Kacholola Case Study

My name is Zaliwe and I was based in a rural community called Kacholola with a team of three other volunteers. The four of us were based at the Community Youth Concern Centre (CYC) in Nyimba. Two times a week, normally on a Monday and Tuesday we visited our outreach community Kacholola. Here we worked in the Kacholola Rural Health Centre, Kacholola Boarding School and briefly Mombe primary school. Towards the end of the programme we also began to do outreach work in the surrounding villages. Moreover in the last remaining weeks we are attempting to set up links with three churches; United Church of Zambia, Seventh day Adventist and Jehovah Witness.

At the rural health centre every member of the team got really stuck in to the day to day running of the centre. As the place is quite understaffed, this is made more severe when staff had to run errands such as delivering reports and picking up medicine, we generally helped to lessen the work load. Some members of our team worked in the antenatal area of the women's ward- this involved weighing patients, measuring their height and recording their BP as well as HB count. Newly admitted pregnant women are required to attend with the baby's father. This sometimes caused difficulty and meant patients were turned away as they did not come with the male. We found this disagreeable as it discriminates against females who need medical attention for themselves and their baby. First time attendees to antenatal classes must provide a detailed record of their medical and pregnancy history. For this task it is crucial a Nyanja speaker is present. Due to the rural setting of Kacholola, many people who attended the clinic did not speak a lot of English or any English at all and therefore it was next to impossible for the UK volunteers to communicate with the patients.

In general our training was very basic. We were encouraged to 'learn on the job' and teach each other. This was fine for the malaria testing as it is straight forward and once you had done it once you can do it forever. However it is not safe to 'learn on the job' when distributing medicine to patients. In this area of the health centre we could had been given more thorough training regarding the names and doses of medication. For example the doctor often prescribed in patient's books the name of the drug but on the packaging the brand name was present- which is very confusing for someone who is not properly trained in pharmaceuticals. Moreover the

doctor made no effort to clarify his handwriting, even after we asked him to do so many times, which further complicated our work. Memory, who is trained in HIV counseling, often conducted herself in that part of the health centre. She was complimented on her work here as she dealt with the patients sensitively but effectively. This placement was particularly useful for her as it allowed her to develop her skills.

As a team we were also granted access to the maternity ward. Here our team saw things that really touched us emotionally. One mother gave birth to twins, tragically one was alive and one was a still birth. They laid the twins next to each other which we were told was customary. It was an honor to be allowed access into such a personal and private part of someone's life and from it we gained memories and experiences that will stay with us a life time. The child had died as a result of emergency health care not arriving to the centre on time. This gave us a firsthand experience of the trauma that lack of access to good health care services causes to individuals, families and communities.

We also created an Anti-Aids club at Kachololа Boarding School. This was very successful as over the seven weeks that we worked with the school we saw a consistent turnout of 65 members. The children aged 13-16 received the programmes and its topics positively. The deputy head of the school gave us feedback stating 'the programme I hear from our students is going very well. Their only complaints are they wish the sessions could go on all night and the grade 12s are annoyed they're missing out and wish you'd come sooner.' We tried to conduct informal sessions so the students felt confident and comfortable to discuss and disclose private and personal information to us. This we felt made the club more effective as the students came to feel 'no question is a stupid question'. Any questions students were to afraid to ask in public they could put in our question and answer box- left with the club's secretary. We would then answer the questions at a later date. As a result we achieved destroying myths and rumors that spread around the school and amongst peer groups and replacing them with fact and important information regarding their sexual reproductive health that will help them through growing up.

The 65 students who regularly attended the club are also now equipped to pass on the information to their friends. We are confident of this as in our final evaluation session the students collectively recapped almost everything we'd covered in our previous sessions. Moreover we tried to build on their confidence, leadership and oratorical skills. This was achieved through group activities that made them act and

present in front of their peers. We also created a club committee to run the club to ensure the club's continuation after we left. Furthermore this demonstrated to the students that they can be leaders and organise events such debates and talent show competitions and mobilize their friends.

There were some challenges we faced with this school. They struggled to allocate us a set place each week to conduct our sessions and did not had resources such as pens and paper readily available before we came, which is something we had prior agreed. Also our liaison, a teacher at the school, dominated our sessions with his own opinions and beliefs. This made sessions run over in time and disrupted the programme. It also caused the students some confusion as his opinion conflicted with the facts and information we had been told to facilitate by a professional nurse. On the other hand the school staff showed they really cared about us and the programme we were running. This was evident by the assembly the head teacher held to introduce us to all pupils and allowed us to promote our new club. Secondly they shifted their extra-curricular programmes to ensure ours had consistency of day and time. They seemed keen to run the talent show and use part of their social activity budget to fund this. Hopefully this will be something that goes ahead in the next academic year with the future VSO ICS volunteers who work at Kacholola. Culturally for one UK volunteer they realised the importance of religion and the teachings of the bible in how people in Zambia make their life choices. For example it was discussed how anal sex is against the teachings of the bible, as is sex before marriage. Culturally these things are therefore largely frowned upon. For the UK volunteer, this was very different as in her culture these things are accepted. Also disagreements over the meaning of virginity and topic of masturbation arose. As a team we portrayed a united front in front of the students as to not confuse them and make the rest of our information seem incorrect. The UK volunteer followed the customs of the Zambian volunteers as she felt they could deal with topics more correctly in accordance with the Zambian beliefs and culture. However for the other UK volunteer being both Zambian and Christian the fact that biblical principles are followed throughout was refreshing. It was easy to conduct the sessions with knowledge that things like abstinence and no sex before marriage were taught to students throughout the school curriculum.

Community Youth Concern (CYC) was a good base as they provided us with invaluable resources when we needed them, for example printing, computers for us to do our work on and Kamulaza provided us with internet access for us conduct research for our sessions.

Mombe primary school was a challenge as it took a long time to get any sessions done. In our initial meeting with the Headmistress, she seemed really keen for us to run sessions with two groups of students; Grades 1-4 and Grades 5-7. However, when we attended went to deliver our first session the school was vacant and we then had to try and locate the headmistress to find out what was going on. The headmistress was nowhere to be found but we were told by other staff to return the next day at 10:00

hours which we were unable to do as there was no more money left for transport. This had the team feeling agitated as this was a wasted journey financially and it meant that we were behind in our sessions. We felt that if the headmistress or someone from the school could had informed us that there wouldn't be anyone there to attend the session ahead of time as they had our contact details. The following week we were faced with the burial of the late president and could not rearrange the time or day with the Headmistress as we could not get through to her on the phone. In the end we decided it was best to visit the primary school in person after leaving the clinic and converse with her in person as trying to reach her on the phone was not fruitful.

We delivered one session with Mombe Primary School which was really good and had 400 students in attendance. It is a shame that it took so long to get started but we had left the school with a letter informing them that another group of volunteers will be coming in the hope that the next group of volunteers attached to Mombe Primary School will be able to pick up where we left off without any difficulty.

In our last week we mobilised a community and were able to deliver a session on cervical cancer, HIV/AIDS, Teenage Pregnancies and STIs. The community was really keen for more sessions to be delivered and look forward to having the next group of volunteers visit them to cover more topics.


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