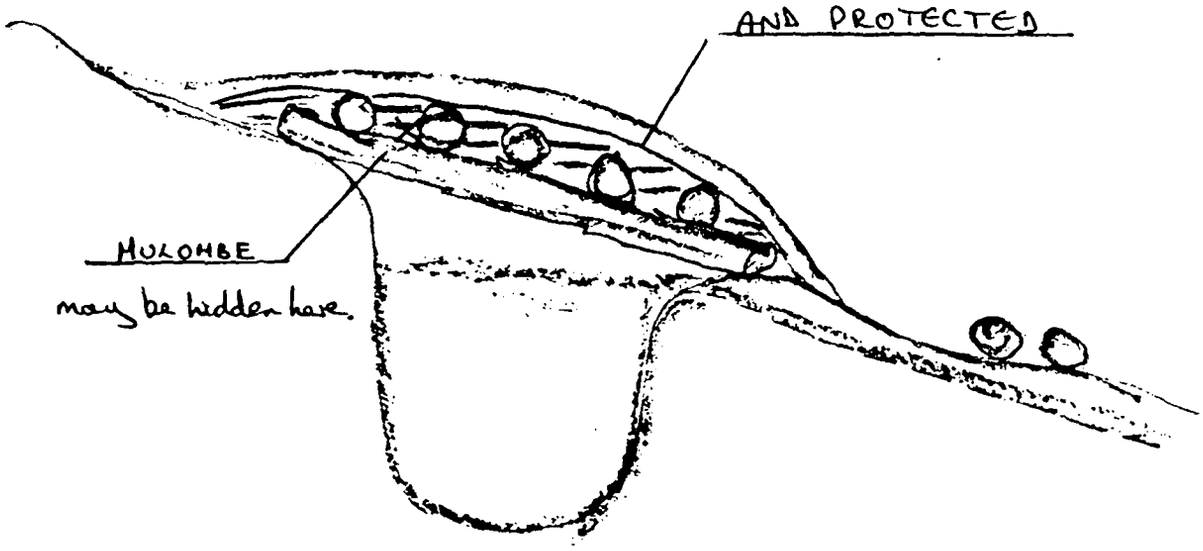
and eventually the discussion connects to things which happened in the past family history - ie his uncle did this/that before he himself died.....[4]

(4) A childs death may be attributed to the mothers negligence or to either of the parents committing adultery. Similarly malnutrition is associated with adultery or breaking sexual taboos while the woman is breastfeeding.

2, 3, 4. Interview Peter Chola, June 1984.







Construction of new well

(5) If a child has measles - the woman moves to a seperate hut. No stranger may touch the hearth or fetch fire incase he or she brings bad luck to the household. The household makes peace with other family members and the neighbours. The headman calls all the people together and advises them to be united in order to get through this time together. This is another way of making an offering to the gods and a realization of the serious threat measles poses.[5]

From the above examples we can see how much these beliefs are an integral part of the essential things in village life.

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5. Ibid.

CHAPTER II. HEALTH EDUCATION AS TAUGHT TO EXTENSION WORKERS (ie. HEALTH ASSISTANTS)

What is health education?

What does this much used, much talked of phrase really mean? The main idea behind the western concept of health education is that most diseases and ill health can be averted by human intervention with the knowledge of;

(a) the germ theory - ie how disease is spread by food, water, poor hygiene and poor sanitation

(b) Diseases originate - from these comes and can be averted by (i) improved hygiene and sanitation
(ii) improved nutrition
(iii) improved water supply
(iv) some medical intervention [6].

This human intervention comes in many guises, but it's main demand is that habits of living are changed. It demands that the community should understand the relationship between faeces, hookworm and a child suffering from severe anaemia (blood loss due to hookworm infestation) .... and that a pit latrine used by all might have saved that child from dying. Yet, at the same time the mother may be asking herself "who caused this child to die? who is witching my child?".

How are health educators taught?

Where do the modern ideas of disease come from? Where are they taught? Who teaches them and to whom are they taught?

