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Promoting Women's Health
Through Functional Literacy
Intersectoral Action

B. Makoni

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CONSULTANCY REPORT

Number 20

**PROMOTING WOMEN'S HEALTH THROUGH
FUNCTIONAL LITERACY AND INTERSECTORAL
ACTION**

**A STUDY OF VULNERABLE COMMUNITIES IN
CHIVI DISTRICT, ZIMBABWE**

B. M. Makoni

ZIMBABWE INSTITUTE OF DEVELOPMENT STUDIES

Harare, 1990

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CHAPTER I

BACKGROUND TO THE STUDY

Introduction

This chapter gives the background to the study. It has four sections. The first section, an overview of the health situation in Zimbabwe, is an outline of Government and non-governmental organisations (NGOs) efforts to promote better health. The second section is a rationale for the project Promoting Health Through Women's Functional Literacy. This section also provides the theoretical framework of the study and gives a guideline for identification of the target population. Then follows a section on research questions. Finally, there is a statement on Chivi District and its vulnerable socio-economic position.

An Overview of the Health Status of Zimbabwe

Health is a service which many nations the world over consider important. Besides assuring a nation of continuity, the level of health of a nation has a bearing on the level of productivity that nation can achieve. Because of this, many nations invest in the health of their citizens, particularly children who are identified as a vulnerable group.¹ In Africa when a country attains political independence its health budget immediately increases. In Zimbabwe the health budget multiplied twice overnight.² This increase was due to, among other things, expansion especially in the number of health facilities and the size of health personnel.

Expansion in the health sector of Zimbabwe led to improved health for her people. One indicator of this improvement is the reduction of infant, child and mother deaths. Child mortality rates (CMR), for example, declined from 79 per 1 000 in 1979 to 23 per 1 000 in 1986.³ Despite apparent improvements, the present status of child health and the present rate of child survival at 88 per 1 000⁴ are far from desirable.

In her battle to achieve Health for all by the Year 2000, and to reduce mother, child and infant mortality rates, Zimbabwe has expanded her primary health care (PHC) programme. PHC now includes mini-programmes like the expanded programme on immunisation (EPI), construction of Blair toilets, construction of protected wells for a safe water supply and training of grassroots personnel. Whereas EPI and training of grassroots personnel are Government programmes, the construction of Blair toilets and wells is initiated by Government departments and supported by NGOs. The Blair toilet programme took place between 1984 and 1987. NGOs like the Lutheran World Federation and the Catholic Development Committee (CADEC) provided cement, the

-
- 1 W. H. Mosley and L. C. Chen (eds) 1984: *Child Survival: Strategies for Research*, Cambridge UP.
 - 2 Government of Zimbabwe, CSO, 1987.
 - 3 Zimbabwe National Family Planning Council 1985: *Zimbabwe Reproductive Health Survey 1985*: p.67.
 - 4 *Ibid.* Compiled from Table 5.1 p. 69.

Ministry of Health (MoH) provided building expertise and the community provided labour to build their own toilets. Material support for the Blair toilet programme ended in 1987. Considering the low economic status of the people and their inability to buy cement, the Blair programme has almost come to a standstill. Construction of protected wells is an on-going programme supported by the Government, local authorities and NGOs.

The most recent programme is the training of Village Community Workers (VCWs). The VCW training programme trains Community Workers (CWs) and Village Health Workers (VHWs). Previously, community workers were part-time employees of the Ministry of Community Development and Women's Affairs (MCDWA). This cadre included Home Economics Demonstrators (HEDs), Women Advisers and Creche Supervisors. Their duties included mobilizing people for development programmes like literacy and day-care centres and also advising people on domestic science. Their target were women. The duty of VHWs was to deliver basic health services like first aid and advising people on basic hygiene and sanitation. Like CWs, VHWs programmes were targeted at women.

Although the duties of these two grassroots cadres, i.e. CWs and VHWs, appear different, in reality they are very similar. There was an overlap and duplication in duties, for invariably they both had a teaching and an advisory component. In order to coordinate programmes directed at grassroots women and to save resources, the two cadres were as from September 1988 merged into one cadre, the Village Community Worker (VCW). To date there are up to 6 000 VCWs in Zimbabwe. Their duties remain the same, but their work is coordinated and supervised by MCDWA. They provide the link between MCDWA, local authorities and the grassroots. They are at the forefront of delivering services in all community-based projects. Apart from VCWs, there is yet another health-related cadre, the community-based distributor (CBD). CBDs are grassroots employees of the Zimbabwe National Family Planning Council (ZNFPC). Their duty is to deliver contraceptives.

Promoting Health Through Women's Functional Literacy

Promoting Health Through Women's Functional Literacy (hereinafter referred to as Women's Health and Literacy) is a community-based project. The project is part of the PHC approach to better health. The aim of the project is to improve the health status of vulnerable groups through non-formal education (NFE). The project is unique in that while seeking multi-disciplinary expertise and inter-sectoral action in promoting health it correlates child's health to mother's child-care practices and subsequently to her level of literacy.

Among the problems which are linked to child health and death are poverty, lack of information and illiteracy on the part of the mother. The thesis here is that illiteracy in a woman sets off a chain of other ills which are health risk factors and which finally contribute to mother and child mortality. This thesis is supported by scholars like Aransky and Fisher. Aransky (1965) argues that illiteracy leads to hunger and disease. Fisher (1982) contends that literacy has a role in promoting health through increased food productivity, better nutrition, increased delivery of information and higher life expectancy. It is also generally believed that with the help of PHC a literate mother can eliminate the six preventable killer diseases, i.e. diarrhoea, diphtheria, measles, tetanus, tuberculosis and whooping cough.

A community-based project is a project which solicits support from the grassroots. This support is in the form of, among other things, materials, skills, labour organisation, leadership and management. This support should be sought at all project stages, i.e. planning, implementation and evaluation. Above all, project beneficiaries, if they have to benefit anything, should be involved in the process of decision-making at all project stages. This last condition, i.e. participatory decision-making, is indispensable to project success for it influences how the target group responds to the project.

The project "Women's Health and Literacy" is in its preparatory stage. As such, it is important for the implementing agency to be very clear about two major project inputs. These are the intended beneficiary target group and the health/functional literacy input. The intended target group are vulnerable women. A woman who is labelled "vulnerable" is one who:

- is in the fertile phase of her life, i.e. between 15 and 49 years.
- has at least one child who is five years old or below (under-five).
- has lost an under-five through any one of the six preventable killer diseases.
- is illiterate.
- is poor.
- lives in an unhygienic environment.

