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**UNIVERSITY OF GHANA**

**A STUDY OF THE WHO/GHANA GOVERNMENT HEALTH  
EDUCATION PROGRAMME FOR ENHANCING THE HEALTH  
STATUS OF WOMEN IN THE DANGME EAST DISTRICT**

**BY  
ALICE POKUA GYENING**

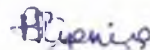


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## DECLARATION

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**ALICE POKUA GYENING**



**MRS. ADOO-ADEKU  
(SUPERVISOR)**



**DR. ODURO-MENSAH  
(SUPERVISOR)**

**DEDICATION**

**To all the disadvantaged  
and  
vulnerable women in Ghana**



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## ABSTRACT

This is a survey study on the contributory role of health education for enhancing the health status of vulnerable groups particularly women. It is a study based on the WHO/Ghana Government Functional Literacy Project for Women in the Dangme East District which is aimed at improving the health status of women through a triad approach of functional literacy, health education and income generating activities.

Specifically, the study set out to i) identify the health educational activities being provided in the field ii) identify the health issues covered iii) find out the kind of educational methods and techniques used and iv) find out if there had been improvements in the health of women through their participation in the programme.

A sample of 60 respondents were selected through a purposive sampling technique from four communities making up the project areas, that is, Akplabanya, Anyaman, Goi and Lolonya. In addition 10 respondents comprising staff of the project formed a separate sample of the study. The interview schedule and self administered questionnaires were the main instruments employed to collect data from respondents.

The major findings of the study indicated that:

- The health educational activities designed to attain programme objectives were mainly: i) educating women to send their children for regular weighing and immunisation through health talks ii) mobilising women to participate in environmental cleanliness and to practice personal hygiene iii) demonstrations on how to prepare weanimix/educating women on nutrition among others.
- Health issues majority of the women were educated on were: family planning; nutrition; immunisation; pre-natal care, maternal care, causes and treatment of diseases, personal and environmental hygiene and teenage pregnancy.
- The majority of the women had derived important health benefits through their participation in the programme. These

included: i) a greater awareness of environmental and personal hygiene issues ii) a better knowledge of the causes and treatment of diseases and iii) improved nutritional diet.

In spite of the health benefits to women, majority of them indicated that they would want much greater improvements in the following health issues: i) immunisation ii) family planning and iii) environmental sanitation.

Logistic support for the programme was found to be inadequate. Other institutional difficulties also threatened the smooth implementation of the programme.

The study concludes that the programme must intensify its activities especially in the area of family planning, immunisation and environmental sanitation. It also recommended among others the adoption of indirect and more innovative methods by personnel in delivering health messages and the adequate supply of logistic to support programme activities.

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## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.0 Background to the Study**

Globally, an increased awareness of the health concerns of women has been documented by social researchers, policy makers and educators.

This concern has arisen out of recognition of several factors. These factors include a realisation of the importance of women as producers of a nation's wealth as reflected in the vital role they play in development and the debilitating effects which poor health has on them. Some of these health problems include complications in childbirth and fertility related problems, which are more prevalent among women in developing countries.

In Africa, women die much more frequently from the complications of pregnancy and childbirth than women in Europe and North America (Arkutu, 1995). This is supported by a World Bank publication (World Bank, 1994) which indicates that maternal mortality rates in Africa are higher than anywhere else in the world. For sub-Saharan Africa the maternal mortality rate according to a United Nations World Survey on Women (1995) is estimated at 700 per 100,000 live births. The World Health Organization (WHO) also estimates that one out of every 22 women in Africa dies from pregnancy related complications. Nearly all of these maternal deaths and pregnancy related complications are preventable.

There is also a further concern for improvement in the health of women because of the important role they play as health care providers in the family. As primary health care providers they customarily do most of the caring in their families. Their state of health and involvement in health care are thus essential keys to health for everyone. Hence, if a woman is knowledgeable on health matters she will be able to use this knowledge to contribute to the welfare of her family.

However, if that woman is ignorant, overworked and malnourished, the health of her family as well as her own health will suffer. In Africa and for that matter in Ghana, majority of rural women are ignorant about health issues, remain overworked and malnourished. This situation has been attributed in part to the high level of illiteracy among women on the continent (United Nations, 1995). Illiteracy thus, is said to impinge on the healthy development of women. Hence, this study looks at the extent to which a collaborative functional literacy and health education programme between the WHO and the Ghana government has contributed to improving the health status of women in the Dangme East District.

In Ghana, illiteracy continues to be a major problem. The health of women, especially that of rural women, is seriously affected. A majority of Ghanaian women who live in the rural areas are illiterate ( 1984 Census Report ) and are not well equipped to perform their important role as health care providers. Available statistical information which is based on the 1984 population census indicated that women accounted for 51.4 percent of Ghana's total population of 12.2 million with 70

percent of women living in rural communities. With an increased population of about 18 million for 1996 (projected population figure Demographic Projection Model) women still constitute a greater proportion of the population and a higher percentage of illiterates. For instance, in 1990, when the illiterate population aged 15+ was estimated at 40 percent, the percentage illiterate for females was 49 percent while the corresponding figure for males was 30 percent (ECA 1990/91). Similarly the adult literacy rate in 1990 showed a higher percentage for males at 71 as compared to 46 for females (UNICEF 1996).

The problem of illiteracy among many Ghanaian women contributes to their low health status and also that of their children. The results of the Demographic Health Survey of 1993, for instance, showed the infant mortality rate for the period 1974-1978 to be 82 deaths per 1000 live births. This, later declined to 66 deaths per 1000 live births for the period 1989-1993 (Ghana Demographic Health Survey, 1993).

Also, child mortality rate for the same period was 81 deaths per 1000 survivors at age one for 1974-1978 but later, improved to 57 deaths per 1000 survivors at age one for 1989-1993. The maternal mortality during 1981-1985 in Korle-Bu Teaching Hospital in Accra averaged 8 per thousand births with haemorrhage and eclamptic convulsions from toxemia during labour and delivery accounting for approximately 40 percent of maternal deaths (Ampofo, 1985). Presently, the maternal mortality rate is much lower.

Despite these declines in infant, child and maternal mortality rates, much needs to be done to reduce the rates to standards comparable with countries of the more developed world.

The health status of women is further worsened by their low socio-economic status and conditions of poverty. Poverty coupled with high illiteracy contributes to making women vulnerable to disease, malnutrition and infections from poor environmental sanitation. Many lack knowledge of the causes and treatment of diseases and modes of infection. The health of their children suffer through inappropriate feeding practices and inadequate care, sometimes resulting in stunted growth and death. A study based on the Ghana living standards survey, for example, shows that generally there is a reduction in the level of stunting with rising expenditure levels and decreasing poverty status. Children in poor households were more likely to be stunted than those in non-poor households (GLSS, 1988 1992).

The poor conditions of women are reflected also in their inability to provide themselves with adequate food, clothing and health care. Jacobson (1995) noted that poor people, in this instance women, have less income to spend on nutritious food, clean water and adequate clothing and shelter. Engaged in a daily struggle to meet basic needs they often cannot avail themselves of preventive health care, or save for the exigencies of unexpected illness. Furthermore they have less access to social tools such as education needed to improve and safeguard health. The situation is particularly grave in view of the fact that women are not only more likely to be poor but also spend a larger proportion of their lives in poverty and deprivation.

Improving rural incomes and making women have easy access to educational opportunities are imperative because women's health is affected by the absence of these factors. Results of a WHO study in 15 countries and data from the world fertility survey indicate that there is an important relationship between parental education, particularly of mothers, and child survival. These sources also indicate that educating the father alone does not have a significant positive impact on the infant and child survival when the mother is illiterate. A few years of schooling for a mother gives her the confidence and capacity for self care and the care of her children and household, the capacity to use health services and to apply any health information in a positive way (Gyekye, 1988).

Improvement in the health of women also enables them to participate more fully in programmes that could help them, their families and the development of their communities. It is on the basis of these findings that the WHO/Ghana Government Functional Literacy and Health Education Project for women was established in the Dangme East District.

### **1.1 The WHO/Ghana Functional Literacy Project**

This is an integrated project involving all sector ministries in Ghana especially, the Ministries of Health, Education and Agriculture. The Department of Community Development under the Ministry of Local Government is the implementing agency. The intersectoral and integrated nature of the project is a result of a resolution reached at the 39th World Health Assembly calling on governments to improve the health

status of vulnerable groups through appropriate intersectoral interventions and WHO's call on countries to develop more integrated health policies and programmes.

The project was introduced in Ghana in 1987 as a pilot study in two districts of the country, the Dangme East District in the Greater Accra Region and the Ho District in the Volta region. In the Ho District the Hodzo cluster of 18 farming villages were targeted, and in the Dangme East District four fishing villages namely: Akplabanya, Anyaman, Goi and Lolonyan were the target. The core elements of the project are functional literacy, health promotion and income generating activities.

Site selection and participation of women in the project were based on a mutually acceptable criteria of vulnerability. This, in particular, applied to the inclusion of women in the literacy programme. Based on data collected from a baseline survey (Gyekye, 1988) the following criteria were set:

1. Women in the reproductive age group of 15 to 49 years and having one child below 5 years and who in addition, satisfied more than three out of the conditions below:
  - i. women who are unable to read and write,
  - ii. women with low income (ie based on nationally accepted level of low income),
  - iii. young unmarried mothers without any employable skills,
  - iv. women living in poor environment,
  - v. women who might have lost one child through any preventable diseases.

Though participation in the project (particularly the literacy programme) depended on the satisfaction of at least two or more

of the above, for practical reasons, some women who could not satisfy the criteria were accepted into the project. These included among others, women above fifty years who had keen interest to participate in the project's activities. It is important to make mention of the fact that project activities on health unlike the literacy programme covered all women in the four fishing communities. Also, though men were not considered a vulnerable group they were not totally excluded from the project but were involved and participated in various community activities under the project.

The aim of the project was to improve the health status of vulnerable groups, particularly women and children by imparting better understanding of the major causes and treatment of key health problems in the community and improving in a positive way the health practices, attitudes and behaviours of women.

Based on the above aim, the activities of the project were implemented within the framework of WHO global plan of action aimed at achieving the following development objectives:

1. to improve the health status of the vulnerable groups through appropriate intersectoral interventions.
2. to promote the use of the health status of vulnerable groups as a benchmark of national development.

#### **1.1.1 HEALTH PROMOTION**

The health promotion aspect of the project is being implemented against the background of the observed health problems, the needs of the women and factors characteristic of any other poor rural setting such as little or no amenities, lack of social services,

high level of illiteracy, especially among the women, ignorance on basic health issues and apathy.

Documented reports on field visits conducted in the two districts before 1987 when the programme started revealed the following. First, in some of the rural communities maternal and child care services were poor as most deliveries were performed by untrained traditional birth attendants (TBAs). For example, as some TBAs cut the umbilical cords with new razor blades, others cut it with scissors or any sharp object and then applied powder exposing the baby to infection.

Secondly, weaning practices involved mainly the preparation of a carbohydrate diet (mainly a corn porridge) as dictated by culture and probably, ignorance on the nutritional value of corn and other staple food items grown by the communities such as black eyed beans suitable for weaning purposes.

Next, it was observed in Akplabanya that fish was rarely an important ingredient in the diet of children as most of the fish caught were sold for cash income. The children therefore suffered from malnutrition resulting from inappropriate feeding practices. Inhabitants in the rural communities were also dependent on streams as the main source of drinking water. This was found to be contaminated through poor sanitation resulting from the absence of facilities for refuse and human waste disposal leading to the rise in diarrhoea cases.

Also observed was the general lack of knowledge about the causes and treatments of ailments like typhoid, guinea worm, convulsions and diarrhoea diseases. Convulsions for example were not believed to be associated with malaria. Enemas were also

used as a form of treatment for diarrhoea in the belief that these would wash out noxious substances from the gut and thus bring the diarrhoea under control. The causes of measles were not known by most of the women in spite of nation-wide immunization campaign since March 1987. There were the beliefs that the causes of measles were related to hot weather conditions and sometimes to supernatural causes.

Finally, family planning awareness and practice was found to be low. Most women sought family planning services after they had given birth to about six or eight children. This was however attributed to the fact that the National Family Planning Programme had not as yet reached most of the rural communities at the time.