Examine the education of a village child, Sepiso. Sepiso used to herd cattle and help in the field work during harvesting. He learnt alot in the village. Then he was sent to primary school but the school was so far that he only went home on weekends. In the school he learnt various things, he passed his Grade 7 exam and was sent to a distant secondary school. His parents were very proud, their son was being 'educated'. What they didn't know was that Sepiso was being indoctrinated in an educational system built on the western/colonial model of past times. He was taught 'facts', taught to memorize but not taught to question or to adapt what he learnt at school to what he

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6. The various components of Health Education may be well known to the reader, and thus are not expounded here.

had seen in his village. Village thinking and school thinking were conflicting, and he now spent very little time in the village at home. The system was forcing Sepiso to make a choice, the books, the teachers must be right, had/d his parents sacrificed alot to send him here? This then is Sepiso, now growing away from his traditional thinking, who comes to the capital city to be trained as an extension worker - a health assistant.

How Sepiso is taught is vital, he has been through a 'western' educational system, he has now come to the city with it's many excitements, but the teaching he recieves in the next 2 years may sway his outlook.

Is he now taught to question, to adopt his learning, to explore his tradition, or is he given 'facts' about hygiene and health to learn and to 'then' teach' as he has been taught? Most people will eventually teach as they themselves were taught "unless something alarming or loving happens to change the way they view and do things" [7].

The health education programs in many third world countries may be culturally oppressive because they are created from behind a desk and not in the field. Western educators (who taught the indiginous educators) have been blind to the old rule; "start with what the people know, not with what you know." [8]
An approach which views a problem from the commoners angle ie the village people - will produce health education more relevant to the people. Central to this entire issue is the way in which the educators and their students views village people.

Unfortunately the education often given portrays rural village peoples lives and actions to be full of mistakes, bad habits and wrong attitudes. This reflects inherent disrespect for the peoples ability to cope with their lives, especially when their ingenuity and creativity are the ultimate resource of any social/behavioural change [9].

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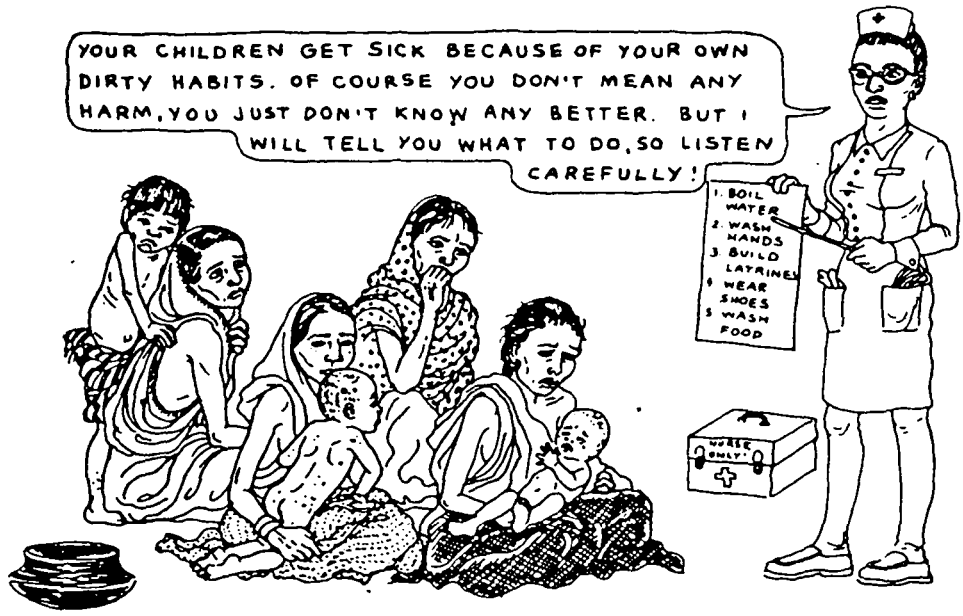
7. David Werner + Bill Bower. Helping Health Workers Learn p. 1-4.
8. Fuglesang. p 123.
9. Ibid., p 92, 124.

The following is an extreme example of why such an attitude is so destructive. Unfortunately these ideas do exist and it is time to challenge them.

Consider, for example, a village health worker who calls together a group of mothers and gives them a 'health talk' like this:



From David Werner + Bill Bower Helping Health Workers Learn, p. 1-1.

CHAPTER III. THE DILEMMA - THE DISPARITY BETWEEN TRADITIONAL BELIEFS AND WESTERN HEALTH EDUCATION BELIEFS.