The age index was modified to include older women, for the study foresaw the possibility of meeting older women who look after children of absentee mothers. For purposes of this study, a person is "poor" if she earns less than Z\$100 per annum. Similarly, an unhygienic environment includes a semi-permanent house, poor ventilation, a pit latrine or absence of a toilet facility, and lack of access to safe water. The study has further identified an additional index of unespoused women who bring up children single-handedly.

The health functional literacy input should provide an intervention to fill the gap between actual health knowledge and desirable health knowledge. It should also link actual health behaviour to desirable health behaviour of the target population. Desirable health behaviour includes such practices as attending ante/pre-natal and baby clinics. The intervention should, therefore, supply the target population with absent yet desirable knowledge, skills and attitudes.

Objectives of the Study

The purpose of this study is to validate baseline data on vulnerable communities by investigating vulnerable women. Specifically, the study seeks to:

- identify vulnerable women
- identify the type of intervention needed for functional literacy
- assess priority community needs and resources.

The study is organised around three key questions and their subquestions which are:

- To what extent are there vulnerable women in the project area?
 - Are their social characteristics of age, parental status and educational level desirable?

- Are housing, sanitation and water in their living environment hygienic?
- What type of efforts do they make to subsist?
- To what extent is there a need for a health/literacy intervention?
 - What is the pattern of desirable health behaviour of the target group?
 - What kind of knowledge, skills and attitudes does the target group need from the literacy intervention?
 - What other intervention does the target group need?
- To what extent is the community resourceful to facilitate the intervention?
 - What are the priority community needs of the target population?
 - What physical facilities and literature are available for learning purposes?
 - Is there adequate expertise and personnel?

Socio-Economic Status of Chivi District

The project "Women's Health and Literacy" is located in Chivi District, Masvingo Province. Chivi has 26 administrative wards which cover an area of 317 769 hectares. A ward has six village development committees (Vidcos) and a Vidco is composed of about five villages. By average a village has 20 households.

At district level a district is led by a District Administrator who is the chief Government executive. He leads a team of civil servants attached to all Government ministries. Some of these departments like Health, Agriculture and Community Development have extension staff based at ward and Vidco levels. As a local authority, a district is managed by a district council(DC). A DC chairman is supported in his duties by councillors at ward level and Vidco chairman at Vidco level. At village level a community is led by a headman.

This study on vulnerable communities is a follow-up of a baseline study. The baseline is a general profile of Chivi. In this profile is an outline of health and NFE facilities, social characteristics of its population and the socio-economic status of households. Below is a resume of this profile insofar as it relates to the present study.

Health and NFE Facilities

Chivi has a total of 12 physical medical facilities. The facilities are three admitting clinics, five rural health centres and a mobile clinic. Apart from trained medical staff, there are 160 VCWs. Chivi has four residential training centres, one at Madamombe Business Centre, two at Chibi Township and one at Maringwe. There are also six social centres (Befura, Davira, Denga, Musvovi, Dare and Nyamahwe) which are used for training purposes. Most of the training is conducted for extension workers of Government departments and volunteer literacy tutors (VLTs). The departments which are active in NFE are Health, Agricultural, Technical and Extension Services (Agritex), Public Service, Community and Cooperative Development, and Education. All these departments have a health input in their programmes, but their training is not coordinated.

There are 130 adult literacy centres in the district. Ideally, there should be 156 centres, one per Vidco, but teacher dropout is a serious constraint. There are also 150 pre-schools, supervised by part-time staff of MCDWA. The pre-school programme was assisted with a supplementary feeding scheme by the Norwegian Save the Children organisation (Redd Barna) and Christian Care. The scheme was stopped in April 1988.

Social Characteristics

The social characteristics studied are age, household heads, education and access to information. A survey of households indicates that in Chivi 70 percent of the female population is adult. Their age distribution is 15-44 years (51 percent), 45-60 years (14 percent) and 61 years and above (5 percent). Out of all the households surveyed, 33 percent have female heads. The level of education of women is rather low: 20 percent never went to school; 30 percent had at most four years of formal schooling; 35 percent had at most seven years of formal schooling and only 15 percent managed to get into secondary school. Although the level of education of the women is low, they have information and knowledge of basic health practices. Among them, 86 percent are aware of PHC, 77 percent know how to treat common diseases, 71 percent are aware of EPI, 46 percent are aware of ante-natal and 42 percent are aware of post-natal services.

Socio-Economic Characteristics

The survey investigated housing, sanitation, water and employment. Information indicates that 78 percent of the population live in temporary houses, i.e. houses built of pole and grass, pole and corrugated iron or brick and grass. The survey also revealed that 6 percent of the population live in houses with no windows at all. MoH is presently assisting people build toilets by providing the expertise. The situation of toilets is that 48.4 percent of the people have no toilets, 18.1 percent have pit toilets, 31.5 percent have blair toilets and 2 percent have both pit and blair toilets. Although there are two rivers each with several tributaries and three dams, persistent drought dries up the waters. Apart from these sources of unsafe water there are 41 community boreholes and 29 protected wells.

The district is generally impoverished, although the northern section and central Chivi are better off. The women are not gainfully employed and only 9 percent of them have husbands who are gainfully employed. Ninety percent of the sampled women have an average household income of Z\$484.00 p.a. and the average income of any individual woman is Z\$393.00 p.a., well below the rural minimum wage of \$1 200 p.a. for farm labourers. Due to drought in the district, 61 percent of the women expressed an urgent need for food and 25 percent were involved in the food-for-work relief programme.

The main economic activity in the district is communal farming which occupies 95 percent of the population. There are also 15 Small-Scale Commercial Farms (SSCF) in Jenya. Farming, however, is hampered by drought. There are three irrigation schemes - Makonese, Musuvugwa and Bonga - but the last two are not operational due to lack of water. Bindamombe and Madamombe are currently under construction. The major sources of income are income-generating (IG) and cooperative activities. The main IG activities are gardening, animal husbandry, cottage industries and crafts. There are 350 cooperatives, but a quarter of them are defunct. Nearly 75 percent of the women interviewed are engaged in cooperatives.

Low productivity largely accounts for the type of food families eat. The bulk of the food eaten by most people is starch (83 percent), followed by vegetables (79 percent). Milk, taken by only 12 percent of the population, is a rare food item; and so is fruit (6 percent), fish (3 percent), meat (2 percent) and nuts (2 percent). As a result of poor diet, malnutrition is common among both women and children.