In promoting the health status of women one approach the project adopted was health education. This is in line with WHO global plan of action. Education features prominently in the Declaration of Alma-Ata. The Global Strategy for attaining "health for all" as well as WHO's Seventh General Programme of Work constantly refer to educational activities as the means par excellence for encouraging the involvement of people from all walks of life and for making them true artisans of health and development (Standard & Kaplun, 1983). The positive impact of education in improving health cannot be doubted from the available statistical findings and data from research. It has also been realised that health science and technology can do little to improve the health standards of a people or make any real impact on their lives without the people themselves becoming full partners in safeguarding and promoting health.

## 1.2 Statement of the Problem

Health education involves the participation of people. It focuses on people's way of life and behaviours so as to promote the type of behaviour that is conducive to good health. Thus, women in the study area were to be helped to understand their behaviour, how it affected their health and to empower them on a healthier way of living. The question is, what kind of educational activities are actually being provided in the field and to what extent are the women benefitting from such activities?

The aim of this study therefore is to identify the health education programme being provided in the field and to find out how it has contributed to bringing about improvements in the health status of women.

## 1.3 The objectives of the study

The following are the objectives of the study:

1. To find out the socio-economic background characteristics of the participants.
2. To identify the health educational activities and issues covered by the health education programme.
3. To identify the methods and techniques used in the health education programme.
4. To find out if there have been improvements in the health status of the beneficiaries.

#### **1.4 Related research questions**

1. What health education activities are being provided to participants?
2. What health issues are covered?
3. What kind of methods and techniques are being used?
4. Which kinds of personnel are involved in delivering health messages?
5. What benefits have the women derived from the programme?
6. Have there been improvement in the health of participants?

#### **1.5 Significance of the study**

The study will throw light on the health component of the project and on the kind of educational activities provided to the women to promote their health status. It is hoped that the study will come out with results that may be found useful in strengthening the programme as well as improving the performance of future programmes.

The strengthening of this WHO Project is significant because, the project is a pilot one intended to be replicated in other third world countries as well as in other rural communities in countries which have benefitted from the pilot scheme.

#### **1.6 Limitations of the study**

Frequent emigration of the population, especially the youth to neighbouring towns and coastal villages is a characteristic feature of the communities in the study area. As a result, a purposive sampling technique, where the cases were hand picked with due consideration to other important factors was adopted for

the study. In view of this, the findings reported are solely restricted to the study area and cannot be generalised to similar groups in the country.

### **1.7 Operational definition of terms**

The key terms used in this study are defined as listed below.

#### **1. Health education:**

- (a) Instructions given on health matters such as causes and prevention of illness, and
- (b) Education that is concerned with promoting healthy behaviour.

#### **2. Health status:**

This refers to the condition of a person's body or mind in relation to others.

### **1.8 Organisation of the study**

The study is divided into six (6) chapters. Chapter one provides the introduction which covers the background to the study, the statement of the problem, objectives and significance of the study. It also gives the limitations of the study, operational definitions and a background to the study area.

The second chapter gives a review of related literature. Chapter three provides the methodology which covers a description of the research design, the target population, the method of sampling and the tools used in data collection. It also identifies the sources of data used. Chapter four presents an

analysis of the data gathered from the field survey. Chapter five provides a discussion of the results and chapter six gives the summary of the results, conclusions and recommendations.

## **1.9 Background of the study area**

In this section a brief profile of the Dangme East District and study area is given. This covers the physical background, traditional authority, human resources, education and social services (i.e. health, water supply and Environmental conditions).

### **1.9.1 Physical background**

#### **1.9.1.1 Location**

The Dangme East District is located in the eastern part of the Greater Accra Region within latitudes 5°45' South and 6°00' North; and from longitude 0°20' West to 0°35' East. It shares common boundaries with Adidome District at the north, Sogakope District and Dangme West District at the east and west respectively. At the south is the Gulf of Guinea which stretches over 45 kilometres (27.9 miles). The District covers a total area of about 909 sq. km. (350 sq. miles), about 28% of the total area of the Greater Accra Region.

Ada-Foah, the District capital is located at the south-eastern part, about 20km off the Accra-Aflao road, along the coast and about 2km from the Volta River estuary. The four fishing villages are located in the Dangme East District which forms part of what is often referred to as the Ada Traditional Area. Other major settlements are Big Ada, Kasseh, Wokunagbe and

Koluedor.

#### **1.9.1.2 Climate**

The District forms part of the south-eastern coastal plains of Ghana which is one of the hottest parts of the country. Temperatures are high throughout the year and range between 23°C-28°C. A maximum of 33°C is attainable during the hot season. Rainfall is heavy during the major season between March and September. The average rainfall is about 750 mm. The area is very dry during the harmattan season when there is no rainfall at all. Humidity is very high, about 60%, due to the proximity of the sea, the Volta River and other water bodies.

#### **1.9.1.3 Topography**

The District is generally gentle and undulating. A few prominent boulders are scattered irregularly over the area, with the highest part being about 240 metres (800ft.) above sea level. The rest of the area is about 60 metres (200 ft.) above sea level.

#### **1.9.1.4 Vegetation**

The vegetation is basically coastal savannah, characterized by short savannah grass interspersed with shrubs and short trees. Along the coast stretches of coconut trees and patches of coconut groves could be seen. A few stands of the mangrove trees can also be found around the Songor Lagoon and the tributaries of the Volta. The northern part of the District has a forest type of vegetation with the major trees being the neem tree. The

savannah provides extensive land for grazing livestock.

#### **1.9.1.5 Soils**

The soils vary from heavy intractable clays to fertile sandy loams, with considerable saline intrusions in the lower lying third of the district which embraces large saline lagoons and estuaries.

There is little spare agricultural land, and the land present is such that about 47 percent of the arable land is cultivated. This leaves little opportunity for restorative fallow, and the overall crop yields are correspondingly low. Cassava is the dominant staple in the area.

#### **1.9.1.6 Traditional Authority**

The people of the area are Dangmes, believed to have migrated from Nigeria. The other Dangme speaking groups are Ningo, Shai, Krobo and Osudoku. They have variously settled at Akrade, Lorlorvor and Okorhuem from where they have spread out to form the respective settlements. The District has one paramountcy, with divisional chiefs, who owe allegiance to the paramount chief, made up of the following clans; who are believed to be the first settlers:

Abibiawe

Lomobiawe

Tekpebiawe

Dangmebiawe

These clans are intersettled by other clans like Kabiawe-Tsu, Kabiawe-Yumu, Kabiawe Kpono, Kudzragbo, Koebo and Ohuwe.

The paramountcy celebrates an annual festival Asafo-Tu Fiam in August.

The chiefs and elders are the custodians of the stool and family lands which they hold in trust for the community. The chiefs and elders:

- mobilize people for development in communities and release land for development projects;
- undertake arbitration;
- collaborate with District Assemblies.

#### 1.9.1.7 Human resources

The population of the District rose from 43,844 in 1960 to 52,164 in 1970 and 71,550 in 1984 (1960, 1970, 1984 population censuses of Ghana). Demographic survey carried out in 1994 put the population at 92,126. In 1995 it was estimated at 92,180 suggesting natural increase in population growth.

The inhabitants of the four fishing villages are Adangbes with few Ewes. The total population for the four villages declined from 7,139 in 1960 to 5,757 in 1970 and rose to 11,142 in 1984. In 1988 when the baseline survey was being carried out the population had considerably decreased to 5,822. This population pattern was indicative of frequent emigration of the people especially the men seeking employment. Most of the fishermen move from one place to another along the coast depending upon where they could get fish. This is a characteristic feature of the people in the four fishing communities.

The structure of the population of the District shows that 39.6 percent of the population is under 15 years of age. 3.07 percent is over 60 years of age and 57.36 percent is in the active age group (15 – 59 years) (Demographic Survey, 1994). The main characteristics of the four communities according to baseline survey data indicated that the age distribution was skewed towards the youth. More than 45 percent were less than 15 years.

#### **1.9.1.8 Economic characteristics**

The inhabitants are actively engaged in agricultural and economic activities with an estimated 12.8 percent of the active labour force employed in the manufacturing industry (1984 population census). Employment activities also centre around the production, processing and marketing of fish. Income generating activities involving women also include mat weaving, salt winning, gari processing and kenkey production. These activities provide a secondary source of income for some women especially during the dry season.

#### **1.9.1.9 Education**

Basic education is one major responsibility of the District Assembly. Statistical data revealed that there are 63 primary schools, and 29 Junior Secondary Schools with total enrolment of 11,426 and 3,383 pupils respectively (see table A1).

Table A1: State of Basic Education in Dangme East District

Type	No. of Schools	Enrolment	Male	Female	Teacher
Pre-School	12	1,249	602	647	42
Primary	63	11,426	6,325	5,101	364
JSS	29	3,383	2,037	1,346	197

Source: Ghana Education Service, Ada Foah, 1995

The pupil/teacher ratio ranges from 31 in the primary school to 17 in the Junior Secondary School. The average school enrolment from the above data was 181 in the primary and 117 in the JSS while the male/female ratio ranged from 1:2:1 in the primary school to 1:5:1 in the JSS. Each of the four communities covered by the study has one primary school. However only three of the communities, that is, Goi, Akplabanya and Anyaman have Junior Secondary Schools in addition to primary schools. Pupils from Lolonya, which does not have a Junior Secondary School have to come to Goi to attend JSS after completing their primary school.

The state of educational infrastructure in the District is about average. Some of the school buildings are dilapidated and are in need of rehabilitation. Problems facing the educational sector in the District are low enrolment, poor quality educational infrastructure and lack of equipment.

#### **1.9.1.10 Social services**

The health service delivery in Ghana is organised on hierarchical basis of hospitals, health centres/post and clinics. There are also traditional birth attendants and herbalists. However as the case is, for most developing countries, the health delivery system outside the urban and metropolitan areas is inadequate and lacks the capacity to cater for the health needs of the population.

This is the situation the district finds itself. The existing health facilities that are currently serving the health needs of the people are one health centre, two health posts and one clinic at Anyaman. The health centre is situated in Ada-Foah while the two health posts are located in Kasse and Sege. There are also seven trained Traditional Birth Attendants (TBAs). The existing health delivery is saddled with the following problems.

- i. Lack of laboratory service for effective diagnosis of diseases
- ii. Poor state of recovery ward
- iii. Lack of potable water
- iv. Inadequate residential accommodation for nurses
- v. Inadequate buildings and
- vi. Lack of drug storage facilities, and sterilisers.

#### **1.9.1.11 Prevalence of diseases**

Malaria and diarrhoea are the two commonest diseases in the District, the two accounting for about 60 percent of the diseases (Table A2). A number of factors account for this situation.

These include:

- i. the swampy nature of some parts of the District, the nearness to the Volta River and the lack of drains which account for the prevalence of the mosquitoes that cause malaria.
- ii. the lack of potable water and the reliance on wells, the Volta River and dug-outs for drinking water and
- iii. the indiscriminate defecation and the resultant pollution of underground water.

#### **1.9.1.12 Environmental conditions**

The physical environmental conditions is a major determinant of health of a population. The existing environmental conditions in the District are far from satisfactory as refuse disposal is indiscriminate in the settlements and major settlements lack refuse disposal sites. Erosion has also taken its toll on the houses. As a result of these conditions, the main health problems in the District include limited access of the population to health services and poor environmental conditions.

The poor environmental conditions is compounded by the inadequate supply of potable water in the District. About 70 percent of the population have no access to potable water. The remaining 30 percent which include Ada-Foah, Ocanseykope, Hwakpo, and Goi get their water from wells some of which are not properly sunk or in unhygienic condition.

The deplorable water situation in the District promote water-borne diseases such as guinea worm, bilharzia, river blindness and worm infection. The situation is severe during the

dry season when most of the people engage in salt winning. Consequently, this situation has a negative effect on productivity.