"Why do you Muzungu (white person) not try to understand the minds of Africans more than their ability to work? Your people do not understand your words do not belong to our minds"[11]

- Mukahamubwatu - an old village from Mapanza in Zambia

The above quote says alot, especially ... "your words do not belong to our minds"... we must try to grasp this idea when we examine the gross differences of how concepts are understood.

Regarding	Traditional Belief	Understanding of Health Educator
Diarrhoea	Witching - of person - of water	Poor hygiene/sanitation Unclean water
Bilharzia	Passing worms when someone with the disease has done so.	Contact with infected water Defecating/urinating near water
Malnutrition	Infidelity of husband or wife	Food shortage Worms, chronic disease
Fitting	'African' spirit sickness	Malaria/Meningitis
Water	Should taste nice Must be 'alive' Common vehicle of witchcraft	Should be palatable Must be free of contaminants.
Illness	Witching Someone else's wrong doing	Organic disease process Poor hygiene/sanitation

The most obvious conclusion which can be drawn from the above comparison lists is that tradition ascribes much ill health to some persons' 'misbehaviour'

11. Fuglesang, p. 20.

in offending a taboo or the spirits while the health educator blames something as small and hard to conceptualize as a pathogen.

While health education continues to ignore the disparity in the 2 ways of thinking, what real impact can any conventional health message have?

Consider the following 3 situations which come from the experiences of extension health workers in Western Zambia

(1). A health worker is trying to explain to an assembled group of villagers about the pathogens in dirty water which may cause illness. He is told...
"Our forefathers never talked of these things - are you saying our ancestors were stupid?"

(2) Another health worker is showing a group of people an enlarged diagram of an amoeba because he is concerned about the high incidence of amoebic dysentery in the area. The response is
"we are sorry that where you come from there are such big animals in the water, but we don't have such animals here - we never saw any...."

(3) The extension worker is visiting people in a nearby village. While talking to the adults he notices a quiet, ill looking child sitting alone, dirty, with flies all over her.
When asked about the child, the grandmother says... "No, it is witched, the mother continued breast feeding her while pregnant." The child is very malnourished and obviously ill. But the adults do not consider it worthwhile to seek medical help because in their view the child is witched, so will die anyway.

Traditional Practices regarding Water and Sanitation

Traditional sanitation and water fetching practices are much older than the germ theory. These practices have long fulfilled a functional or ritual role often unrelated to disease control.[12]

12. Harry Elmendorf and Patricia Buckles, World Bank App. Tech. for Water

Yet experts of health education say that we must change peoples habits and attitudes. But...

"such a goal points the finger at <u>what people do wrong</u>, rather than building on <u>what they do right</u>. It is based on the paternalistic view that 'ignorance' of poor people is the main cause of their ill health, and that it is society's (health education's) job to correct their bad habits and attitudes!" [13].

But if we wish to promote behavioural change it is vital that we first understand how the village people live and think [14].

In the area of western Zambia where I was working with a team of Health Assistants we came to realize that most of our health education just didn't seem relevant to the people. So we started looking for ways of improving the understanding between the health workers and villagers. (see Case Study in Chapter II).

13. Werner + Bower, p. 1–29
14. Hanneke T. Boot. <u>Making the links</u>, p. 62

CHAPTER IV. USING LOCAL BELIEFS AND PRACTICES TO MODIFY HEALTH MESSAGES

There are varying ways to use local beliefs and existing practices to modify or reinforce some health messages. The following are a few simple ideas which are applicable for a small area of Western Zambia. I do not wish to give the impression that any one idea is of use for universal application - it is not. The main aim, in my view, is to build on what the people know and do, and not to try to change everything. Strong traditional beliefs are there - they were there long before written Western health education came and they will doubtlessly be there for a long time to come. Therefore I think it is advisable to work WITH the traditional system as far as possible. Working AGAINST anything eventually brings conflicts, and our aim as village workers surely is not to introduce conflict into the village.

Existing practices which can be reinforced and built upon. This is not a comprehensive list - it is purely an indication of hygiene/health practices existant in the rural villages.

