

NJONJOLO CLINIC PROJECT

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To: District Secretary, Kaoma
District Governor, Kaoma
District Medical Officer, Kaoma
Provincial Medical Officer, Mongu
Hon. J. Kalaluka, M.P., Kaoma
Regional Secretary, United National Independence Party, Kaoma
Women's Secretary, United National Independence Party, Kaoma
Youth Secretary, United National Independence Party, Kaoma
Secretary, Kaoma Rural Council, Kaoma
Mr. J. Biemba, Ward Councillor, Litoya Ward, Kaoma
Chief Kahare, Nominated Councillor, Kaoma Rural Council, Kaoma
Secretary, provisional Njonjolo Clinic Committee, Kahare, Kaoma
and whoever else may take an official interest in this matter,
in Zambia or abroad

Introduction

In this report the writer shall present a project to establish a rural health centre in Njonjolo, Kaoma district. After a very brief sketch of the local medical situation, he shall report on such organizational activities as have already taken place, and present a plan for further action. The nature and purpose of this report necessitate the inclusion of some data which to one who knows the area well, may seem superfluous; for this the writer offers apologies.

Medical background

Njonjolo is a remote area in the eastern part of Kaoma district. Along the Njonjolo, or Litoya, stream lives at present a population of about 650, distributed over about 40 villages. Half of this number of villages cluster closely around the royal establishment of Chief Kahare, a member of the House of Chiefs and of Kaoma Rural Council. Kahare Government School, an outreach of the National Agricultural Marketing Board, and an agricultural adviser reflect the Zambian government's developmental action in the area, where commercial maize production has made considerable progress during the last few years. These government services also cater for the population

of the neighbouring Kazo valley, where about 400 people live distributed over about 20 villages.

The Njonjolo area has no medical facilities whatsoever. The nearest rural health centre is in Shimano, at a distance of 37 km over the road. Another clinic is part of the Tobacco Scheme of the Tobacco Board of Zambia, about 30 km from Njonjolo. Kaoma district has three hospitals, but these are at distances from 80 to 130 km from Njonjolo. Apart from an occasional vehicle sent from the boma for some specific official business, there is practically no motor transport on the 22 km track which connects Njonjolo with the Lusaka-Mongu tar road. Kazo bridge, on one-third of this distance, is very difficult to negotiate in the rainy season, even with a four-wheel drive vehicle. In the Njonjolo area, bicycles are scarce and seldom in good running order. As a result, the people of Njonjolo can only very rarely, and then at considerable cost of time and money, make use of such medical facilities as are offered within the district but outside their immediate environment.

The incidence of disease and the rate of mortality in the Njonjolo area may be similar to those in other remote parts of rural Zambia, but they are nonetheless cause for serious concern. Malaria, gastro-enteritis, and respiratory tuberculosis are common conditions. Widespread hookworm infestation further adds to the general anaemic condition which greatly reduces the resistance particularly of children and women in their productive age. Mortality soars particularly high in the last months of the year, when food is relatively short and the weather unhealthy. Infant mortality is high, and fertility exceptionally low. Since clinics are remote, hardly any under-fives have gone through the series of standard immunizations; for the same reason, virtually all children are born without any medical attention before, during or after delivery.

In the absence of readily available modern medicine, traditional medicine is widely practiced in the area. But whereas its successes in some fields (particularly psycho-therapy) may be undeniable, traditional medicine has no adequate cure for the common somatic disease patterns outlined above. On the contrary, as is well-known among medical personnel practising in the district, application of traditional medicine in cases of malaria, gastro-enteritis etc. often gives rise to weird complications which may jeopardize subsequent modern treatment. Moreover, traditional healers tend to be expensive.