Inadequate health facilities, an uncoordinated system of health information, low level of education, poor housing, poor sanitation, unsafe water and low productivity are all health risk factors. Undoubtedly, these factors contribute to a CMR of 52/1 000.⁵ Considering the correlation between literacy and health, it appears there is need for a health-literacy intervention. This intervention is to be provided by the project "Women's Health and Literacy".

5 S. T. Chirawu: Chivi Baseline Report, ZIDS, Harare, 1986.

CHAPTER II

METHODOLOGY

Introduction

Chapter II (Methodology) is a description of how the study was designed and how fieldwork was conducted. There are four sections, namely, population, instruments, fieldwork and limitations. The section on population describes the population studied. The section on instruments describes and justifies methods of data collection as well as fieldwork preliminaries. Then follows a section on fieldwork. This section describes and justifies the research strategy adopted by the study. The final section highlights the limitations and warns the reader of weaknesses of the study.

Population

The population for this study is "all resident women who take care of children of age five years or under". Six wards, i.e. Wards I, IV, VIII, XII, XVI and XX, were selected for the study. The criterion for selection is that these are the very wards which had been sampled for the baseline study.

The study did not apply any other sampling scheme for four reasons. First, although Central Statistical Office (CSO) indicates that Chivi District has a female population of 30 482 (CSO : 1982) in the age group of 15-49 years, the statistics do not show the ward distribution of this population. It was not certain if the six wards could raise adequate numbers of the required target group (500). Secondly, the project instructed⁶ that a vulnerable woman should meet at least four of the seven prescribed indicators. Here the study feared that if some sampled areas did not have vulnerable women, the number of the target population would be consequently reduced and this would reduce the validity of our findings. Thirdly, the six wards have altogether 150 clusters in the form of villages. The study wanted to survey a large number of clusters in order to make its findings valid. Fourthly, due to the pilot nature of the study it is important that the identified target of 500 women is not only vulnerable, but the most vulnerable lot picked out of a larger group of vulnerable women. Considering the large number of 500 vulnerable women to be picked from an estimated 3 000⁷ interviewees whose distribution was unknown, it was not wise to sample further.

6 WHO Inter-Country Workshop Report, July 1988, Lagos.

7 "Project of the Government of Zimbabwe": Project Document 7628M, p.14.

The unit of investigation for this study is an individual rather than a household. There are two reasons for this decision. First, although a household (with several women) may have one of the women as the senior woman, in practical terms each woman is singularly responsible for the care of her children. The study did not want to assume, therefore, that this senior woman would have knowledge or information pertaining to other children in the household. Even if these other children were to be left out of the project, the mechanism to determine and ascertain which child is absorbed into and which one is left out of the project would be rather superficial. Secondly, a household is today questioned as a unit of social investigation for research on women.⁸

Based on available statistics, and the need to infer findings of the target population to the whole district, child care responsibility, and current methodological trends in research on women, the population of the study was not further sampled. All resident women who were available in the six wards and who presented themselves for investigation were surveyed. Finally, a total of 1 892 women were interviewed from 120 villages.

Instruments

The study employed an interview schedule because Chivi peasants do not have a literate culture to be able to handle a questionnaire. The interview schedule was loosely structured so that it would be possible to vary, repeat or modify a question depending on how a respondent understood it. When interviewing rural people, clarification may be necessary due to dialect differences. For, although interviews were conducted in Shona, the local vernacular, the researcher appreciates that rural vocabulary sometimes differs from urban (researcher's) vocabulary. In this study clear cases of language misconceptions were observed with terms like "married" and "income".

The instrument was pretested by reviewing it with colleagues at work and the National Steering Committee. It was also tested on a group of 100 women on the outskirts of Harare. This schedule was then taken to the field. After administering it on 200 subjects it was discovered that questions which sought information on marital status and income were misleading. It was also discovered that answers to questions seeking information on what women know and what they do not know were not valid. The questions on knowledge assumed that the health behaviour of a subject was an indicator of that subject either knowing or not knowing desirable health behaviour. This was not always the case.

On revision, the question on marital status "Are you married?" was changed to: "Do you have a husband?" If Yes: "Are you still together?" If No: "What happened to your husband?"

Similarly, the question "What is your annual income?" was changed to: "If you save all the money you earn without spending it, how much would you accumulate in one year?" Other income-related questions included: "How many bags of maize, sorghum did you harvest last season?" and "How many did you sell?".

⁸ A. Imman; Households and the Crisis in Africa: a paper presented to a conference of the Association of African Women on Research and Development (AAWORD), Dakar, Senegal, August 1988.

The questions on health behaviour were given additional dimensions like "why; how often; always or sometimes". These additional questions seeking reasons for and frequency of behaviour were expected to provide qualitative data which would help assess the learning needs of the target group.

Fieldwork

Fieldwork was in two stages, namely preliminaries and data collection. Preliminaries included training of research assistants by the project consultant, familiarisation with project areas and consultations with leaders at district and ward levels. Consultation focused on creating structural support for the survey team to design an appropriate research methodology.

At first it was agreed that each ward constitute a support mechanism composed of political party chairman, secretary and youth representative, and VCWs led by their councillor. The role of the grassroots mechanism was to inform both men and women about the project and the expected survey team. Their other duty was to identify vulnerable women and ask them to convene at selected venues. By consensus, the grassroots team decided that schools should provide the venue because they are socially accessible.

The turnout of interviewees at these schools was poor. This was apparently partly because of distance and partly because the grassroots team had not involved the heads of schools, and they had not mobilized women adequately. After further consultation the number of venues was increased in order to reduce walking distance. District Education Officers were also drawn into the support team in order to liaise with heads of schools. At this point turnout improved just a little, but it was still unsatisfactory.

The district authorities would have preferred fieldwork to be conducted on Sunday and *Chisi* (a holy day) when people do not work in their fields. Considering the massive fieldwork, this would not be possible. It was finally agreed that the research team make village to village visits. At this level, village headmen were incorporated into the support team. A village headman's duty was to ascertain that all women with children of five years or under (under-fives) from the 20 homesteads he heads turn up for the interview. The venue this time was the headman's homestead. At this point the turnout of interviewees improved.