Table A2 Most Common Diseases in Dangme East District

Diseases	No. of Cases	Percentage
Malaria	6,498	50.0
Diarrhoea	1,320	10.2
U.R.T.I	981	7.6
Skin Diseases	649	5.0
Injuries from Accidents	404	3.1
Measles	219	1.7
Others	2,923	22.52

Source: Dangme East District Profile, 1994.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.0 Introduction**

In this chapter, a review of literature relating to the problem under study is presented. The areas covered include the following:

- i. Women's health from a global perspective
- ii. Women's health in Africa
- iii. Women's health in Ghana
- iv. Health education
- v. Benefits of health education

#### **2.1 Women's Health: A Global View**

Women's health is generally about the health needs of women and includes a knowledge of, and removal of the factors that contribute to the creation of these needs. In broad terms it may be defined as

devoted to facilitating the preservation of wellness and prevention of illness in women, and includes screening, diagnosing and managing conditions which are unique to women, are more common in women, are more serious in women, have manifestations, risk factors or interventions which are different for women. It also recognises multi-disciplinary team approaches, includes the values and knowledge of women and their own experiences of health and illness, recognises the diversity of women's health needs over their life span, and how these needs reflect

differences in race, class, ethnicity, culture, sexual orientation and levels of education and access to medical care, includes the empowerment of women, as for all patients, to be informed participants in their own health care" (Sheriff and Levisen, 1996 with reference to the national Academy on Women's health Medical Education, Philadelphia).

This definition is an expanded and all embracing one that departs widely from the narrow conceptualisation of women's health as it has come to be associated with over the past few decades, that is, reproductive health. It agrees with the current thinking by several authors (1990; Kane 1994; Koblinsky et al 1993 and Van der Kwaak, 1991) who see women's health as going beyond viewing it only as reproductive health.

The definition also emphasizes prevention and wellness in contrast to other definitions of women's health which emphasize the absence of disease. It also considers the total well being of women, which is not determined solely by biological - factors but the many social aspects of women's lives that may impact on their health.

In looking at the overall health situation of women, one approach is to look at their health status, by comparing particular aspects of their health with that of men and secondly by comparing the different health situations of different groups of women, for example, women of different social classes or nations (Kane, 1994). By looking at the first approach, Kane, (1994) identifies certain basic differences in health between men and women. In the first place more girls than boys are born. Secondly, in their teens and early twenties, women have less

illness and death from accidents and violence than men, but suffer more from things like Anorexia, as well as having problems with menstruation and pregnancy.

Thirdly adult women have different patterns of mental illness. They also have child bearing, contraceptive, and reproductive problems. As they get older, women die from a different group of diseases from men. Finally, women live longer, and are more likely to spend their last years alone with the disabilities of old age. Although this is not an indepth comparison of the particular aspects of men and women's health it points out two important observations. First of all, women suffer from certain illnesses which are uniquely different from illnesses suffered by men, and secondly, women have a longer life expectancy than men. It is these differences that lie at the crux of women's health problems and puts their health at a disadvantaged state to that of men.

World wide it has been observed that women generally live longer than men. Findings from a United Nations World Survey on women (1995) reveals that female life expectancy in the developed regions and in Central Asia, exceeds that of males by 6 to 8 years with smaller differences noted for most developing regions.

Higher life expectations notwithstanding, for most women, especially in the developing world, it is a poor quality of life filled with social, economic hardships and poor health as compared to men. Every year millions of women die from these uniquely different diseases which are nearly all preventable and suffer unduly from certain lifestyles and health related problems. Some of the major health problems of women include maternal reproductive health, anaemia and infections.

### **2.1.1 Maternal Reproductive Health**

One of the main problems associated with women's health has to do with their reproductive health system. In some developing countries it is the major cause of death. Globally between 150 and 200 million women become pregnant yearly. Out of this number it is estimated that half a million of women, 500,00 die from complications of pregnancy and child birth each year, while millions more are damaged for life ( Safe Motherhood, 1994). Ninety-nine percent of these deaths take place in the developing world; 89 percent in Africa and South Asia alone (Koblinsky et al, 1993). The major causes of maternal deaths include haemorrhage, obstructed labour, infection, hypertension, disorders of pregnancy and septic abortion. In addition, millions of women suffer morbidities and long term disabilities resulting from pregnancy and childbirth that damages them for life. According to Koblinsky et al(1993), sixty-two million women suffer maternal problems annually.

### **2.1.2 Anaemia**

The consideration of anaemia is very important. It causes weakness, fatigue and leads to lower work output. In some developing countries where the workload of women is unduly heavy, the effects of anaemia interfere with a woman's economic advancement, her family and the entire society. This is more so where health care centres are distantly situated and not within reach for her to take advantage of its services. Available statistics indicate that 350 million women world wide, including 75 percent of women in sub-Saharan Africa suffer from anaemia. In Asia, the problem is also acute. According to (UNICEF, 1993),

70 percent of Indian women of child bearing age are anaemic. Severe anaemia contributes significantly to maternal mortality and is also the main cause of low birth weight in 22 million babies born every year. Improper diet, and laborious activities underlie the main causes of anaemia in women.

### **2.1.3 Infections**

The infections that occur in women include a broad range. A few of these are sexually transmitted diseases (STDs) like, syphilis, gonorrhoea and Human Immuno Deficiency Virus (HIV), and infections acquired through unsafe abortions and deliveries (Mcdermott et al, 1993).

Reproductive Tract Infections (RTIs) in women, have profound health and social consequences for their lives especially for women in developing countries. It is estimated that about 250 million new cases of sexually transmitted diseases are reported each year. RTIs and STDs constitute a major health problem largely because of the long term complications associated with them. These include pelvic inflammatory diseases (PID), ectopic pregnancy, infertility, miscarriage, low birth weight, congenital infection, cervical cancer and HIV infection (Wasserheit, 1993). According to Wasserheit women are more susceptible to infection for a number of biological and social factors. Some of these factors include the fact that women are more likely to be asymptomatic, over half of women with gonorrhoea for example, do not have any symptoms. This is supported by Arkutu, (1995). There is also the social stigma of STD infection which makes women reluctant to visit STD treatment clinics or discuss their symptoms with health workers in other health facilities.

Human Immuno Virus (HIV) infection is presently a serious health threat to women. Cases of HIV infection are on the increase. In 1992, it was estimated by WHO that it affected up to 10-12 million people. In the major cities of the Americas, Western Europe and Sub-Saharan Africa, the Acquired Immune Deficiency Syndrome (AIDS) which develops from the HIV virus was found to be the leading cause of death for women 20-40 years old; and up to 40 percent of women aged 30-34 years in Central Africa cities (Dixon Muellar and Wasserheit, 1991 in McDermott et al,1993 ). AIDS contributes significantly to morbidity and mortality among women particularly in developing countries.

## **2.2 Women's Health in Africa**

In looking at the health of women on a global level there is also the need to look specially at the health concerns of women as it pertains in Africa. In so doing it is hoped that a deep appreciation of the health concerns of African women may be realised as well as the concern attached to the need for improvement in their health status as the World Health Organisation (WHO) Functional Literacy Project seeks to achieve in some African countries including Ghana.

Africa has made positive advances over the past quarter century in improvements in health levels. A World Bank Report (1994), notes that infant mortality has been cut by more than one third, and the average life expectancy increased by more than 10 years. It notes further that at the beginning of the period, only one in seven Africans was supplied with safe drinking water whereas twenty-five years later about 40 percent of the African population was obtaining drinking water from a safe source. By

the end of the 1980s around half of all Africans were able to travel to a health care facility within one hour (UNICEF, 1992; World Bank, 1994).

Despite this progress, a majority of African nations continue to lag far behind other developing countries in the vital task of improving health. High rate of disease and premature mortality is characteristic of the health status in Africa. Women are the more seriously affected. Life expectancy in 1991 was fifty-one years compared with sixty-two years for all low income countries, and seventy years for the industrial countries (World Bank, 1994). For women in Africa life expectancy is higher than that for men. Women outlive men by 3 years in Africa, although this is much less than for women in the developed regions and in Central Asia where female life expectancy at birth exceeds that of males by 6 to 8 years (World Survey, 1995).

Life expectation at birth is a measure which summarises the current frequency and age pattern of deaths in the form of single index. According to Payne (1994) this is often said to be the best single measure of a country's overall development because the progress made in extending the expected length of life reflects not only economic conditions but levels of health, education, the status of women and so on. In a sense therefore, life expectation may be said to reflect the quality of life of a particular population. Within the same population, it is also just as possible to know the different life expectation of various groups of people to be able to know who is doing better. Data produced by the United Nations Population Division (1983) in Payne, (1991) showed that for developing countries where even

the average life expectation is very low (around 40 years), women show additional years of lives. This confirms the fact that women in developing countries live longer than men just as the case is for women in the advanced countries.

Although worldwide women do live longer than men this does not in any way reflect progress in the health status of African women. This is because the conditions of life, for a vast majority of these women who live in the poorer sections of their countries, without access to enough nutritional foods, health care, education and so on cannot be said to measure up to any standard 'quality of life'. This will be made more apparent in later discussions.

Women suffer from many health problems, some of which are specific to their areas of origin, for example, female circumcision and frequent child bearing, for some countries in the developing world. In Africa they are the hardest hit, in terms of pre-mature mortality. Maternal mortality is noted to be a leading cause of death for women of reproductive age in the developing countries. Africa records the highest at 700 maternal deaths per 100,000 live births as at 1988 (United Nations, 1995). It is twice as high as in all low-income developing countries and six times higher than in the middle income developing countries (World Bank, 1994). The major causes of maternal deaths haemorrhage, obstructed labour, infections, anaemia, hypertensive disorders and unsafe abortions have been stated already.

Africa also faces persistent, and new health threats in the form of malaria and the Acquired Immune Deficiency Syndrome (AIDS) respectively. WHO estimates the global number of malaria cases per year at 110 million, with nearly 80 percent of them

occurring in sub-Saharan Africa and only 1,000 cases in North Africa (World Bank, 1994). Pregnant women, foetuses and young children are particularly susceptible to malaria infection.

AIDS, the recent health problem to threaten Africa, develops as a result of infection from the human-immuno deficiency virus (HIV). HIV infection is said to be spreading in Sub-Saharan Africa. It is estimated that about 8 million African adults are believed to be infected with the virus with more than 600,000 estimated to have developed the disease (Arkutu, 1995; World Bank, 1994). Women, unfortunately, are especially vulnerable to infection from the HIV virus and AIDS. Arkutu, (1995) and McDermott et al in Koblinsky, (1993) conclude that the virus contributes significantly to mortality among women in developing countries including Africa. Arkutu notes that for some African countries the disease is the leading cause of death for adult women.

In addition to these health problems, Africa's health status is also affected by rapid population growth. A World Survey Report on women showed that for the period 1990-95 the average total fertility rate (average number of children ever born to women of reproductive ages) for countries of Sub-Saharan Africa was estimated at 6.1 births per woman. A World Bank publication though notes a slightly higher rate of 6.5 in 1992 as compared with about 3.6 for all developing countries. The important observation, however, is that both estimations point to the fact that Africa is a continent of exceptionally high fertility. It is also low in contraceptive use. In 1992, contraceptive use rates were only 11 percent on average compared with approximately 51 percent for all developing countries (World Bank, 1994).

Contraceptive use varies according to urban-rural residence. Women in urban areas are more likely to use contraceptives than those in the rural areas. This can be attributed to a number of factors. One such factor is that contraceptive services, information and health care are more easily accessible within the cities or urban centres. (United Nations, 1995)

Also related to these factors is the problem of adolescent fertility. According to Antwi, (1995) countries of sub-Saharan Africa have the highest level of early child bearing in the world. She notes for instance that in a study carried out in Cameroon, findings revealed that 23 percent of all births were to women aged 15-19. Surveys conducted in Northern Nigeria also showed that 43 percent of girls aged 14 were married. Such early marriage, which is characteristic of most African societies only results in early child bearing for young women with all the attendant risks and complications. Motherhood at very young ages poses a higher risk of maternal mortality, and children born to these mothers have higher rates of disease and death (United Nations, 1995). In addition, these women are at risk to sexually transmitted diseases, unsafe abortion, anaemia and malnutrition. Antwi, explains that the health risk for very young mothers is due mostly to the fact that they have not finished developing. The pelvis is relatively small and pregnancy related complications thus occurs more often (Antwi, 1995). It is important to note that the problem of adolescent fertility does not only affect the health status of very young women but also impedes their educational progress and economic well being.

The availability, and, distribution of health care facilities, is another major factor to consider in discussing the

state of health of African women. This is because the ability of a government to improve the health of its people is to an extent dependent on making health care facilities available and accessible to everybody.