1. Cooked food is always covered with another plate to prevent flies and dust getting into it.

2. Raw food is not eaten - apart from fruit, and occasionally raw cassava on a journey. Meat and vedgetables are washed before being thoroughly cooked

3. The cooking pot, while soaking to loosen the sticky maize porridge, is usually left covered until it is washed.

4. Woodash is used to clean pots and plates which are then left to drain on racks about 1 to 1½ Metres off the ground, where they will dry in the sunshine and be out of the way of dogs, children and chickens.

5. Water is brought for handwashing before meals - noone eats without washing their hands however scarce water is.

6. Body washing is frequent - even small children can be seen washing themselves frequently (see photo 1.)

7. Defecation is done far from the huts and covered

1.

2.

with sand in this sparsely populated area.

8. Scabies is treated with a solution of woodash and water (HULOLA WA FAAISO' ie literally "soap from fire") which makes a soda-like, soapy solution with which the affected person is frequently washed. (This is as effective as modern medicine and encourages frequent use of water.)

9. A spring may have a gourd as a dipping utensil on a stick near it — the handle never touches the water and individual household containers do not contaminate the source. The gourd is kept sterile and dry in the sunshine (see photo 2.)

I need not expound here on how these practices can be reinforced and adapted. Suffice it to say that this is an illustration of how much hygiene knowledge already exists in the village. The lack of a pit latrine is not indicative of poor hygiene practice — only of an alternative health practice.

Using traditional beliefs/superstitions to help make an health education programme.

Some examples of how this is possible are;

1. Using a given person's faeces for witchcraft purposes is impossible if a pit latrine is used. So this is a strong point in favour of latrines.

2. If the stream is used to bury still born babies there is a persuasive element to build and use a well. (This may be a better persuasive than the high Bilharzia infestation from the stream).

3. The taboo of not using cold water with a fever can be used by suggesting that a feverish child needs frequent washing with warm water (The water will be fairly cool by the time it gets onto the childs body, it is the evaporation of the water on the skin which has a cooling effect — very important with small children with high temperatures because high temperatures cause fitting.)

Again, of vital importance is that we understand the thinking behind peoples actions and behaviour. The following is an example;

The old grandmother of a small child brought him to the Sejamba health post because he was ill. She wanted medicine for him. The child was grossly underweight, showing signs of kwashiokor (a malnutrition problem) and had pneumonia. The child needed special care at the hospital if it was going to live through the next week.

Despite knowing that the child might die, the grandmother flatly refused to come with the clinic team to the hospital. When it was discussed she said she was responsible for 2 HULANJO's (maturing girls being prepared for the maturing rites) and that she couldn't help it if the child died.

To understand her thinking we must understand that in her tradition a sickly child who has barely survived 2 years is relatively unimportant compared to her responsibility for the Hulanjo's. The maturing ceremony marks not only maturity, but is in someway a recognition of that girl having become a whole person

> "Birth is a slow process, not concluded by the physical birth, but by the 'coming out' of the initiation ceremony."[15]

Hers is a huge responsibility, the teaching of the girls entrusted to her is vital. In the future, when the girl is married, she is disrespectful to the elders or 'misbehaves' her husband will hold this old woman responsible. So this responsibility is serious and not easily set aside for other things, not even temporarily.

Finally, the health team went to discuss it in the village and most people felt the old woman was right to refuse to go to the hospital with the child. (children are always accompanied by a close relative)
When the health team then pointed out that instead of celebrating a maturing 'coming out' ceremony, they would be mourning this child's death, the collective opinion of the village suddenly changed. Everyone now insisted that the child must go to the hospital

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16. Englesang, p. 39.

and another relative volunteered to take the child.[16]

It was not the fact that the child might die which forced the issue, but the issues around the funeral which did so. I do not wish to make a judgement on another peoples value system, but merely to make the point that at times it helps to understand the peoples way of thinking in order to perceive the true issue at stake.

16. This story is from my experience as a Primary Health Care worker.

CHAPTER V. - SUGGESTIONS ON MOTIVATING EXISTING EXTENSION WORKERS TO BRIDGE THE GAP

In Zambia there is a large network of extension staff in rural areas. There include Health Assistants, Agricultural Assistants, community development staff. vetinary assistants. Zambia has been training this cadre of worker since pre-independance so there has been a long, ongoing effort in this for over 30 years. there extension workers are widely dispersed and often work in very isolated conditions

Even the most enthusiastic worker can become discouraged and dispondant when faced with the task of field work, especially if there is little support / contact with others of the same profession.