Although after changing the research strategy three times the target group could now be "seen" there were other problems which greatly reduced the numbers the research team was able to handle. Either the women were not informed or were misinformed about the purpose of the survey team's visit. Many believed the team was investigating a sexually transmitted diseases (STD) cases, or they were distributing medicine. Apparently, husbands had not been informed, so naturally they wanted to know what it was their women were being queried about. Some men wanted to be interviewed, too. Sometimes when leadership personalities were in conflict the programme had to be revised. These problems were complicated by wrong timing of the fieldwork. The four months from October to January comprise the rainy planting season. This is also a festive season, so people were not easily available.

Despite the problems outlined above, fieldwork continued and missed villages were revisited. One of the six wards (Ward I), however, was not well covered because of some natural and technical problems. In the end, six research assistants and 60 days in the field produced 1 892 valid interviews. The data collected is deemed reliable and valid because the interview schedule was field pre-tested twice and research assistants were trained and supervised. Further, at the end of each day, filled-in questionnaires were inspected and there was a session when the team exchanged field experiences and decided on how to handle problems.

Limitations

This study has four limitations. They all relate to assessment of vulnerability; two are methodological and the other two are conceptual. Poverty is a relative term and it is difficult to measure. Although the study provides an income yardstick, poverty is not measured by money alone, it is the result of an interplay of many factors and it is not a static position. Further, a person's income is private information; it is possible therefore that the data on income is biased. It is also possible that some subjects deliberately inflated their income in order to appear better off than they actually were. Similarly, some subjects might-have declared a mean figure in anticipation of material benefits. This limitation on the conceptualization of "poverty" is overcome by assigning poverty a subordinate position in prioritizing the seven indicators.

The question of killer diseases posed a problem, as some subjects were unfamiliar with the medical terms of some diseases. There were also cases when a killer disease was inferred from its symptoms. Considering the situation it is possible that the data on killer diseases is not a true reflection of reality. This limitation on conceptualization of medical terms for killer diseases is also overcome by assigning killer diseases a subordinate position when prioritizing the seven indicators. The study decided to concentrate on death of under-fives through diseases, regardless of the identity of the diseases.

The study did not administer a literacy test to the target population. Subjects were simply asked to declare their literacy status. It is possible therefore that some subjects wanted to be seen to be literate when they were, in fact, not. This particularly refers to those who declared they could read and write "with difficulty".

The methodological limitation of assessing literacy is overcome by co-opting semi-literacy into vulnerability. Further, literacy is not the only indicator of vulnerability. Literacy in this study is only one of the four priority indicators which the study has finally settled on.

A child's age is the second methodological constraint. Although the study did not ask women to bring along evidence of children's age, some women turned up with baby clinic cards. For those who had no evidence of their children's ages it is possible that they reported ages which were not exact. This limitation, however, is overcome by the fact that within the Zimbabwean context the study is not strict with the specific age of a child. The study is more interested in pre-school children. In Zimbabwe children start school when they turn six years.

Considering constraints in assessing vulnerability, of women the study has ranked the seven indicators into priority and subordinate positions as follows:

Priority

Caring for an under-five

Illiteracy/Semi-literacy

Unhygienic environment

Loss of an under-five

Subordinate

Age

Absence of husband

Poverty

The most vulnerable women, therefore, are those who qualify for at least four indicators including at least three from the priority list.

CHAPTER III

DATA PRESENTATION AND ANALYSIS

Introduction

Chapter I of this study outlines efforts made by Zimbabwe to promote health of the grassroots in general and health of children in particular. The main assumption underlying these efforts is that delivery of health in a developing country is most effective through PHC and community participation. In the process of this delivery a child's mother should be the focal point. The pragmatic and vulnerable context in which she survives, the ideal situation in which she should exist and the support she needs from the rest of the community are of vital importance. In view of this, the study set out to investigate different aspects of her vulnerability, to identify interventions which would eliminate her vulnerability and to explore resources which would facilitate the interventions.

This chapter reports our findings from the field. The chapter is divided into three sections which provide information to answer the three research questions on mother vulnerability, health literacy intervention and community resourcefulness.

The Extent of Vulnerability Among Women

The study surveyed different aspects of vulnerability among women. They are age, parental status, literacy level, housing, sanitation, water, economic activities and income. This study expects that the extent of vulnerability among the study population is similar to the extent of vulnerability in the district. This study expects, therefore, that most subjects are within the 15-44 years age group, they are semi-literate and they bring up children single-handedly. The study also expects that their living conditions, i.e. housing, sanitation and water, are unhygienic. On subsistence, the study expects that the target population subsists on communal farming and has a negligible income. However, the study also expects that their efforts are supplemented by small incomes from various activities and remittances from relatives. Finally, the study expects that within the context of undesirable social characteristics unhygienic living environments and unrewarded subsistence efforts, the CMR is similar to the average for the district. The degree of vulnerability is expected to increase as one moves along the district from the North through central Chivi to the South.

Graph I (Appendix A) is a composite presentation of different aspects of vulnerability among the target population. Although all women interviewed above 15 years, data indicates that the 15-44 years age group is relatively bigger (85.7percent) than other age groups. However, age distribution of the population is highest in the 25-34 years age group (40.4 percent). Only 3 percent of the target group is above 55 years. On further analysis, data (Table I) reveals that in each of the six wards the 25-34 years age group accounts for at least one-third of the target group. The highest relative concentration of this age group is in Ward VIII.

o

Social Characteristics: Graph I and Table I

Table I
WARD DISTRIBUTION OF WOMEN WITH VULNERABLE
SOCIAL CHARACTERISTICS (n = 1 892)

	Ward	25-34 Age Group		Non-Parents		Non-Unespoused		Illiterate		Average	
		F	%	F	%	F	%	F	%	F	%
n = 93	I	32	34.4	18	9.9	11	11.8	20	21.5	20	19.4
n = 272	IV	101	36.5	32	17.7	37	13.4	62	22.4	58	22.5
n = 257	VIII	116	45.1	24	7.7	36	14.0	44	17.1	55	21.0
n = 384	XII	163	42.4	22	12.1	29	7.9	88	22.9	76	21.3
n = 328	XVI	141	43.0	26	14.5	57	17.4	86	26.2	78	25.3
n = 553	XX	211	38.2	69	38.1	68	12.3	167	30.2	129	29.7
n = 1 892	Total	765	40.4	181	9.6	239	12.6	467	24.7	413	21.8

Parental status has been measured in two ways. One measurement seeks to establish whether a woman who takes care of an under-five is the actual parent of the child or otherwise. The other measurement seeks to find out whether she has a husband or she has no husband (widowed, divorced or single) and she brings up the child/children single-handedly. Information from the field indicates that 10 percent of the women surveyed are not the parents of the children they look after. They are grandmothers (8 percent) who keep the children of absentee mothers. Cases of non-parents are more pronounced in Ward XX and less pronounced in Ward VIII. Further information reveals that 21.6 percent of the population are unespoused women who look after children single-handedly. Of the 87.4 percent women who have husbands, 33 percent have employed and possibly absentee husbands. Although the figure of unespoused women is smaller than the average for the district (33 percent), it is possible that the number of women who look after children single-handedly (no husband and absent husband) can be as high as 54.6 percent.