Africa, has made significant progress since independence in the provision of health care. This progress has however been uneven and has varied from country to country (Timyan et al 1993; World Bank, 1994). Women in particular have not had an equal share. According to Timyan et al, the availability of care in pregnancy and child birth provides an example. They note in reference to Petros Barvazian, 1991 that of the 130 million deliveries that take place each year in the developing world only 50 percent are attended to by trained personnel. For sub-Saharan Africa, excluding South Africa, the percentage number of births attended to by trained health personnel is 40 (United Nations, 1995). This indicates that a significant number of births are attended by Traditional Birth Attendants (TBAs) which is a common feature of African societies. Aside from this it also reflects on the nature of distribution of health care facilities. This is, if one considers the fact that a high percentage of the estimated 130 million deliveries that take place are likely to be by the poorer, less educated women who live mostly in the rural areas.

Commenting on African health systems, the World Bank notes that within most African countries, access to personal health care tends to be highly unequal across administrative district and between rural and urban areas. For example, among thirty states in Nigeria, the number of health facilities ranged from one per 200 people in Lagos state to one per 129,000 in Benue State. Three-fourths of the country's public and private health

facilities were located in urban areas, which contained only 30 percent of the population. The Doctor-patient ratio, is also skewed in favour of urban dwellers. In Kenya, there was one doctor on average per 500 people in Nairobi, compared with one per 160,000 people in the rural Turkana district (World Bank, 1994). Primary Health Care identified at the Alma Ata Conference (1978) as a means of attaining 'Health for all by the year 2000' certainly has a long way to go in making its impact felt among all communities throughout Africa.

Other health problems facing Africa include environmental related diseases such as diarrhoea, tuberculosis (which is rising in Africa) nutritional deficiencies and violence against women. The latter is a significant cause of female morbidity and mortality in Africa (World Bank, 1994) while malnutrition underlies more than one third of infant and child mortality in rural and urban subdistricts of many African countries and 20 to 80 percent of maternal mortality (World bank, quoting from McGurre and Austin, 1986).

### **2.3 Women's Health in Ghana**

Since independence, the Government of Ghana has made considerable progress in improving the health status of its people. Notable progress includes an increase in the number of government health institutions and trained health personnel, increase in life expectancy at birth from 47 to 58 years, increased immunization coverage in almost all parts of the country and decline in infant and maternal mortality rates.

Ninety-four percent of households are reported to live in communities where there has been immunization campaign in the

last five years (GSS, 1993). The infant mortality rate is estimated to have declined from over 100 per 1000 in the early 1970s to about 77 in the 1983-88 period and to 66 in 1993 (National Population Council, 1994). The maternal mortality rate estimated at 5-10 per 1000 live births in the mid-1970s has declined to 2.7 per 1000 live births in 1994 (Maternal & Child Health, 1994). For women in Ghana, improvement in health is significant because of the important roles they play and also in view of the fact that they constitute a majority of the population. However, despite the progress in health as noted, the health status of Ghanaian women, like their counterparts in sub-Saharan Africa is still very low. The decline in infant and mortality levels to the present levels for instance does not necessarily indicate improved health status for women and children since the rates are far below standards and rank among the highest in the world.

Again trends in infant and maternal mortality levels can only suggest the fact that many Ghanaian women and children have been and still continue to lose their lives through deaths which in nearly most cases are preventable.

Some of the immediate causes of infant and child mortality include malaria, measles, diarrhoea, anaemia, low birth weight and prematurity. In the case of the former, low birth weight has been identified as the leading cause of death whereas in the latter case measles is the leading cause of death.

Regarding women, haemorrhage, septicemia and pregnancy related hypertensive diseases especially eclampsia, which are direct causes of maternal mortality accounted for 42 percent of deaths as at 1989 while indirect causes such as sickle cell

disease, anaemia and other respiratory and cardio vascular disease accounted for 32 percent of deaths (Antwi, 1989 cited by Government of Ghana report, 1992).

The nutritional status of women and children is also low. Adequate supply and intake of food and drink provides the body with the necessary nourishment to live a healthy life and acquire the strength to go about one's business. Insufficient food intake therefore has damaging effects on one's health. The World Bank, (1994) notes that inadequate quality and quantity of food intake (including breast milk) causes growth failure, decreased immunity and learning disabilities in children. Other severe effects include stunting and wasting. Stunting, describes the effect of prolonged undernutrition whereas Wasting is an indicator of current or short term undernutrition.

A study, based on the Ghana living standard survey revealed for the period 1987/88 and 1988/89, that over 30 percent of Ghanaian children were found to be very short for their age. In 1987/88 alone, almost a third of children under the age of 5 years were stunted. The study also showed that a general reduction in the level of stunting occurred with rising expenditure levels and decreasing poverty status. This would suggest that children in poor households are more likely to be stunted compared to those in non-poor households. This is confirmed by the Ghana Demographic Health Survey report (GDHS), (1993). It indicates that the prevalence of stunting is higher in the rural areas (30 percent versus 16 percent in urban) with the highest record of 36% occurring in the Northern Region. The northern regions of the country also records the highest occurrences of wasting compared to the southern part. Wasting

accounts for 11 percent in children in Ghana. The survey reveals an increase of about 40 percent over the 1988 level of 8 percent, indicating a worsening in the nutritional status of Ghanaian children. The effects of inadequate food intake in women can also be found in the form of Protein Energy Malnutrition and micro-nutrient deficiencies. The former is especially severe in pregnant and lactating mothers. The most prevalent micro-nutrient deficiency in women is iron-deficiency anaemia. Vitamin A deficiency is also noted to be severe especially in the three Northern Regions. Goitre, caused by iodine deficiency is estimated to affect up to a third of the population in parts of the Northern and Ashanti Regions (World bank, 1989 in UNICEF/Ghana, 1990). Data from the same source also indicates that 36 percent of women were found to be severely underweight in the lean seasons in the north compared with 19 percent during the rest of the year. Comparative rates for men were 23 percent and 3 percent respectively.

The finding points to a situation of severe hunger as a possible cause for the underweight problems among this percentage number of women. This should not be considered as startling when the low poverty level for many Ghanaian women, unfavourable climatic conditions and other traditional practices are taken into consideration. It nevertheless indicates some lack of food security at most household levels throughout the country. This refers to the inability of families to obtain adequate food both in quantity and quality to satisfy their nutritional requirements throughout the year. Improvement in household food security through appropriate policies and programmes is one step to achieving improved nutritional status for both women and

children. Other areas where much progress needs to be seen are for example, the traditional, cultural practice in many families where the men and boys eat first and have the best part of the meal followed by the girls and finally the mother. This practice is not helpful to female children as they require proper nutrition to enable them grow and for their bodies to develop well enough to take on the effects of child bearing in later life.

High fertility rate and high rates of consecutive births among Ghanaian women are also a reflection of their poor health status. The Total Fertility Rate (TFR) is currently estimated at 5.5 children per woman (GDHS, 1993). This is a decline from the Total Fertility Rate of 6.71 reported by the Ghana Fertility Survey in 1979/80. However, compared to a TFR of under 2 for most developed countries, Ghana's TFR is still high. The prevalence for high fertility levels can be explained by a number of factors. One factor is the special value of children to both men and women in the Ghanaian society. A woman who is able to bear and have many children is well regarded. A woman who is unable to give birth or is infertile is in contrast stigmatized either by relations, friends or by other people living in her environment. To bring honour to herself and gain the respect of people in her community an infertile woman would go to any length to have a child, sometimes at great risk to her health. As Arkutu (1995) explains also, the desire for status can lead women to continue having children even when pregnancy and child birth carry serious health risks. Frequent births which imply less spacing between births or the lack of family planning is dangerous to the health of both mother and child, for example

closely spaced pregnancies are more likely to result in low birth weight for infants (Population Reference Bureau, 1991) which is a leading cause of death for children below the age of one in Ghana as already noted. A mother also becomes weak through frequent child bearing especially where she lacks proper nutrition and increases her risk of illness and death.

The use of contraceptives or family planning methods can lead to a reduction in fertility levels and improve maternal and child health. In Ghana, however, the acceptance and practice of family planning methods are very low despite the very high knowledge by women of family planning methods. According to the Ghana Demographic Health Survey (1993), 91 percent of women know about family planning methods while only 19 percent of women use any method. Studies further show that contraceptive usage tends to be more prevalent among women with more than primary school level education (UNICEF, 1990). This may account for the higher fertility rate (6.4) among rural women than among urban women (4), since women living in the urban areas are likely to be more advanced in education and resist child bearing norms and behaviour expectation. Low contraceptive usage may also be attributed to traditional thinking and culture. According to findings by Manu and others, (1992), fertility decisions of women are rooted in a social milieu in which they are generally subordinate to man in the home. This subordination is reflected at the level of decision-making which is usually left to the man, even in matters relating to fertility and family size. Involving women in decision-making as well as taking joint decisions on family size would go a long way to increase contraceptive use by couples as well as reduce fertility rates.

The distribution of health care facilities in the country and access to the use of these facilities also explain the low level of health of a majority of Ghanaian women. There is a greater concentration of health facilities in the urban areas as compared to the rural areas. It is reported for instance that only 30 percent of health facilities are located in the rural areas, where over 70 percent of the population resides. The largest proportion of highly trained health personnel are also to be found in major urban hospitals, a situation which is particularly common in Africa (World Bank, 1994). In 1988 there were 965 physicians in Ghana and more than 80 percent worked in urban areas. In Accra, the Korle-Bu Teaching Hospital alone had almost one-third of the total number of physicians in Ghana (Benneh, 1990).

The case of the Dangme East District provides a further illustration of the above situation. A survey of medical personnel, the size of facilities and the population indicated that Big Ada and Anyamam, both Area Councils, did not have any health facility. Access to health care facilities measured in terms of bed/population ratio was 1/3179 while the nurse/population ratio was 1/2561 (Dangme East District Profile, 1994). There were no doctors or midwives. The Ghana Statistical Service reports that only about 3 percent of rural households live in communities where there is a doctor (GSS, 1993). Because of their lack of access to adequate health care facilities most dwellers depend on traditional healers and Traditional Birth Attendants and practices some of which are detrimental to their health. The percentage of rural households living in communities where there is a Traditional Birth Attendant or traditional

healer is reported to be over 80 (GSS, 1993).

Safe water in adequate supply is an essential pillar of health. Where this is lacking the health of the population suffers. The situation of water and sanitation in the country is particularly severe in the rural areas. In 1992, only 2.2 million people of the estimated 9.2 million rural population had any access to improved water supplies. A UNICEF supported service coverage survey in 1992, showed an overall national water supply coverage of 57 percent with 76 percent and 46 percent urban and rural coverages, respectively. For sanitation the national average is 29 percent with 61 and 11 percent urban and rural coverages respectively. This may suggest that health and social service condition for the majority of the rural population are generally poor or lacking. This is in spite of general improvement in water supply system (i.e. hand pumps, piped system) to about 30 percent of the rural population during the past 20 years (UNICEF/Ghana, 1996).

The absence of potable water means rural dwellers have to rely more on other sources of water such as streams, rivers and ponds. These sources of water supply may be contaminated with water borne diseases and parasitic diseases from defecation in and around the water source. Thus people who depend largely on these sources particularly if their water is not treated will be exposed to diseases such as bilharzia, diarrhoea and guinea worm infections. Data from the 1989 GDHS reveals that about 34 percent of Ghanaian children have episodes of severe diarrhoea each year, with children in rural areas having a higher prevalence than those in urban areas. This finding points to the important contributory role women can play in affecting the

health of their households. In many rural households women are mainly responsible for fetching water or for providing water to the home. They are also the primary health care givers in the family. If women are not able to assess the quality of their water supply or the source of drinking water they are definitely bound to endanger the health of their family if the water is untreated or contaminated. Research on the determinants of infant mortality have for example proven that the mother is the most important health worker for her children (Schultz, 1989).

With regards to sanitation, there are hardly any workable sanitation system in rural areas. According to a UNICEF/Ghana report (1900), refuse dumps are cited haphazardly, and these pose a health hazard to children playing in such environments. The health risk for women and children is made more worse where poor personal hygiene prevails. Good personal hygiene involves the adoption of healthful practices that help prevent disease for example keeping the body clean. The report states further that as a result of the inadequacy of potable water supply and waste disposal facilities the practice of personal hygiene particularly in rural communities and urban slum is poor. All these conditions contribute to the poor status of health among women in Ghana.