For this reason I feel that much of the answer to the health education problem lies with encouraging and motivating the health workers and other extension staff. This requires patience, change comes slowly if it is to last. Any change can be perceived as threatening if it happens too fast. We must remember their training may have been very orthodox, so new ideas may not be welcomed initially.

Why should the emphasis be on motivating extension staff?

Because,

1. their job is hard and needs support to be effective.
2. they may be isolated and not included in the planning stages of projects which will affect their work
3. they are nearest to the people.
4. with more responsibility they may become more involved.
5. If they are supported and backed up in front of their villages of work, their local standing will go up.
6. to keep young enthusiasm and idealism alive

How can this idea of enthusing extension staff be put into practice?

First of all it is necessary to establish what the health workers themselves feel about their work, about it's pro's and cons, about the people in the villages. How do they view the knowledge of the people? Do they

feel village people are to be respected or ignorant? What do they think of the methods of health education which are currently used? How have they used their training? Have they felt the need to adapt it - and how? These things must be looked into in the area/district being considered by individual visits to workers in their place of work and collectively at a workshop for all extension staff. It is vital that the entire process is done not as a teacher-learner exercise, but is a shared experience in which each person feels that he/she has an equal voice.

From these methods of joint learning can be explored. Some ideas are outlined below and then will be followed by a case study of how this has been done in an area of Western Zambia.

Ideas on getting more health worker/village understanding which can lead to improving joint understanding of health and hygiene practices.

(1) Discuss with extension staff alone, as an informal seminar where everyone can air their ideas, hopes and frustrations.

(2) Discuss village beliefs and customs and ask a traditional leader, an elder and a traditional healer to come and discuss the traditions and origins of various taboos and beliefs.

(3) Reinforce the 'people centred' approach which is a part of Zambian tradition but which the health worker may have 'unlearnt' in the process of schooling and training.

(4) Village meeting discussions as a forum for information exchange. Also to utilize informal gatherings - such as around the beer containers or where the women are working. Don't forget the old people, they hold much wisdom (see photos 4, 5 and 6.)

(5) Try out theatre for development method (described in case study)

(6) Working through School Children and teachers.

3.

↑ With the men drinking beer under the tree

4.

Talk/discuss with the people

← With the women

5.

Don't forget that the old ones hold much wisdom. →

⑤ Make an effort to find out what the women think and feel. They are the main users of water and teachers/practicers of food and hygeine use.

It is even better to work with women all the time - when you teach a woman, you have taught a whole family, if you teach a man you have taught only one individual" [17]. This was a comment of an agricultural assistant who had discovered this from his experiences in village work.

But as Hariëke T. Boot puts it so well... "the most important aid to hygiene education can never be a set of guidelines, audio visual materials or the like but rather the hygiene promoters themselves. What counts is their ability to stimulate and support the community in working things out and 'making the links' between water supply and sanitation and the potential for improving health." [18].

Time and time again we realize it is not the actual health education which is vital, it is the motivation of the worker using that method.

Case Study - background

Because 'health education' is not an isolated part of the work the health extension workers do, it cannot be artificially extracted and set out alone.

The sharing of health knowledge between villagers and extension staff is just a small part of the big whole of working together in daily life. I feel it is vital to be realistic about the speed of this knowledge transfer - it must be allowed to come at the rate of the peoples choosing NOT at the expected rate of the health education planner sitting behind a desk in the main city.

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17. Interview with Bennie CHIZONGO, Agricultural Assistant, Sichili, Western province, Zambia, 1982

18. Hariëke T. Boot, p. 3.

CASE STUDY - Covering a period from August 1980 to Sept 1983

The district hospital had a Maternal/child Health mobile clinic visiting a radius of 140 km around the hospital once per month for each centre. The health assistant[A] for each area was involved in helping on the days which the clinic team was in his area. Thus the chance arose for the clinic team leader to meet and understand the each health workers work and frustrations.

An informal meeting of several interested Health Assistants was arranged and the discussions led to an expressed wish to be able practically to help the people achieve the health goals they wanted. The main need seemed to be water wells, which are fairly easy to construct, and the Health Assistants had the technical knowledge. But the wells required cement which was unavailable from the goverment and beyond the means of most villagers. The H.A's felt that all their talking about clean water, diarrhoea, bilharzia etc was useless if they could not even assist the people in constructing a safe water source.