Literacy was measured in both Shona and Ndebele. Shona is more commonly spoken in Chivi than Ndebele. The data herein therefore refers to literacy in Shona. Although Table I shows that just about a quarter of the population are illiterate, there are 493 semi-literate people. Unless their literacy level is reinforced, these semi-literates are likely to relapse into illiteracy. The total sum of women who are vulnerable to illiteracy therefore is 960 or 50.7 percent. Among the total population surveyed this illiterate/semi-literate group is relatively more concentrated in Ward XX (62.4 percent) followed by Ward XII (52.9 percent), Ward I (47.3 percent), Ward XVI (46.6 percent), Ward IV (45.1 percent) and Ward VIII (35.0 percent).

On further analysis, the data shows that 1 793 (94.8 percent) women are aware of the adult literacy campaign. Assuming that all the 932 literates are aware, then 861 illiterates/semi-literates are also aware of the campaign. It is discouraging to note, however, that only 14.2 percent of the illiterate/semi-literate women attend literacy classes. Despite the proliferation of adult literacy groups in the district it appears that the target population, especially in Wards XX and XII, have been missed by the national adult literacy campaign. This situation is further emphasized by the fact that only 1.7 percent of the literate subjects achieved literacy by attending adult literacy classes.

Hygienic Status of Living Environment: Graph I and Table II

Table II

WARD DISTRIBUTION OF THE TARGET GROUP WHO LIVE IN ENVIRONMENT OF POOR HYGIENE AND SANITATION BY ACTUAL FACILITY (n = 1 892)

	Ward	House		Ventilation Toilet		Water		Average			
		F	%	F	%	F	%	F	%		
n = 93	I	80	86.0	39	41.9	84	90.3	31	33.3	59	62.9
n = 277	IV	200	72.2	135	48.7	243	87.7	158	57.0	184	66.4
n = 257	VIII	148	57.6	117	45.5	173	67.3	78	30.3	129	50.2
n = 384	XII	233	60.7	205	53.4	356	92.7	318	82.8	278	72.4
n = 328	XVI	212	64.6	168	52.1	257	66.9	191	58.2	207	60.5
n = 553	XX	388	70.1	266	48.1	484	87.5	284	51.3	356	64.3
n = 1 892	TOTAL	1 261	66.9	930	49.2	1 597	84.4	1 060	56.0	1 212	64.1

Key: House : Semi-Permanent House; Toilet : Pit or no Toilet; Ventilation : Poor Ventilation; Water : No access to safe water supply.

Figure I (Appendix A) and Table II indicate that two-thirds of the target group live in temporary houses. This figure is less than the average for the district (78 percent). Data also reveals that a further 30.1 percent live in mixed houses, i.e. some (main houses) are permanent, but some (kitchen) are temporary. Only 3.3 percent of the target group have fully permanent shelters. The range of distribution of people with temporary houses in the six wards is as high as 28.4 percent, and each ward has at least half of its people living in temporary houses. The worst hit ward in terms of housing is Ward I followed by Wards IV and XX. It is encouraging, however, to note that everyone is housed and no one sleeps in the cold. This may be due partly to availability of inexpensive local building materials.

The study also notes that all permanent houses are built of burnt bricks and corrugated iron, also locally available. On further observation it was noted that construction technology and art are also local.

The study makes an interesting observation on the floors of houses. On comparison, the number of people who have cement floors in their houses is much higher (17.9 percent) than the number of people who have fully permanent houses (3.3 percent). This is an indication of efforts to improve the condition of houses and maintain a healthier environment.

Data reveals that only 2.9 percent of the population (half the average for the district) have no windows at all in their houses. Although this figure seems small, in reality people with poorly ventilated houses are more than this figure (Table II). An additional 46.3 percent have four windows or less. The local construction structure provides two brick size windows per house, but this does not provide adequate ventilation. About half the people in the study area have poorly ventilated houses; the trend of distribution of women who live in poorly ventilated houses in the six wards is normal, but Ward XII is the worst hit.

Graph I shows that 69.8 percent of the target group have no toilets at all. This figure is higher than the average for the district (48.4 percent). In each ward at least half the people are affected (I : 83 percent, XII and XX: 75.8 percent each, IV : 70.8 percent, XVI : 62.8 percent and VIII : 50.6 percent). This unhygienic situation is made worse by the fact that among those people who have toilets half of them have undesirable pit latrines. The actual position of vulnerability in terms of toilet facilities is depicted in Table II. The average rate of vulnerability is 84 percent, although Wards VIII and XVI are well below average. Wards XII, I, IV and XX, in that order, are the worst hit.

Analysis of data from the field indicates that of the 832 women who have access to a safe drinking water supply, 83.3 percent have access to boreholes, 8.4 percent (of whom 93 percent are in Ward VIII) have access to tap water and the remaining 8.3 percent have access to protected wells. According to Table II, at least half of the target group have no access to safe drinking water and in each ward at least one-third of the target group is affected. Their source of water in this semi-arid area is also unreliable.

Data clearly indicates that the percentage of people who use water for general purposes from unsafe sources is higher (72.5) than the percentage of people who use water for drinking purposes from unsafe sources (56.0). Among this latter group of people one-third of them treat their water before drinking it. The implication of this is that 18.6 percent of the surveyed target population are not only aware of the dangers of drinking unsafe water but they also take action to make their water safe.

Although by average half the women in each ward have no access to safe water, the range of distribution of the vulnerable women is as high as 52 percent. Ward XII is the most affected followed by Wards XVI, IV and XX in that order. Wards I and VIII are the least affected.

Table III shows that at least (89.3 percent) of the target group are involved in various self reliant economic activities..