There seems to be, therefore, a clear case for the establishment of a rural health centre in the Njonjolo area. But might not the people's traditional views concerning illness and health prevent them from utilizing such a clinic to its full potential? On the basis of prolonged medico-sociological research among people in and from this area (1), the present writer is inclined to think that these traditional views are not likely to stand in the way of the utilization of modern health services, if these were provided. While at present the inhabitants of the Njonjolo area are far from the outlets of modern medicine, many of them have considerable experience with clinics and hospitals elsewhere. This experience derives from occasional visits to distant medical outlets while living in Njonjolo, but particularly from earlier residence in both urban and rural areas where medical facilities were more easily accessible. (2) As a result they know what to expect from modern medicine. Their present limited utilization of modern medicine, and their use of traditional healers, should not be attributed to their traditional attitudes but rather to the fact that modern medicine is, for them, much too far away.

On various occasions have the people of the Njonjolo area attempted to improve their access to modern medicine. As long ago as 1963, they constructed, by self-help, an improvised airstrip so as to enable the aircraft of the Africa Evangelical Fellowship (catering for Mukinge Hill and Luampa Mission hospitals) to land in their area. However, this strip was used only twice, mainly due to lack of coordination between the local people and the missionaries. The airstrip has now been covered with bush again. In more recent years, various presentations were made by the local people, to ask the district authorities to build a clinic in their area. Their interest in, and desire of, modern medicine was particularly intensified when, in the period 1973 - 1974, the present writer and his wife, as researchers from the University of Zambia's Institute for African Studies, conducted sociological research in the area. They spent a considerable, and increasing, part of their time on improvised health care, dispensing drugs and taking serious cases to the Rural Health Centre or the district hospital. A report on their findings in the medical field has now been completed and will shortly appear in print (cf. note 1).

Towards the end of 1974 Mr. Biemba, the Ward Councillor of Litoya Ward to which the Njonjolo area belongs, moved before the Kaoma Rural Council that a clinic be built in the Njonjolo area (3). This proposal was passed on to the District Development Committee, Kaoma, for final authority, but it appears as if no further administrative action was taken. Anticipating positive developments, the people in the area made one kiln of fired bricks towards the construction of a clinic; but since the money, the local organization, and the official permission were all lacking, they soon had to abandon their efforts, and the kiln is now desintegrating, not far from the overgrown airstrip.

The present writer revisited Kaoma and the Njonjolo area in 1977 and 1978. Finding that the medical situation of the people had not improved, and that their desire of a clinic was stronger than ever, it was felt that effective action should no longer be delayed. Long consultations were held with: Chief Kahare; his traditional councillors; the officials of the Litoya East Branch of the United National Independence Party; the headmaster, deputy-headmaster and teachers of Kahare Government School; and leading women in the area. These consultations resulted in a formal meeting on 14th August, 1978. At this meeting the provisional "Njonjolo Clinic Committee" was formed, its executive elected, and a plan was drawn up for the realisation of a clinic in the Njonjolo area.

The meeting

After a date had been selected, the meeting took place at Kahare Royal Establishment. Party officials and the Chief's messengers had been sent out to inform leading people throughout the area. Present were about 30 men, including Branch officials, the headmaster, deputy-headmaster and several teachers of the school, the Senior Councillor and several other traditional councillors of Chief Kahare, and several headmen. Miss Mary Nalishuwa, Nominated Councillor of Kaoma Rural Council, happened also to be present; she explained the proceedings to a group of about 30 women who were likewise attending the meeting. The meeting was chaired by Mr. Kasamba, headmaster.

The present writer explained at length why so far the Njonjolo people had failed to have a clinic built in their area. He divided the problem in three parts:

- funds
- official permission
- local organization

As his argument is relevant for subsequent action, it will be summarized below.