As enthusiasm from the two most keen H.A's grew, a decission was taken to loby various goverment departments for help in cement or money. Visits to these departments produced no financial help, some encouragement in words, but also active diccouragement from their immediate boss. Things did not end there, the H.A's now realized exactly how much help they could expect.

The next stage was another discussion after they had explored all other possible avenues of help in their own areas again. One worker managed to obtain 2 sets of well ring moulders on loan from the railways, what was now needed was cement.

With a donation of cement the first wells were made, but the immediate problem of village co-operation rose. (Community participation problems are beyond the scope of this paper, suffice it to say that this aspect is often overlooked but actually needs much attention) However, the H.A's had now discovered for themselves that if they wanted to, they could find ways of getting financial

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A. Health Assistants have a wide job description including health education and the promotion of Maternal/Child Health = Health Assistants abbreviated H.A. from here on.

or material aid. Now they also found that their 'health education' of the past had it motivated the people to perceive the need of clean water as important enough to overcome the problems of the co-operative effort needed for the hard work of construction.

Theatre for Development method introduced

A seminar/workshop was organized for all H.A's in the area. A Theatre for Development motivator was invited from Lusaka and the group decided to use this method in order to find a way of improving village/H.A. understanding and finding a way to make Health Education more relevant.

Briefly, Theatre for Development is a means of collective learning in which a group of people identify the concerns of a community and then use this information to create a story, play or performance, dramatizing one of the main areas of concern for that particular community. The performance and follow-up discussions are a first step in a collective problem solving and idea-sharing approach, which requires long term follow up by the newly motivated field staff, local leaders and the villagers themselves.[20]

Firstly the workshop participants discussed their perception of village health problems and then went on to a village to talk to the people and hear their views (see photos 6+7). This was done first with the entire village gathering and then in smaller groups.

Many ideas, beliefs and concerns were expressed, but the health concerns of the villagers turned out to be almost exactly as the health workers had perceived them. This was a real affirmation of the closeness of the H.A's understanding of village concerns and problems. The H.A's themselves were surprised how freely the villagers talked when a specific meeting to discuss health matters was held, they were quite excited at the village response.

The next stage was to make a simple story incorporating the issues brought up and an element of health teaching.[21] Then with some villagers a play was made and acted out before the entire village (see photos 8, 9, 10, 11 and 12.).

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20. Cavanna, S.R., Report on Namushakende Workshop, Sept. 83.
21. See Appendix for samples of stories written by H.A's.

6.

HOUSE TO HOUSE VISITS
TO TALK TO PEOPLE
(Mongu, Namushakende).

7.

8.

9.

Acting out play in a village
(- children and dogs take part)

10.

11.

the Villagers watch.

12.

Singing and Drumming make it lively entertainment.

Then immediately following the play, small discussion groups are made, preferably some with women alone to allow them the freedom to speak in the absence of men. Two health workers go to each group, one writes down what is said, peoples comments, reactions, suggestions of solutions. Then the whole village reconvenes a general meeting and all ideas are reported - there discussions become very lively and animated.

The response of the H.A's was enthusiastic, especially as they felt there had been a good exchange of ideas and that here was a new tool to use in bringing up the issues of disease, health, and other problems.

The well construction, as a response to village requirements, was started. Construction was on a self-help basis, with cement and technical assistance coming from the H.A. of that area in conjunction with the Wakes Well Project co-ordinator. By now funds for cement and a vehicle had been found, but the bulk of the contribution was the peoples in labour.

Frequent working in a particular village allowed more chances for both villagers and H.A's to know each other and for mutual trust to grow. At last the villagers could see that the H.A's were keen to help them and were not mashy goverment agents to talk, promise empty promises and then leave again. As the work was going on, the daily life of the village continued and many chances to discuss various health issues arose - not by formal 'health education' but as and where the problems arose.

For example, when several children had diarrhoea and the mothers asked for advice, it was a natural and easy point to start discussing first oral rehydration and then the wider issues of hygiene.

The H.A's found that because they could work in a more shared way with the villagers, that health information was also shared at the same time. As the drought had made water shortage acute, water was a frequent topic and basic well protection an important issue. These things were discussed round the well, while sorting stones into sizes, over a cup of beer

13.