Data also shows that a negligible 2 percent are regularly employed and another 2.2 percent are irregularly employed. The study notes that nearly two-thirds of the surveyed population supplement their subsistence efforts with IG and cooperative activities. IGs are more popular than cooperatives. In both sectors, however, farming is the most popular activity averaging 74 percent, followed by craft (14.6 percent) and animal husbandry (9.0 percent). By average in the surveyed area less than one-third of the women supplement their subsistence efforts with IGP and cooperatives activities.. Ward XII leads the way with 36.2 percent of its women involved in such efforts. Ward I (32.3 percent) and Ward XVI (30.2 percent) closely follow behind. Ward VIII has the least initiative (13.2 percent) in supplementing subsistence efforts.

Efforts to Survive: Graph I and Table III.

Table III

WARD DISTRIBUTION OF ECONOMIC ACTIVITIES AND INCOME (n = 1 892)

	Ward	Income - 400 p.a.		Peasant		IGP		Cooperative	
		F	%	F	%	F	%	F	%
n = 93	I	66	70.96	93	100	57	61.29	3	3.22
n = 277	IV	194	70.0	230	83.0	109	39.35	6	3.16
n = 257	VIII	145	56.4	237	92.21	139	15.18	29	11.28
n = 384	XII	221	57.6	357	92.96	182	47.39	96	25.0
n = 328	XVI	198	60.4	279	85.06	157	47.86	74	22.56
n = 553	XX	303	54.8	493	89.15	220	39.78	83	15.00
n = 1 892	Total	1 259	66.5	1 689	89.3	864	45.7	291	15.4

Key: IGP - income generating project

The study observes that none of the women surveyed is a dependant, each one of them is busy trying to subsist. Their efforts to subsist, however, are not well rewarded, for the individual income for 66.5 percent of all women is below Z\$400 p.a., and this figure (Z\$400) is similar to that of the district which stands Z\$393.00 p.a. Some 1 116 women (59 percent) earn less than Z\$100.00 p.a. The low-income status of these women is further evidenced in two ways. First, 8.6 percent of them cannot afford kitchen utensils for boiling water. Secondly, whereas 7.1 percent of them use firewood as fuel for light, only 0.2 percent can afford paraffin as fuel for cooking. These low-income women are relatively concentrated in Wards I and IV. It is strange, however, that despite IG and cooperative efforts Ward I's income is this low. This may be a reflection of low productivity due to inadequate investment and drought.

On further investigation, the study discovered that only 33.0 percent of the target group have husbands who are regularly employed, and only 19.8 percent receive remittances (from husbands and relatives). The remittances are negligible, for 72.7 percent of the women end up with less than Z\$600 p.a., Considering the rural minimum wage income of Z\$1 200 p.a. the target population is poor.

According to Table III, the main occupation of the target group is communal farming. In fact, in each of the six wards at least 83 percent of the women are involved in communal farming. The women cultivate grain, tubers, nuts and vegetables. Almost all women (98.8 percent) preserve food. The food items preserved are vegetables (83.4 percent), meat (81.0 percent), grain (22.1 percent), nuts (7.4 percent) and tubers (2.2 percent). This data indicates that agricultural productivity is very low, for those who do not preserve food explained that they had no surplus.

The prevalence of preserving animal products (beef, fish and ants) calls for further investigation as district data indicates that barely 2 percent of the population feed on animal products. Apparently, both women and children are likely to be malnourished and children are likely to face the threat of death. The child mortality rate (CMR) recorded in this study (see Graph I in Appendix A) for the last five years is less than one per 1 000. This rate is lower than the average for the district which stands at 52 per 1 000. Ward I has no record of child death, but Wards IV, XVI and XII have lost at least 15 percent of their under-fives.

The Need for a Health Literacy Intervention

This study set out to investigate the need for a health literacy intervention for the target population. The need for the intervention is determined by assessment of three areas: their level of literacy, awareness of basic health information skills and attitudes as well as the pattern of desirable health behaviour. The study also expects that the women have some basic health information, and they have acquired basic health skills. The average rate of awareness of basic health information for the district is 64.4 percent. The study expects that since the women are aware of basic health information, they apply that information in their daily lives and exhibit desirable health behaviours.

Basic Knowledge, Skills and Attitudes Required for the Literacy Intervention

Table IV
HEALTH INFORMATION WHICH WOMEN ARE AWARE OF

Type of Information	F	%
Salt Sugar Solution (SSS)	1 801	95.1
Home Cleanliness	1 448	76.5
Baby Care Clinic Vaccination	1 325	70.0
Toilet and Sanitation/Refuse Disposal	1 262	66.7
Family Planning	864	45.7
Ante, Post, Neo-Natal Clinic	624	33.0
Agriculture and Nutrition	246	13.0
No Information	125	6.6
General Awareness Average	962	50.8

On investigating knowledge of health information and behaviour, the study found that the target group is aware of various types of information which relates to health. The high prevalence of knowledge on SSS, home cleanliness, baby care, toilet and sanitation and family planning are partly a reflection of the contact the grassroots have with VCWs and CBDs. This is further evidenced by the fact that 99.3 percent of the target population declare that they have a VCW in their villages. Although a similar percentage also declares that they have an Agritex worker, not so many women are advised on agriculture and nutrition. No wonder apart from poverty ignorance contributes to their poor diet.

Although women are aware of the need for toilets and sanitation, their toilet and sanitation environments are not hygienic (see section on "Hygienic Status of Living Environment", also Graph I in Appendix A and Table II). The study did not seek to know why they do not have toilet facilities.

Knowledge, however, does not necessarily lead to appropriate behaviour. Data on this section already indicates that although almost all women know about, and use, SSS to treat diarrhoea, at least one-third of them do not know the correct measurements.

The restriction of information on ante, post and neo-natal clinics may be attributed to inadequate medical personnel.

Data indicates clearly that considering the high illiteracy semi-literacy rate of 50.7 percent (see section on "Social Characteristics") there is need for a basic literacy intervention. Apart from basic literacy skills, the women also lack awareness of the importance of adequate ventilation (49.2 percent), and ability to read and interpret the baby clinic card (70.1 percent). The intervention that relates to attitudes also relates to behavioural patterns.