In the light of the above, it will be observed that still much improvement is needed to raise the health status of Ghanaian women. Equipping women with health knowledge and skills is one major step to achieving this.

The next section looks at health education, its aims and the methods of communicating health messages towards achieving improved health for individuals or groups of people.

## **2.4 Health Education**

There appears to be very little information or comprehensive texts that deal with the subject of health education, its practice in developing countries and that of Ghana. The available literature that exists also focuses mostly on health education in schools and health education as practised under specialised fields, for example, Nursing and Public Health. In spite of this, an attempt has been made in this section to provide information on health education relevant to the purpose of the present study.

### **2.4.1 Improving Women's Health**

Some of the health problems women suffer from and which contribute to their low health status arise not out of the lack of adequate medical facilities nor the income to buy drugs and nutritious foods but from certain actions and behaviours on their part. Some of these actions and unhealthy behaviours include defecating anywhere on the open ground, fetching water from streams also shared by livestock, not sending a child for periodic weighing and such beliefs that deter pregnant women from eating eggs lest they experience difficult deliveries.

Achieving an improved health status for women would first have to begin by educating them on these harmful practices, beliefs and actions that contribute to poor health, and encouraging behaviour that promote good health. This action involves the process of health education. The question that might be asked is, what is health education? This is an abstract term that has many definitions, and which also means different things to different people. In its broadest sense health

education may be defined to "include all experiences of an individual, group or community that influence health related beliefs, attitudes and behaviours as well as the processes and efforts that go into producing these health related changes" (Pappoe, Unpublished Mimeograph).

The goal of health education is not merely to inform but to produce changes in behaviours that negatively affect one's health. To do this women have to be provided with the requisite health related skills and knowledge to enable them competently take up the responsibility of improving their own health. As noted by Titmus, (1989) education aims at producing more competent, better informed, more understanding people and has implied within its goals the possibility that its activities will indirectly cause change in the society inhabited by those who undergo it. Health education like general education is concerned with changes in knowledge, feelings and behaviour of people. In its most usual forms it concentrates on developing such health practices as are believed to bring about the best possible state of well-being (WHO, 1958). The definition implies knowledge, attitudes and behaviour components of health education like the earlier definition. Activities in health education are to be geared towards affecting change in these components. This should be planned and done with the involvement of the people. As noted by Scotney, (1976) health education aims at planned efforts, to secure beneficial-health promoting changes in people's behaviour.

It also aims at involving people as individuals, families and communities in taking action on their own behalf by adopting healthy behaviour and ensuring a healthy environment (WHO, 1988). Similarly, Kreshnaswamy and Ramakrishna, (1958) both identify the

involvement of people as necessary to improving their health. They define health education as a "process...leading to programme planning, utilising available resources modifying health behaviour, breaking down barriers of ignorance, prejudice and misconception after an intelligent thoughtful consideration of relevant health knowledge...". Health education by this definition is to be seen as a process involving a series of steps and efforts by people. This definition falls within the broader concept of health education which gives fuller recognition of the ability of the common person to think and act constructively in the identification and solution of his or her problems.

Traditionally, health education was committed to the goal of giving information and working towards individual attitude and behaviour changes based on a cognitive model approach. With time, changing disease patterns, cultural expectations and new views about the relationship between the governed and the governing and between community members and health care providers led to a re-orientation of the concept, to the acceptance of a more holistic view with greater emphasis on people's involvement (Standard and Kaplun, 1983). As also stated by a 1969 technical report of WHO, health education aims at persuading people to adopt and sustain healthful life practices to use judiciously and wisely the health services available to them and to take their own decisions both individually and collectively to improve their health status and environment". As observed by Pigozzi, (1982) this puts the onus of responsibility for improved health status on individuals to change their lifestyle and indicates also the possibility of acting collectively to bring about changes. Commenting on women's health problems Hammad, (1995) cautions

that the fact ought not to be overlooked that women themselves, with their strength and versatility are responsible to a large extent for improving their own health.

The involvement of the individual in his or her own healthy development is significant and worth discussing. Recent approaches to rural development focuses on a human-centred and bottom up approach which stress the need for a greater and more participation of people in their own development. According to Pigozzi, (1982), participation is highly valued because it demands the involvement of individuals in the steps or process toward goal achievement. At each step is a decision-making point. This is implied in the definition by Cohen and Uphoff (1980) which states that "participation in development should be broadly understood as the active involvement of people in the decision-making process so far as it affects them".

Participation also implies a notion of self-reliance. To be self-reliant is to take charge of affairs in a responsible manner, and to be able to participate in making decisions which affect one's life. It also means working together as a group or unit in order to overcome problems facing the community as a whole (Tengey, 1991).

Participation is central to the health education process. According to WHO, (1988) the role of the health worker is to encourage participation at every step, from identifying the problems to solving them. By encouraging participation, people will be more interested in helping themselves. They will also be more committed to taking the actions necessary to improve their health and fulfil the goal of self-reliant development. In addition they will be in a better position through their

collective efforts to effect change in their communities and help sustain health programmes that are implemented.

From the above, the aims of health education may be summarised as follows:

- i. To make good health an asset valued by the community.
- ii. To encourage the full use and development of health services.
- iii. To teach people how to achieve good health, and
- iv. To encourage them to achieve good health by their own actions and efforts (Holmes, 1964).

#### **2.4.2 Concept of Health Education**

Health education programmes may be a part of health care and personal social services as explained above. In view of this it is useful to understand the following concepts of health education, that is, primary, secondary and tertiary health education.

Primary health education according to Ewles and Simnett (1992), is directed at healthy people, and aims to prevent ill health arising in the first place. It involves for example, educating people about adequate and balanced foods providing enough nutrients, fibre and energy for the body. Secondary health education is directed at people who are ill. It involves educating patients about their condition and what to do about it. By providing health education it may be possible to prevent ill health moving to a chronic or irreversible stage, and to restore people to their former state of health. This, according to Ewles and Simnett (1992), may involve the patient in changing behaviour or in complying with a therapeutic regime and, possibly, learning

about self-care and self-help.

Finally, tertiary health education is concerned with educating patients and their relations about how to make the most of the remaining potential for healthy living, and how to avoid unnecessary hardship, restrictions and complications. It involves a process of rehabilitation.

The concept of secondary health education as already explained may be applicable to the present study and to the problem under investigation. In this instance women who are the target group can be described as being ill (not necessarily medically ill) or as having been diagnosed with a problem for which cause health education is required to educate them about their conditions (i.e. poor health) and what to do about it. In order to avoid a deterioration of their condition, health education is given to these women by helping them understand the negative contributing factors, and also to restore them back to a state of good health.

As indicated earlier on in chapter one, some of the factors contributing to the poor health of women in the study area were first, the use of Enemas as a form of treatment for diarrhoea in the belief that these would wash out noxious substances from the gut and thus bring the diarrhoea under control, and secondly the reliance on contaminated streams as their source of drinking water. The major role of health education here is to let women understand these unhealthy practices in order to improve their health.

### **2.4.3 Communicating Health Education Messages**

#### **2.4.3.1 The health educator**

Health education, unlike some other professions can be carried out by a variety of health workers who may not have necessarily been specially trained in health education. They include, nurses, dispensers, sanitation officers, health volunteers with little or no background in health work, community development workers and other personnel and persons committed to bringing about changes in behaviour that do not promote health. According to WHO, health education is really the duty of everyone engaged in health and community development activities (WHO, 1988). For example, a doctor treating someone with malaria has the duty to educate the patient about the cause of the illness and teach preventive skills.

Likewise, it is not right for a sanitation expert to see his duty as providing sanitary facilities to arrest poor sanitary conditions in a locality only, but also to educate the inhabitants about the need for using these facilities.

#### **2.4.3.2 Methods**

Health education uses a variety of methods in communicating health messages to a target group, families or Communities. These can be broadly categorized into two groups, that is, the direct person-to-person method where the health worker is the principal communicator and the indirect method in which health messages originate elsewhere, for example, radio and television programmes (WHO, 1988).

Both types of health education methods are listed as follows:

Health talks	Photographs
Proverbs	Projected materials
Posters	Tape recordings
Displays	Films/movies
Flip charts	Newspapers
Flannel graphs	Magazines
Radio	Public, Local or Traditional media
Television	

Effective communication requires that accurate information is presented to an identified group in order to help change their behaviours. This can be done through a combination of a variety of methods as and when appropriate. Health education thus provides the key to equipping women with the requisite skills and knowledge to improve their health.

Health education programmes are also planned opportunities for people to learn about health, and to undertake voluntary changes in their behaviour. As Ewles and Simnett (1992) note, such programmes may include providing information, exploring values and attitudes and acquiring skills geared towards behaviour change. They can happen on a personal one to one level such as health visitor/client or by means of reaching large audiences through the mass media.

## **2.5 Benefits of Health Education**

Health education as noted from the above is concerned with promoting healthy behaviour. The need for health education at all levels is backed by the fact that most of the diseases or

poor health people suffer result from certain behaviours and actions on their part, for example, drinking water from a river, stream or pond without purifying it and not washing hands before eating. Again, certain decisions a person takes, not to visit a health centre but rely on other traditional healing practices may be influenced by the beliefs, values and attitudes that he has. According to Scotney, (1976) "decision", "actions", "seeking help", "ignoring symptoms", "going for treatment" are all behaviours that influence or affect our health. He states that the health of people and their behaviour - their customs, habits and lifestyle - are closely linked such that changes in one make for change in the other. Successful health education programmes therefore requires that the behavioral practices that cause, cure or prevent illness or any health problem be identified and the people affected helped to understand their behaviours and how it affects or promotes their health.

Some of the benefits to be derived from the successful implementation of health education programmes especially at the community level include:

- i. the use of organised health services such as Maternal and Child Health Clinics;
- ii. the proper spacing of births and high immunisation coverages in children;
- iii the proper treatment of water before drinking, and the practice of improved personal hygiene;
- iv. covering food to protect it from dust, insects, and other animals;
- v. putting waste in a dustbin or a pit covered with soil, or burning it;

vi. providing proper nutritious diet for children.

Some of the benefits and successes of health education as revealed from studies and programmes undertaken are presented below. It is important to note though that many of these successes are limited to particular districts and projects (Scotney, 1976).

Improved personal hygiene is a positive outcome of health education. In a survey conducted on factors affecting the transmission of diarrhoea, Adjei (1984) showed that children whose hands were washed before meals or who did not use their hands at all for taking meals suffered considerably less than those whose hands were not washed at all.

In the Gambia, an information, education and communication programme named 'The Happy Baby Lottery Campaign' was successful in teaching mothers the proper mixing and administration of oral rehydration such as ORS to reduce child mortality caused by dehydration from diarrhoeal diseases. An independent evaluation carried out after two years showed that, in diarrhoea cases treated at home, the share treated with ORS increased by 22 percent to 94 percent (Rasmuson, 1985). Similarly 'The Man is Health' programme to educate villages in Tanzania on disease control led to the construction of hundreds of thousands of latrines and to significant increases in sales of mosquito nets (Hall, 1978).

Increased immunisation under the Primary Health care initiative and recent efforts at promoting healthy sexual behaviour to counteract the AIDS pandemic has also resulted in some success among rural communities and individuals in Ghana and elsewhere. The latter is especially true of Zimbabwe which has

recorded remarkable progress in promoting contraceptive use and healthy sexual behaviour among its people.

A World Development Report (1993) also noted on the declines in child mortality in the USA, that recent research showed that affluence and education made little difference until scientific knowledge showed households how to reduce the dangers to their health through public health education.

The experiment of the Kumasi Metropolitan Area (KMA) health education programme in improving sanitation in the Kumasi district is another example of the successes and benefits that result from health education. (KMA Report, 1991-1994).

## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.0 Introduction**

This chapter gives information on the target population, the sampling technique used and the research procedures adopted for the field work. It also indicates the sources of data and the method by which the data was analysed.

#### **3.1 Population**

The target population constituted women in the Akplabanya cluster of villages in the Dangme East District. These villages were, Akplabanya, Goi, Anyaman and Lolonya. Also included as part of the research population were staff of the WHO/Ghana Government Health Project from selected sector Ministries and Departments in Ghana.