14.

There are many opportunities for discussion and health learning

15.

16. A discussion between the health assistant and villagers about snake bite medicine.

- note front man holding stick (medicine) and snake skull.

at the end of the day (see photos 13, 14, 15). Other health practices also can be learnt from the villagers such as where the village headman is skilled in treating snake bites (see photo 16.)

Sometimes health message impact comes later than the message delivery, as in Sonyai where one man remembered the H.A's discussion about Pit Latrines and 6 months later stated constructing one for his family. When asked what had prompted him to do it, he replied he had remembered the discussion and decided to build one. What he didn't say, but is also important, is that the words of the H.A. now had more credibility after all wasn't he helping them construct their well?

Some of the villages decided that they wanted to celebrate completion of their wells. With some it was done by making the well festivities part of the annual KUCHIKOTHELA - rain praying ceremony. With others a 24 hour feasting, dancing and drinking celebration which showed their 'joy at having "clear water in our midst."[22] (see photos 17, 18 + 19)

At some, the school children with the H.A and local primary school teacher made a play on a health/hygiene theme to perform for their parents in their own village (see photos 20, 21)

The completion of the well is not the end of Health education/villager contact, the closer links now forged will ensure continuing contact, ongoing learning from each other and hopefully more influence on the health practices of those villages.

From the above case study, it can be seen how being involved in the village work, the health workers had a better position from which to understand and share health ideas with the villagers. Above all, they were now much keener to discover their own ways of working with villagers towards the common goal of improved health.

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22. Headman of Mupenga Village, Sept '82.

SANYAI FEAST.

20.

Mupengu - School children perform a play about water use for the village celebrations.

21.

CONCLUSION.

I have attempted to show that conventional health education and traditional are potentially far from each other. But it is possible to motivate extension workers to try to bridge this gap slowly while still having respect and understanding of the traditional beliefs and way of life.

This requires a change of attitude from the entire education system, but particularly the institutions who train these health field workers. An awareness of how education can be used to mould the attitudes of students towards participative problem solving needs to be part of the educators philosophy.

Extension staff already in the field for many years need support and back-up. They are close to the village people and if encouraged can be important change agents for improved health if given a chance to find new ways to approach the problems they face in their work.

These changes in health patterns can't be created behind desks by health education experts - they must happen at the place where the consumer lives - ie in the village. Health education then becomes a shared health learning for both the health workers and the community, not a printed blueprint document on 'Health Education'.

22.

Feasting / dancing and giving thanks
for the clear water from the ground.
(SANYAI 1983)

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APPENDIX. - Theatre for Development Story's. - D. K. NAHATAHA

Story 1. = about water

There was a certain lady. She was beautiful, brown and tall. Her main problem was she never washed and it was really difficult to tell whether she was brown or not. All her body was covered with dirt. Many people disliked her for the same reason. A Health Worker once appeared before her. She listened to his health talk about the uses of water and later showed improvement.

Later she fell in love with a certain gentleman. Their marriage materialized, but with difficulty due to her bad habits of not using water.

Later she got pregnant. She gave birth to a baby boy resembling the father. Unfortunately, at the age of 3 years the child passed away due to dirtyness - though water was available in the area. The husband decided to divorce her. Later a health worker came for some more advice on the use of water. She took it this time all-heartedly. Later in her lifetime she became a health demonstrator and worked well.

See, water is good for health generally.

Story 2. = about hygiene.

In Sichili village there used to live a certain family. They were compleatly out of sanitation and hygiene knowledge. They thought they were leading a good and healthy life without proper disposal of human and house refuse and even keeping themselves and their surroundings clean.

The family was just a small one - two parents and two children.

In the long run they started seeing some signs and symptoms which were compleatly against their lives.

1) The father started to pass out blood in his urine and stool (Bilharzia). He thought within a short period it will be over, but it remained for years.
2) The Mother started to pass out some round worms in her stool. She also thought it will be on for a week but it has now been there for months.
3) The first born developed some sores all over his body (Scabies). It remained for months
4) The second born developed a big belly with some little white worms. It was there for months.

In the end a Health worker came and advised. They constructed a latrine, washed clothes and body's all the times. Their living improved. Rel-

Rel & Namalomba, Sichili, March 1982