Table V shows that by average each surveyed woman makes only two out of the expected six visits to the clinic/hospital for any one pregnancy. Table V also shows that by average 28 percent of all the living 2 826 under-fives in the study area were born at home, and relatively more children live in Wards XII, IV and XX. Data also reveals that by average only 7.7 percent of all children are either not vaccinated at all or partly vaccinated. Most of them are in Wards XX, XII and VIII. Other information indicates that an average of 27.3 percent of all children in the study area do not attend baby clinic regularly. This shows that the women do not regularly attend ante-natal clinic or sent their babies to the clinic. They do try, however, to deliver their babies at medical centres; and they are particular about immunization. The great disparity between ante-natal and baby clinic on attendance on one hand and delivering at the hospital and immunizing the baby on the other may be explained by two factors. First for delivery a woman may be detained in hospital on the day she appears due to deliver her baby; drinkinsecond for immunization the mobile clinic follows the women to strategic points like schools.

One pleasing observation that relates to immunization and baby clinic is that the women do practise what they are advised. For those who do not, when asked to explain their actions, they gave a variety of reasons (see Table V). Below are some extracts:

Ignorance includes reasons like:

- "I was not ill" (health visit)
- "Baby was not ill" (baby clinic)
- "I did not know this"
- "I was not aware it is important"
- "The water is clean"
- "Is it necessary, anyway?"

"Domestic" includes reasons like:

- "I was too busy"
- "There was no one to look after my other small children"

- "It doesn't help me to boil water. When I visit other people's homes, shall I not drink unboiled water?"

Religious reasons are attributed more to the Apostolic Faith and less to traditional beliefs.

Resources-related reasons include:

- "I have no time to do such things, it's a waste of my time"
- "I have no utensils to boil/cover the water"
- "Firewood is a problem. I look for firewood for cooking. Now you want me to look for firewood for boiling drinking water as well"
- "I had no bus fare"
- "I had no money for hospital fees"
- "Those people at hospital, they demand so many things. I have no money to buy baby clothes and toiletry"
- "You know I am poor. I have no nightie, I can't afford good food. I don't like exposing my poverty".

Facility-related reasons include:

- "There is no clinic in my area"
- "The clinic is way out at ... That is too far. Why don't they give us our own clinic nearby ...?"
- "The nurses that day never came"
- "Sometimes the nurses leave too early"
- "They give us wrong dates"

It is important to note that there is a higher frequency of ignorance and domestic-related reasons for not treating water than for other practices.

The survey on health behaviours and their explanations has indicated the Pattern of health behaviour, constraints and attitudes the women have. Excuses like "... too busy, not necessary, ..., visit other people's homes ..." indicate that the women do not think seriously about what contributes to good health. Some of the desirable behaviours are practised irregularly, partly or sometimes only. Such frequency is a sign of ignorance as well as lack of seriousness. They need to know that sending a baby to the clinic irregularly will deny it of an opportunity to have its growth and health monitored. Similarly, part-immunization and treating water only sometimes do not guarantee prevention of disease. Religious attitudes, mostly of the Apostolic Faith, are a constraint to all health behaviours except treating drinking water.

A training programme will be offered to the target group. The aim of the programme is to provide important health information, practical skills and positive attitudes, all of which provide contribute to better health. The content of such a programme includes:

KNOWLEDGE

- factors which contribute to good health
- importance of adequate ventilation

- importance of attending ante, post and neo-natal clinic
- appropriate technology
- risks involved in drinking untreated water
- risks involved in not sending babies to clinic
- agriculture and nutrition
- types of domestic fuel
- conservation.

SKILLS

- Literacy
- interpreting baby clinic card
- preparation of SSS
- activity skills like farm practice, toilet construction, maintenance of water sources.
- making stoves.

ATTITUDES

- religion should not conflict with medical care
- need to practise what is learnt
- need to exploit available facilities
- need to be systematic about health behaviours.

Considering the reasons given for the various health behaviours, it appears there is need for interventions which are not directly related to literacy.

Other Interventions

The study has identified two other non-literacy interventions; they are infrastructural and management interventions. The infrastructural interventions include financial inputs for the construction of toilets and safe water supply outlets. Considering the unhygienic environment and the poverty of the people, these inputs have a contribution to the achievement of project goals. Further inputs of finance and practical skills and project management are required for reviving defunct, and establishing new, IG and cooperative activities.

The management intervention relates to MoH and MCDWA personnel who operate at the grassroots level. Nearly one-quarter (23.1 percent) of the women who do not fully vaccinate and who do not regularly send their children to baby clinic complain that the mobile clinic does not observe time schedules. This could be caused by technical inconveniences, pressure of work or, in this case, mismanagement of time. Another management problem is that health staff immunize women against tetanus toxoid (T/T) without telling them. As a result of this about half of the women are not sure if they had T/T or not; and of those who were certain they had T/T, they could account only for one vaccination. The issues of time schedule and T/T may be an indication of a training need for health personnel.

One other issue which relates to health delivery is the question of traditional birth attendants (TBAs). Out of a total of 886 births/child deliveries that occurred at home, 2.9 percent were assisted by a medical person, 22.0 percent were assisted by TBAs and the remaining 75.1 percent were assisted by laymen. Considering the demand placed on TBAs and the prevalence of laymen assisting in child birth it seems there is need to investigate knowledge practices and the role of TBAs.

CHAPTER IV

COMMUNITY NEEDS AND RESOURCES

Basic Needs

Once the draft report was out, the project was faced with two tasks, namely validating the findings and drawing up a plan of action for Phase II - project implementation. Validation of findings related to apparent community needs identified by the surveyed target. There was need to ascertain whether these needs were real or felt needs and also whether they were priority needs for the community.

Findings of the survey identified community needs such as water for domestic consumption, animal consumption and irrigation, medical facilities, fuel power, labour-saving devices, technology, conservation and occupational resources. Although these need were identified by individuals, they also formed a basis for discussion on community needs. An exercise to validate community needs was therefore carried out at two levels - district and ward. At district level, the intersectoral district team was involved. At ward level councillors, Vidco chairmen and Village Community Workers participated in the exercise.

Priority Community Needs

The district team confirmed that priority and tangible community needs are, in order of priority - water, food, clinics, fuel power, conservation and labour-saving devices. Water is the top priority need for both individuals and communities. People who have no access to a safe water supply get their water from rivers, streams, shallow wells, ponds and dams. Because of intermittent drought, both rivers and wells tend to dry up during the dry season. When this happens people rely on stagnant pools of water on river beds. When even these dry up, the women dig into the river bed. In Ward XII this practice provodes a very common source of water for both human beings and animals.