#### **3.2 Study Sample**

This constituted selected women from the four fishing communities who were within the reproductive age group of 15-49 years and those who were beyond their reproductive bearing age. The women selected had either been involved in the functional literacy programme or the health education programme.

#### **3.3 Sampling Technique**

The sampling method adopted for the study was the purposive non-probability sampling technique. Women included in the study sample were hand picked and interviewed based upon their satisfaction of certain conditions mentioned above. This, and the fact that some of the women especially the young and able had

migrated to other coastal communities and neighbouring countries to work was the main reason for the adoption of this method.

#### **3.4 Selection Procedure**

In all a total of 60 respondents from the four fishing communities were selected for the study. Before the start of the survey, the researcher had intended to interview as many as 20 women from Goi, 15 women from Akplabanya and Anyaman and 10 women from Lolonya, guided by the size and population of the communities. However, during the survey, less than the intended number of women from Anyaman were interviewed whereas more than 10 women from Lolonya were included in the study. This was due to certain constraints especially the unavailability of some of the women in Anyaman. This, however, did not pose a threat to the validity of the study since the health education programme being implemented was the same for all the four communities just as the women also constituted a homogeneous group with the same characteristics i.e. those required for their participation in the programme. The sample size was justified in view of the particular circumstances encountered at the field as mentioned already, and the descriptive nature of the study for which there was a need for more reliance on secondary sources of data and information from project staff. A sample number of 10 project staff comprising members of the District Intersectoral Committee at the field level and key personnel of the department of Community Development of the Ministry of Local Government, the Non-Formal Education Division of the Ministry of Education and the Ministry of Health were targeted. Since the project is an

intersectoral action it was considered necessary to acquire information on the health educational aspect from the various sector Ministries, specifically, those that were actively involved in the project.

### **3.5 Research Design**

The research design employed in the study was a field survey using the descriptive analytical method. The research design was chosen on the basis of the following:

- i. The general aim of the study, which was set out largely to identify the health education programme being provided to the women in the study area to promote their health status.
- ii. The research design which offered the researcher the opportunity to describe the existing relationship among variables in the study area, the effects that were being felt through health promotion, and to analyse and interpret this relation based on set objectives.
- iii. The lack of time which imposed a major constraint on the study and thereby limiting the study to a descriptive other than an experimental study.

### **3.6 Sources of data**

The data used for the study was based on primary and secondary sources. Primary data was gathered from participants in the health education programme and staff of the project. The latter included members of the District Intersectoral Committee and key personnel from active participating sector ministries and departments in the project. Primary data was also gathered

through observation.

Secondary data was obtained from both published and unpublished studies, surveys, research and, other technical reports from specific governmental ministries and departments to provide information on, for example, the health component of the project and the health education programme.

### **3.7 Method of data collection**

The interview schedule and the self administered questionnaires were the main research instruments used in the collection of primary data. Information was also acquired through direct observation of the state of environmental hygiene of the area and on matters related to the health education programme.

The structured and unstructured forms of interview were adopted. The oral interview method was chosen because of the fact that a majority of respondents (i.e. women) were illiterate. The unstructured interview method employed on some members of the project staff served a useful purpose of gathering a lot more information on the health education programme aside of what was required of them on the questionnaire format.

### **3.8 Interview schedule**

The interview schedule was designed to collect relevant information that reflected the objectives of the study under three broad sections, A, B and C. The first section, A, covered the socio-demographic background of the respondents, and included six items. Section B covered the health education programme and

related activities as well as the participation of the women in the programme. It included 9 items. Finally, section C, covered mainly the benefits the women had gained as a result of their participation in the programme and aspects of the programme that they felt ought to be improved.

### **3.9 Questionnaire**

The questionnaire was administered to some members of the District Intersectoral Committee of the project and key personnel in a few sector Ministries and Departments. Community Health Nurses at Anyaman were also targeted but were away at the time of the survey. The order and sequence in which the questions were arranged was done with the view to reflect in the entire questionnaire a unity relative to the purpose of data collection. This was particularly necessary because of the type of questionnaire used and also to generate intelligent and reliable responses from the respondents. Unlike the interview schedule the questionnaire was not structured into various sections. The questions that were asked sought information on the health education programme and related activities. All the items with the exception of one, were open ended questions. This was purposely done to allow respondents to freely put down what they knew and understood of the health education programme and activities. (see appendix B)

### **3.10 Interview procedure**

The researcher did not have the opportunity to pre-test the questions due to constraints in time and resources. Interviews

were conducted with the assistance of three interviewers who had a good command of the native language. The researcher spent time to go through the interview schedule with the interviewers, and explained each question to them and the kind of information that was being sought. Interviews were conducted throughout the day, beginning at 9.30 a.m. and ending at 6 p.m. in the evening. Women who were involved in the health education programme and satisfied other conditions were approached and interviewed.

### **3.11 Method of Data Analysis**

Data collected from the field survey was edited, coded and analysed on the computer. The coded information was then processed on the marginals to obtain frequencies, percentages and cumulative percentages. The data was then analysed using percentage frequency distributions, pie charts and bar graphs.

## CHAPTER FOUR

### RESULTS

#### 4.0 Introduction

In this chapter the data collected from the field is presented in frequency and graph form. The presentation is in three parts. Part one deals with the socio-economic background and characteristics of the respondents. The second part covers a description of the health education programme and related activities. The third part looks at the benefits the women have derived from the programme.

#### 4.1 Socio-Economic Background /Characteristics of Respondents

In this section, the major characteristics presented include the age, occupational and educational status of respondents.

##### 4.1.1 Ages of participants

The WHO/Ghana government project in the Dangme East District was intended mainly for vulnerable women in the reproductive age group of 15 – 49. Also, women who had passed their child bearing years but showed keen interest in participating in the programme were targeted. The question on age therefore was asked to find out the age range of women who were represented in the sample selected.

Table 1 Age Structure of Respondents

Age Structure	Frequency	%
15-19	5	8.3
20-24	9	15.0
25-29	8	13.3
30-34	9	15.0
35-39	7	11.7
40-44	7	11.7
45-49	6	10.0
50+	9	15.0
<b>TOTAL</b>	<b>60</b>	<b>100.0</b>

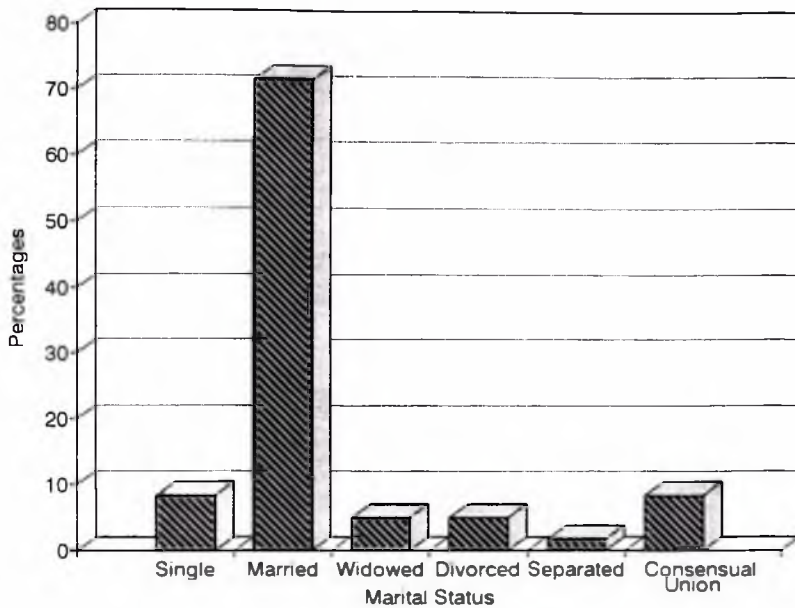
Table 1 shows that a significant number of respondents constituting 91.7 percent were found between the age group of 20-50 years and above while the smallest percentage of respondents represented were within the youngest age group of 15-19 years. On the whole women in the various age groups were fairly represented in the study.

#### 4.1.2 Marital status

Marriage is the socially approved way for the establishment and maintenance of family life in society. As an institution, it confers on a wife important responsibilities of reproduction and the care of her family. The performance of these roles is however not without certain health risks and problems both to her and her family. This is especially so in traditional rural communities where the provision of basic amenities such as good drinking water, is usually lacking and where there is reliance

on untreated sources of water and traditional healing practices detrimental to health. A knowledge of the marital status of respondents therefore shows the number of married women represented and the kind of educational activities they are likely to be exposed to for enhancing their health.

**Fig 1 Marital status of respondents**



As clearly shown in fig 1 a significant number of the respondents were found to be married. Those who were single, widowed, divorced, separated and in consensual unions constituted a fairly small percentage.

The high percentage of married respondents is indicative of the important value placed on the institution of marriage in the Ghanaian society.

#### 4.1.3 Educational Levels of Participants.

Education is an important factor influencing people's perceptions, behaviours and the acceptance of information that may be of benefit to them. It was therefore considered necessary to find out the educational level of respondents.

Table 2 Level of educational attainment of respondents.

Educational Status	Frequency	%
No Formal Schooling	16	26.7
Non Formal Education (Adult Literacy)	18	30.0
Middle School	2	3.3
Primary Incomplete	11	18.3
Primary Complete	8	13.3
Junior Secondary School	3	5.0
Senior Secondary School	1	1.7
Vocational School	1	1.7
Total	60	100.0

The results in table 2 indicate that a little over half of the total number of respondents constituting 56.7 percent had not attained any formal level of education. 31.6 percent did not go beyond the primary level; 6.7 percent had acquired secondary level of education while 3.3 percent and 1.7 percent had attained middle school and vocational levels of education respectively.

#### 4.1.4 Occupation of Respondents.

A person's occupation is important to his or her survival. This is because it is the major means by which the person is able to feed, clothe and take care of himself or herself. The kinds of occupations respondents are engaged in is presented in table 3.

**Table 3      The occupational status of respondents  
in the Dangme East District**

Main Occupation	Frequency	%
Fish Smoking	30	50.0
Petty Trading	15	25.0
Selling Food	6	10.0
Farming (Crop/Livestock)	3	5.0
Hair Dressing	2	3.3
Student	1	1.7
Dressmaking	2	3.3
Teaching	1	1.7
Total	60	100.0

As can be seen from table 3, the main occupation for a majority of the respondents was found to be fish smoking. The production and processing of fish is a major occupation for many of the inhabitants in the four communities which are located along the coast in the Greater-Accra Region.

The second main occupation the respondents were engaged in was trading, which is traditionally considered a female occupation in Ghana. Other occupations some respondents were found to be engaged in included hair dressing, dress making and teaching. These respondents however made up a very small percentage.

#### 4.1.5 Participation in the programme

The health education programme was introduced in the project area as far back as 1987. In view of this the study was interested in finding out the number of years respondents had been participating in the programme.

**Fig 2** Number of years respondents had been involved in the programme.

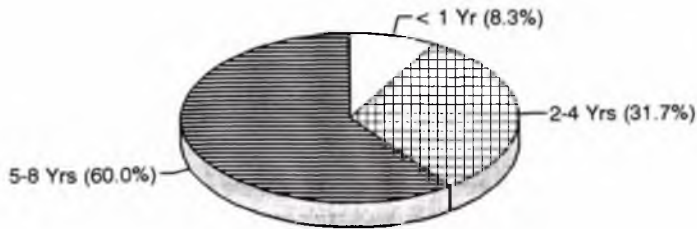


Fig 2 shows that a significant number of the respondents had been involved in the programme for five to eight years. Some of the respondents were also found to have been participating in the programme for about two to four years while only a few had been participating in the programme for just one year and less.

#### **4.2 The Health education programme and related activities**

This section aims generally at a description of the health education programme. Specifically, it provides information on the objectives of the health education programme as described by project staff, the health educational activities, the kind of personnel responsible for health education and the health issues covered. It also gives information on the kind of methods and techniques used among others. Information on all these aspects was obtained from both categories of respondents, that is, participants and project staff.

##### **4.1.2 Aims and objectives**

In any educational activity objectives have a central role, and a knowledge of the objective of any activity enhances the likelihood of a successful outcome. (Donerty, 1982). By stating

objectives, a learning outcome is understood. Also the outcome of the learning activity can then be measured against the objectives set. The aims and objectives of the health education programme are therefore important to the analysis of this study.