Funds. The Government of the Republic of Zambia has no capital available to finance the construction of rural health centres. It therefore encourages people to construct clinics on a 100% self-help basis. At the same time certain minimal requirements must be met, so as to ensure that the clinic will function properly and that the staff who run it will be suitably accommodated. Present government regulations (4) require a rural health centre to consist of:

- a main building (stage-1 rural health centre)
- sanitary accommodation
- three 3AA staff houses
- adequate water supply,

all to be constructed according to government specifications. Any application also has to include a proposal as to where, precisely, the rural health centre is to be built. Bricks can be made locally, and labour has to be offered free of charge by the local population. This means that it is mainly building materials, and their transport from the "line of rail" (Lusaka), which involve capital expenses. In 1975-76, Citwa clinic was built in a different part of Kaoma district, on a 100% self-help basis. By that time the costs of building materials (excluding transport) had been just of K8,000 (about \$11,000). Since, prices have gone up tremendously. It is estimated that to build a similar rural health centre in Njonjolo today would cost between K20,000 and K30,000. The average money income of the households in the Njonjolo area is not more than K100 a year. Obviously it is impossible for the local population to finance the clinic entirely, or even for the greater part. The present writer, however, expressed his belief that it might be possible to find most of the money needed with organizations for development aid in the Netherlands. In addition, however, donations from the local people would be necessary: they would give people the feeling that the clinic is theirs, and that its completion (including all the hard work that this involves) is their own responsibility. Moreover, donations should be sought from people from Chief Kahare's area who are now staying in town: it is their younger

and elder relatives, and in some cases their wives, that the population of Njonjolo consists of. Collection of donations, however, should wait until the authorities have been duly informed of the project, along the proper channels.

Official permission. The present writer explained the importance of obtaining official written permission for the rural health centre, before construction can even begin. Only when this permission is given, can the government (the Ministry of Health) be expected to provide the new clinic with staff, drugs and equipment. For this permission two things are required:

1. The rural health centre must comprise the total set of main building, sanitary accommodation, three staff houses and water supply, all constructed according to government specifications.

2. The permission must be sought along the proper channels. First, the Councillor for the area must move a motion before the Rural Council. From there the proposal will be passed on to the District Development Committee. From the District Development Committee, the proposal will be sent to the Provincial Development Committee. If the Provincial Development Committee accepts the proposal, it will send it on to the Provincial Medical Officer, Western Province (Mongu), who will consult with the headquarters of the Ministry of Health (Lusaka). Only when the proposal has gone through all these levels, and has been approved throughout, will it be possible to start building. This also means that at all stages the proper forms, drawings, memorandums etc. must be produced necessary for administrative action at each level. If one does not stick to this procedure, the Rural Health Centre will remain without staff, drugs and equipment, and therefore be useless. Moreover, this procedure is to take considerable time. During this waiting time the local people should remain patient, collecting money and preparing for the building. If they lose their patience and take rash action, their chances of obtaining the permission and completing the clinic will, of course, be in danger.

There is yet another reason why the permission must be sought along the proper official channels. The agencies for development aid will refuse to donate any money unless it is absolutely sure that the clinic, once completed, will be staffed and supplied with drugs and equipment. Only the Zambian government (notably the Ministry of Health) can assure this, but it will only do so if the proper channels are being operated.

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Local organization. To get the project going, to collect and make a record of the donations, to make the bricks and construct the buildings, and to attend to the many official matters involved in obtaining government permission and funds from abroad, some form of local organization is required. This organization should be a cross-section of the local community. Women should be part of it; for it is them who are most confronted with the health risks of that most vulnerable section of the rural population: the children. If a Ward Development Committee had been in operation in the Njonjolo area itself (as distinct from the total Litoya Ward), such a Committee would have been the proper local organization to prepare for the clinic. However, since there is no Ward Development Committee whose activities effectively extend to the Njonjolo area, a new committee had to be formed for this specific purpose. After discussing the total project along the lines summarized above, forming the committee did not present any difficulty. The following officials were elected unanimously during the meeting:

chairman	Mr Watson Kabimba (Branch Chairman)
secretary	Mr Alan Mumbici (Deputy Headmaster)
treasurer	Mr Adam Matiya (Branch Official; nominated in his absence)
vice-chairman	Mr Induna Yabisha (formerly Court Justice, Muleka Local Court)
vice-secretary	Mr Haciwa (Teacher)
vice-treasurer	Mrs Mandamo Lengwanya (Kahare Village)
committee members	Mr Kasamba (Headmaster)
	Mr Simon Kabimba (Branch Official)
	Mr Lingstone Kikambe (Youth Official)
	Mrs Emeliya Shibizi (Shibizi Village)
	Mrs Mukwanga (Mukwanga Village)
	Mrs Emeliya Kashanda

external representative Drs Wim van Binsbergen (Research Affiliate, Institute for African Studies, University of Zambia / Research Officer, African Studies Centre, Leiden, the Netherlands)

It will be noted that the composition of this committee is largely such as would have been expected, had it been a Ward Development Committee.

As name for the committee was chosen: Njonjolo Clinic Committee.
The official address of this provisional committee is:

The Hon. Secretary
Njonjolo Clinic Committee
Mr A. Mumbici
Kahare Government School
P.O.Box 34
Kaoma (Zambia)

It was agreed that the committee should meet regularly, and that full minutes should be taken, for further reference of those officials of Local Government, Ministry of Health, of the United National Independence Party who might require them.

It was also agreed that the first action to be taken was to be the writing of the present report.

Plan for action

The following tasks now lie before us:

1. This report should be distributed among all district and provincial officers concerned (see p. 1), to inform them of the provisional steps that have been taken, and to ask them for their advice and comments. In particular, the District Secretary should advise whether the provisional Njonjolo Clinic Committee, which practically acts as a Ward Development Committee, should yet be registered under the Societies Act.

2. The official procedure should be set in motion through which official, written, valid permission for the construction of the Njonjolo Clinic can be obtained. As a first step, a Councillor should move a motion to this effect in the Kaoma Rural Council.

3. Pending the official permission, the Provincial Medical Officer, Mongu, must be approached. He will be requested to

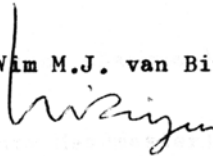
forward copies of the official plans (5) for a government-approved Rural Health Centre stage-1. He will also be asked to comment on the present report, and help with advice, particularly in case current procedure happens to differ from the one indicated here.

4. On the basis of this report, and such material as will be forwarded by the various officials at the district and provincial levels, will the present writer seek financial assistance for the project, from development aid agencies in the Netherlands.

5. For this project to succeed, it is necessary that the local committee, through its secretary, and the external representative (the present writer) communicate regularly with each other on the progress that is being made on either side.

Lusaka, 17th August 1978 -
Leiden, the Netherlands, 7th
September 1978

Drs Wim M.J. van Binsbergen



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(1) Cf. W.M.J. van Binsbergen, The Infancy of Edward Shelonga: An Extended Case from the Zambian Nkoya, in: J.M. van der Geest and K.W. van der Veen, eds., Doctors and Patients: Essays in Medical Anthropology, Anthropological-Sociological Centre, University of Amsterdam, Amsterdam, the Netherlands; to be published late 1978. This 60-pp. article includes a full bibliography.

(2) People from this area move frequently, both between village and town and from one village to another; this important feature of the local society has both positive and negative effects, from the point of view of health services.

(3) Kaoma Rural Council, Minutes of the Meeting of 19th December, 1974, CM/60/74. I am indebted to Mr. Milupi, formerly Secretary, Kaoma Rural Council, for making these minutes available to me.

(4) Cf. Circular letter D/35, from the Office of the Provincial Medical Officer, 21st April, 1969, on the regulations concerning self-help schemes.

(5) Unless this has been superseded by a new design, reference is made here to drawing ST/456/81, Standard Rural Health Centre, obtainable from the Office of the Provincial Medical Officer, P.O.Box 22, Mongu.