Water sources and outlets were also found to be very unhygienic environments. In Ward I leaders reported that in Nyamadzawo village there is a shallow well which has been proved by medical authorities to be the source of water-borne diseases. In Ward IV residents of Gomo village compete with cattle to get water from the Musaezi River bed. In Ward VIII there is an open well which was drilled by an NGO to construct a borehole. The borehole was not completed and the open well is now a health hazard. Ward XII has the least access to safe water, and perhaps here more than in the other five wards people rely on streams and stagnant ponds. In Ward XVI residents of Jaka village get water from a dam because the water table is too low for a well. An NGO had tried to drill a borehole, but after drilling 50 m below the ground and finding no water they gave up. Kuriri village in Ward XX gets water from a borehole. At the site of the borehole there is water which is intended for animals. This water has now turned into a breeding place for mosquitoes and flies.

A survey of water sites indicated that safe water is a priority community need. Provision of safe water, however, will not reduce health problems unless the environment of the water source is kept in a hygienic manner.

The problem of water has a bearing on agricultural productivity and the ability of a community to feed itself. Food is therefore a need which is directly linked to water. The need for food is clearly indicated by the drought relief programme in the district. Because of the inadequacy of food relief handouts and the indignity related to handouts people scramble for the food/money-for-work programme. In this programme people provide labour for development projects (bridge, road construction, etc) in exchange for a negligible Z\$2.00 per day.

The other high ranking need is a clinic facility. Other needs are market outlets draught power, agricultural inputs and domestic fuel. Additional needs are knowledge on budgeting and income-generating projects like sewing, knitting, goat rearing and poultry.

Priority Community Resources

These refer to personnel to write literacy materials personnel to train support staff in project management and physical facilities for training. Consultations with district authorities revealed that the district lacks expertise to develop literacy materials. Considering their few personnel they would not be able to provide a team to be trained particularly for course writing. The general opinion is that the exercise of writing literacy materials should be left to the Ministry of Education and the Adult Literacy Organisation of Zimbabwe (ALoz).

The district has, however, a team of trainers. These include two Local Government Promotion Officers (LGPOs), a District Community and Cooperative Development Officer (DCCDO), a nursing sister a health inspector, two district literacy coordinators (DLCs), an Agritex officer, a cultural officer and an education officer (NFE). LGPOs mount courses on training of trainers (T/T), the DCCDO mounts courses on T/T, community mobilization and how to establish cooperatives. The nursing sister and the health inspector organise courses on primary health care (PHC). The DLCs organise courses on functional literacy and Agritex officers organise courses on agricultural extension. These district staff have each a team of field extension workers.

Physical facilities for training are training centres and literacy centres. Both these are available.

After identifying priority community needs and resources a plan of action was prepared. The plan includes two resource/support mechanisms one for writing literacy materials and the other for training of trainers.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This section summarises and concludes the study. Major findings are summarized. This summary relates to vulnerable aspects of the target group, their learning needs and ability of the community to facilitate learning. Based on this summary, conclusions and recommendations are made.

Summary

Data analysis and interpretation shows that 25-34 years is the age group with the highest concentration of mothers who have under-fives. Of the other social characteristics, illiteracy/semi-literacy ranks highest. It is also clear that attendance of adult literacy classes is minimal. The number of women who have no husbands is small. Similarly, the number of women who look after children of absentee mothers is also small. These two characteristics may need to be reassessed in conjunction with priority indicators when forming project groups. In general, 1 652 women (87.3 percent) have vulnerable social characteristics. Wards XVI and XX in the southern part of the district, however, are the worst hit as expected.

Data analysis and interpretation indicate that although two-thirds of the target group live in temporary houses, and about half of them live in poorly ventilated houses, there are attempts to improve housing. These attempts are evidenced by the presence of semi-permanent houses and cemented floors. The status of toilet facilities is undesirable, with at least two-thirds of the target group having no toilet facility at all. The position of water is also undesirable, although there are attempts to overcome the problem. Out of the four vulnerable facilities, i.e. housing, ventilation, toilets and water, toilets are the worst, followed by water and housing in that order. By average, nearly two-third of the target population live in unhygienic environment; and for each ward at least half the target group is affected. The range of distribution between the most affected (Ward XII) and the least affected (Ward VIII) is as high as 22.2 percent. As expected, the southern wards are more affected than the northern wards.

Data analysis and interpretation reveal that the target group is actively involved in various activities to ascertain their survival. They cultivate food and rear animals for meat. Whenever they have a food surplus they preserve it using the cheapest and most readily available local technology. Farming efforts are supplemented by productivity from IGPs and cooperatives. Despite their multifarious efforts their rewards are below average. Although, these women have for the last five years managed to survive at below subsistence level, it has not been possible for all their children to survive. Wards I and IV in the north are more impoverished than the other four wards and Wards IV and VIII are less enterprising in IGPs and cooperatives, probably because they are near Chibi, Madamombe Business Centre and they can earn occasional wages.

The study reveals that there is need for a health literacy intervention for those things which the women do not know. In general, only half of them have access to important health information.

It appears that despite acquisition of health information the women act contrary to that information. The reasons given for behaving thus range from ignorance to lack of resources and facilities. This problem may, therefore, be partly solved by training. The training will impart appropriate knowledge, practical skills and positive attitudes. Apart from literacy, other interventions include financial, infrastructural inputs and strengthening of the health delivery systems.

The study observes that water is the top priority need for the community. Other needs/activities for which the community needs to be mobilized are construction of wells, ventilated houses, Blair toilets and participation in literacy. Data indicates that the district lacks expertise to write learning materials, but they do have a core of trainers to implement the training programme.

Conclusions

Based on our findings from the field, the study concludes that although all the six wards have vulnerable communities, women in Wards IV, XII, XX and XVI are more vulnerable than those in Wards I and VIII. It also appears that knowledge is not the only intervention required to improve the health status of the people - there is a strong need for skills, change of attitudes towards health practices and a safe water supply. Considering the fact that the district has some health/literacy literature and a training team, the study concludes that with support from course writers and resource personnel, the district is resourceful enough to facilitate the health literacy intervention.

Recommendations

The study recommends that:

- The project be offered to the most vulnerable communities in all the wards, but relatively more people should be mobilized from Wards IV and XII;
- Writing of literacy materials be done by a team composed of writers from the Ministry of Education and ALOZ;
- An infrastructural project for safe water be introduced as a project within the project;
- The toilet construction programme be revived.