Table 4 Aims and objectives of the programme as described by project staff

Aims & Objectives	Frequency	%
To promote environmental and personal hygiene, prevent out break of diseases.	6	60
To educate women to participate in the immunisation of children and ante-natal and post-natal activities.	4	40
To decrease population growth and promote the health of women and children through family planning.	4	40
To educate women on proper nutritional practices.	3	30
To provide appropriate infrastructure to support health education.	2	20
To decrease maternal and child mortality rates.	2	20

Note: Multiple Responses

Table 4 indicates the specific objectives of the health education programme as reported by the project staff. It appears respondents attached more weight to the first three objectives which were:

- i. To promote environmental and personal hygiene/prevent outbreak of diseases.
  - ii. To educate women to participate in immunisation of children, ante-natal and postnatal activities and
  - iii. To decrease population growth and promote the health of women and children through family planning.
- Respondents on the other hand attached low importance to the objectives of educating women on proper

nutritional practices, providing infrastructure to support health education and to decrease maternal and child mortality rates.

#### 4.2.2 Major educational activities

To achieve the overall goal of improving the health status of women in the project area, the women were encouraged to participate in educational activities that had been designed for them. Table 5 presents the various educational activities provided by the programme.

Table 5 The main health educational activities covered by the programme as reported by project staff

Health Educational Activities	Frequency	%
Educating women to send their children for regular weighing and immunisation through health talks (MCH).	9	90
Educating women to attend ante-natal and post natal clinics (MCH).	7	70
Educating women on the causes and treatment of diseases, and family planning.	6	60
Demonstrations on how to prepare weaninmix, educating women on nutrition.	8	80
Mobilising women to participate in environmental cleanliness and to practice personal hygiene.	10	100
Organising regular educational talks for women and rest of community on the construction of pit latrines, KVIPS, hand dug wells etc.	4	40

From table 5, it was found that the highest percentage of respondents reported on the following activities:

- i. Mobilising women to participate in environmental cleanliness and to practice personal hygiene and
- ii. Educating women to send their children for regular

weighing and immunisation through health talks.

The lowest percentage of respondents on the other hand reported on organising regular educational fora for women on the construction of KVIPs etc. as an educational activity covered by the programme.

From the above it may be said that respondents placed more emphasis on some activities as compared to others.

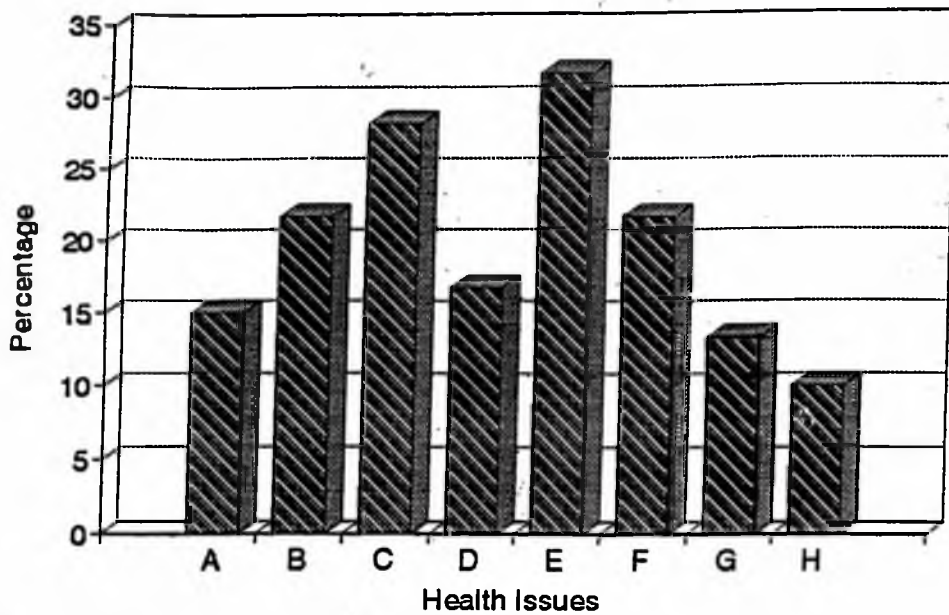
#### 4.4.3 Content of the programme

Table 6 Health issues respondents treated In the programme

Health Issues	Frequency	%
Family Planning	59	98.30
Nutrition, Weaning Practices	60	100.00
Immunisation	59	98.30
Pre-Natal Care, Maternal Care	56	93.34
Causes & Treatment of Diseases	60	100.00
Personal & Environmental Hygiene	60	100.00
Teenage Pregnancy	4	6.70

Note: Multiple responses

The results displayed in table 6 indicate the kind of health issues respondents were educated in. It can be observed that the programme gave the least emphasis to teenage pregnancy. Of the other areas, respondents indicated that family planning, disease control, nutrition and immunisation were given immense emphasis. Indeed, they indicated that these issues constituted the greatest problem areas to them. Of all the issues, family planning and disease control were however found to be the most emphasised. This is presented in **Fig 3**

**Fig 3 Health issues emphasised****KEY**

A - Pre-natal care

B - Nutrition

C - Causes &amp; treatment of diseases

D Environmental sanitation

E Family planning

F Immunisation

G Child care

H - Same emphasis

**4.2.4 Personnel**

Health education is not the sole responsibility of persons engaged in the health profession but also the responsibility of all those others involved in community development work. The study was thus interested in finding out the kind of personnel involved in providing health education to the participants.

Table 7 Personnel involved in the health education programme as indicated by personnel

Personnel Involved in Health Education	Frequency	%
Community Health Nurses	60	100.00
Dept of Community Dev't Staff	60	100.00
Community Health Volunteers	60	100.00
Environmental Sanitation Officers	60	100.00
Community Clinic Attendants	49	81.90
Literacy Facilitators	45	75.00
Church Leaders	1	1.70
Others (Visiting WHO Officials)	3	5.00

Multiple responses

The results in table 7 show that all of the respondents had been educated on health issues by Community Health Nurses, Community Development Officers, Environmental Sanitation Officers and Health Volunteers. A Significant majority had also received health instruction from Community Clinic Attendants and from literacy facilitators. Only a small number of respondents constituting 6.7 percent indicated receiving health messages from church leaders and visiting WHO officials.

#### 4.2.5 Methods of instruction

The choice and application of a method is instrumental in ensuring the successful outcome of any educational activity. The kind of methods used in the health education programme is presented in table 8.

Table 8 Methods used in communicating health messages

Communication Methods	Frequency	%
Face to Face Interaction	59	98.30
Proverbs	15	25.00
Group Meetings/Discussion	60	100.00
Health Talks	60	100.00
Drama	59	98.30
Demonstrations	39	65.00
Role Play	10	16.70
Video/Films	6	10.00
Posters	57	95.00

As indicated in table 8, respondents were exposed to a variety of communication methods through which health messages were delivered. Group meeting/discussion and health talks were found to be methods that all of the respondents had been exposed to while proverbs, drama, role play and videos were methods they had been less exposed to.

#### 4.2.6 Methodology

This subsection provides information on methods adopted by the programme implementors in delivering health messages.

Table 9 Ways in which personnel are equipped to deliver health messages

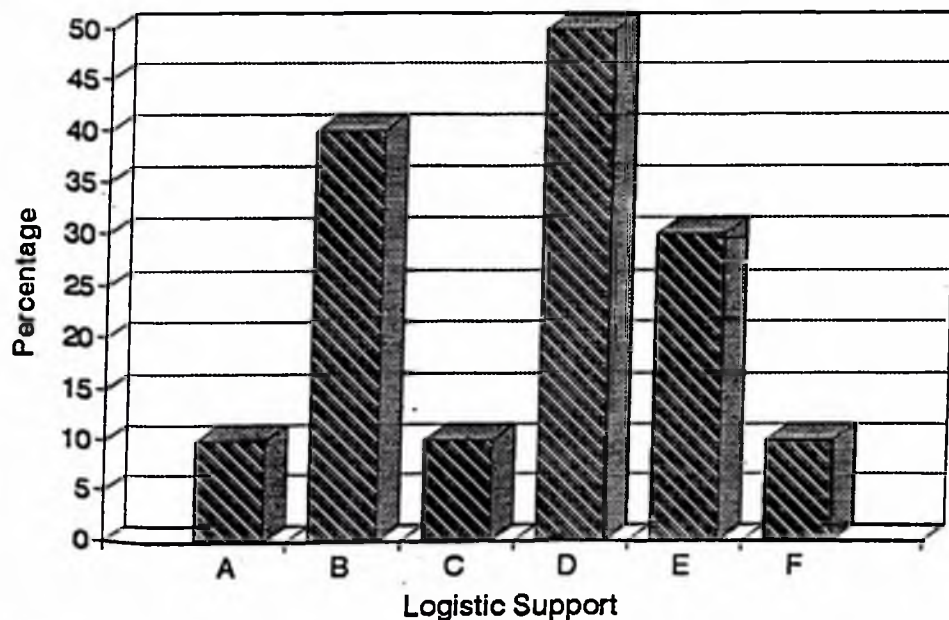
Ways Personnel are Equipped	Frequency	%
Training	9	90
Use of Manuals	9	90
Hand Books	8	80
Others (Includes Drugs, Vaccines, Health Equipment e.g Weighing Scales, Films, Cinema Vans and Overhead Projector).	3	30

The results in table 9 show the various ways by which personnel were equipped to deliver health messages. Most of the respondents indicated training, the use of manuals and hand books as ways in which they were equipped to carry out their work. Others representing a small percentage included Drugs, the use of weighing scales and cinema vans.

#### 4.2.7 Logistic Support

Adequate logistic support facilitates the implementation process of any well designed programme. The study sought to know therefore the kind of logistic support enjoyed by the programme.

**Fig. 4 Logistic Support for Programme**



#### Key

- A - Provision of drugs
- B - No support
- C - Tools for communal work
- D - Financial support from WHO/Community Department
- E - Support in personnel, cars and stationery
- F - Quarterly meetings and Intercountry meetings

As shown in Fig 4 the most significant support indicated was financial aid from WHO and the Department of Community Development. Support in personnel, cars and stationery was also indicated by 30 percent of the respondents. Interestingly however, as much as 40 percent of the respondents indicated that no special support as such had been received to facilitate the implementation of the programme.

#### 4.3 Value of the Programme

The value or worth of the health education programme is in the attainment of the major goal of bringing about an improvement in the health status of women through their application of the knowledge gained. This section provides information relating to the above among others.

##### 4.3.1 Application of lessons gained

Respondents were asked the kind of health related activities they had been involved in as a result of the health education programme. To this question a fairly large number of respondents constituting 66.7 percent indicated the construction of KVIPS while all of them indicated their involvement in sweeping their compound (See table 10).

Table 10 Health related activities respondents were involved in

Health Activities	Frequency	%
Construction of KVIPs	40	66.70
Sweeping of Compound	60	100.00
Construction of Wells	4	6.70
Weeding the Environment	3	5.00
Disposal of Waste in the Ground	4	6.70
Boiling Drinking Water	1	1.70
Construction of Clinic at Anyaman	1	1.70

Note: Multiple responses

The other activities which were least represented, included the construction of wells, weeding the environment, disposing waste material in the ground, boiling drinking water and the construction of a community clinic. Some of the respondents claimed that they were not around when their communities embarked on the construction of KVIPs and Wells. However project staff interviewed on the field indicated that most of the women in the study area had been taken through all of the activities with the exception of the clinic which was restricted to the Anyaman Community. The conclusion that can be drawn from table 10 is that the respondents perceived some activities to be more health related than the others.

#### 4.3.2 Intrinsic value of the programme

In terms of the usefulness of the health related activities all the respondents found the activities to be useful. Of the number, 45 percent said the activities helped to prevent the outbreak of diseases, 28.3 percent indicated that it promoted good health while 51.2 percent stated that the activities helped

to improve sanitation in the area (Table 11).

Other ways respondents found the activities useful were that it reduced the presence of flies (5.0%), it helped to maintain proper hygiene in the home (3.3%) and lastly it promoted a communal spirit among the people in the community (1.7%).

Table 11 Usefulness of health related activities as indicated by the respondents

Ways in which activities were found useful	Frequency	%
Helps to prevent the outbreak of disease	27	45.0
Promotes good health	17	28.3
Improves sanitation in the area	31	51.7
Reduces the presence of flies	3	5.0
Helps to maintain proper hygiene	2	3.3
Promotes communal spirit	1	1.7

Note: Multiple responses

#### 4.3.3 Participatory Skills

Health education involves the participation of people. This means that the intended beneficiaries work actively with the health workers and others to solve their own problems (WHO, 1988). By participating in a programme therefore people will be more committed to taking the action necessary to improve their health and hopefully derive much benefits from it.

In line with this, respondents were asked the extent of their involvement in certain aspects of the health education programme such as the planning stages. Responses to this question are provided in table 12.

Table 12 Aspect of programme respondents were involved in

Aspects of Health Education Programme	Frequency	%
Planning of specific activities	47	78.3
Fund Raising Activities	58	96.7
Assisting Health Workers	32	53.3
Research and Collection of Data	30	50.0

Note: Multiple responses

From table 12, fund raising activities stand out clearly as an aspect of the programme that majority of respondents had been involved in. Aside from this also a significant majority indicated that they had been involved in the planning of specific activities, for example, the construction of KVIPs. Another 50 percent indicated their involvement in research and collection of data while a little over half the respondents also indicated assisting health workers to carry out their programmes.

Respondents were also asked if they should be involved in the planning and implementation of the programme and why. To this question all the respondents replied in the affirmative. As will be seen from table 13 very good reasons were advanced by the participants as to why they should be involved in all aspects of the programme. Most of them explained that their involvement in the programme would ensure a healthy environment and secondly would achieve greater results in the health of participants.

Table 13 Reasons why participants should be Involved in the health education programme

Reasons	Frequency	%
To ensure a healthy environment	28	46.7
To achieve greater results in health	15	25.0
Because of the benefits to be derived	6	10.0
Prevent the outbreak of diseases	5	8.3
Because the programme is for the Community	6	10.0
Total	60	100.0

#### 4.4 Specific outcome of the programme

As a way of determining the extent of benefits respondents may have derived from the programme, they were asked to indicate the main health problems they and their families had before participating in the programme. The information is presented in table 14.

Table 14 The main health problems of respondents and their families prior to their participation in the programme

Health Problems	Frequency	%
Cholera, Diarrhoea	26	43.3
Measles	15	25.0
Poor Sanitation	25	41.7
Poor personal Hygiene	15	25.0
Malaria	17	28.3
Convulsion	3	5.0
Guinea Worm	1	1.7
Gonorrhoea	2	3.3
Malnutrition	1	1.7

Note: Multiple responses

The results of the study in table 16 above shows that the main health problems respondents had, before participating in the programme were measles, Malaria, poor sanitation, poor personal hygiene and cholera/diarrhoea. Other health problems included malnutrition, gonorrhoea, guinea worm and convulsion. These were however the least represented.

Since participating in the programme most of the respondents constituting 98.3 percent indicated that there had been some reduction in these health problems in their lives.

Asked on how the programme had helped to solve their problems, a majority of them indicated that they had acquired knowledge on how to prevent the incidence of diseases through such activities as boiling their drinking water and sweeping their surroundings. A smaller percentage making up a quarter of the total number indicated that they had come to understand the causes and treatment of the diseases that had bothered them while a further small percentage indicated that they had learned how to provide better nutritional diets for their children through the preparation of weanimix, and knew what healthy foods to eat during pregnancy (See Table 15).

On the whole one of the major ways in which the programme had contributed to improvement in the health status of respondents was a knowledge and practice of activities that prevented the incidence of diseases in their lives and those of their communities.

Table 15 Ways in which the programme has helped to improve respondents health Problems

Various ways Programme has helped to improve respondents health problems	Frequency	%
Taught ways of preventing the incidence of diseases	38	63.3
Through an understanding of the causes and treatment of diseases	15	25.8
Through weanimix preparation and intake of nutritious foods	6	10.0
Not applicable	7	1.7
Total	60	100

#### 4.4.1 Individual benefits

One of the major objectives of the study is to find out any improvements that may have occurred in the health of respondents as a result of their participation in the programme. In Table 16 the individual benefits derived from the programme is presented.

Table 16 Benefits derived by respondents

Benefits	Frequency	%
None	1	1.7
Improved personal & environmental hygiene	58	96.7
Healthier children	40	66.7
Proper maternal care	34	56.0
Improved nutritional diet	35	58.3
Positive change in attitude	46	76.7
Illness Prevention	53	88.3
Improved Health	51	85.0
Enhanced my occupation	20	33.3
Participation in international Conference	1	1.7

Note : multiple responses

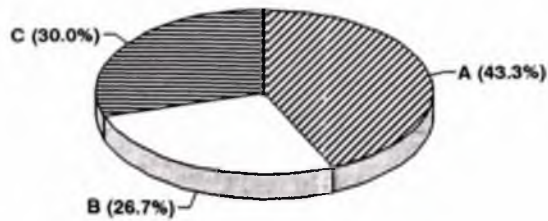
The results from table 16 clearly show that all but one of the respondents had derived some benefits from participating in the programme. Of the kind of benefits indicated, improved personal hygiene was found to be the most derived by respondents. This was followed by the prevention of illness. Generally it can be said that the results show important health benefits to a majority of the respondents including such other indirect benefits as participation in an international health conference and improved occupational status for some of them.

#### 4.5 Sustainability of the programme

Specific questions relating to programme implementation and sustainability of the programme were asked from both the participants and project staff with the view to making recommendations and suggesting improvements in aspect of the programme where necessary.

##### 4.5.1 Continuation of the programme

Respondents were asked if the health education programme should continue. To this question all the respondents (100%) responded in the affirmative. They were further asked the reasons why the programme should be continued. According to 43.3 percent of the respondents if the programme was continued then it would continue to improve their health. Another 26.7 percent indicated that the programme would help to ensure a clean and healthy environment while 33 percent said the programme had improved their health and should therefore be continued. (See fig 5)

**Fig 5 Reasons why the programme should continue****Key**

- A- To improve our health
- B- To ensure a clean and healthy environment
- C- It has improved my health

**Table 17 Aspects of the health education programme respondents would like to see improved**

Aspects of Programme	Frequency	%
Family planning	13	21.7
Environmental Sanitation	14	23.3
Training of Traditional Birth Attendants	2	3.3
Supply of drugs & organisation of weighing	2	3.3
Provision of KVIPS	2	3.3
Causes and treatment of diseases	3	5.0
Immunisation	12	20
Nutrition and Child care	5	8.3
Provision of good drinking water	1	1.7
Pre - natal care	3	5.0

Note: Multiple responses

Some of the respondents were of the view that aspects of the programme specifically the health issues covered and related activities should be improved or have a greater impact in their lives. In table 17 the main areas indicated were family planning, immunisation and environmental sanitation. Aspects of the programme which were least represented were the provision of

water, KVIPs and the training of Traditional Birth Attendants (TBAs).

On the issue of why these aspects should be improved the main reasons given were that family planning would check population growth in the communities; improved sanitation would prevent the outbreak of diseases and attract visitors to the area while immunisation of children would help cut down on medical expenses and prevent infant mortality (Table 18).

Table 18 Reasons For Improving Aspects (Health Issues) of the Programme

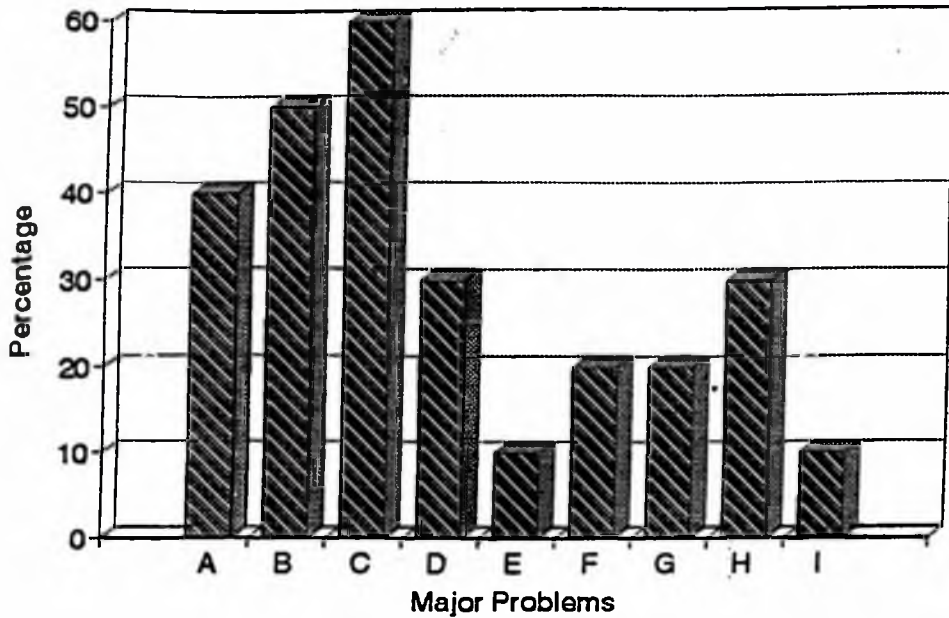
Reasons Given	Frequency	%
To limit the number of children and take good care of them	2	3.3
To check population growth in the community	11	18.3
To improve Sanitation	19	31.7
Drug supplied by nurses are insufficient, no permanent place for conducting weighing	3	5.0
TBA's should be given training to handle emergencies	2	3.3
To cut down on medical bills & prevent infant mortality	12	20.0
To improve my health status	1	1.7
To ensure easy child birth	2	3.3
Not - Applicable	23	38.3

Multiple responses

#### 4.5.2 Institutional difficulties

Respondents were asked to indicate the major problems they faced in the implementation of the programme. This information is provided in Fig 6

Fig 6 Major problems encountered

**Key**

- A - Transport to project areas
- B - Apathy in some members of staff
- C - Lack of funds
- D - Lack of incentives for health volunteers & staff
- E - Programme sustenance by the community
- F - Migration of people
- G - Timely supply of logistic
- H - Lack of personnel & administrative support
- I - Lack of potable water

From Fig 6 a majority of the respondents indicated the lack of funds, apathy of some members and transport to the project sites as some of the major problems encountered in implementing the programme.

The lack of personnel, and incentives for health volunteers and staff were also found to be major problems identified by an equal majority of respondents.

Other problems which were the least represented included the lack of potable water and sustenance of the programme by the communities.

#### 4.5.3 Overall impact

Table 19 presents the overall impact of the programme as seen by Project Staff.

Table 19 Major achievements of programme

Major Achievements	Frequency	%
A greater awareness on personal and environmental hygiene	9	90
Improvement in environmental cleanliness and communal sweeping	8	80
Reduction of malnutrition and control of diseases eg. Diarrhoea	8	80
Regular attendance of women to child welfare clinics / positive response to MCH activities	6	60
Improvement in health status of women	9	90
Rise in immunisation Coverage	7	70
Participation of Women in public discussion	5	50
Construction of KVIPs and wells	8	80

Generally from the frequencies recorded in table 19 a lot of achievements were attained by the programme. Notable achievements were a greater awareness on personal and environmental hygiene; improvements in the health status of women; improvements in environmental cleanliness and communal sweeping; a reduction of malnutrition and control of diseases and the construction of KVIPs and wells.

## **CHAPTER FIVE**

### **DISCUSSION OF RESULTS**

#### **5.0 Introduction**

In this chapter the major results of the study will be discussed. To facilitate coherence the discussion is categorized under the following sub headings:

- i. Socio-Economic Characteristics of Participants.
- ii. Programme Objectives, Activities and Content.
- iii. Methods Employed in Teaching Participants.
- iv. Programme Resource: Personnel.
- v. Logistic Support.
- vi. Value of the Programme.
- vii. The Future.

#### **5.1 Socio-Economic Characteristics of Participants**

Data on the socio-economic background of participants revealed that most of them were married and in their reproductive years. The WHO project was initially targeted at women within their reproductive years and who satisfied other conditions of vulnerability. This explains therefore the higher involvement of this group of women in the project as revealed in the study.

Participants were also found to be of relatively low educational status and were engaged mainly in fish smoking and petty trading. Participants with no formal schooling and those with non-formal educational background were in the majority. However a substantial number of them had also had some formal education (43.3%).

On health problems background data identified the health needs of the women as improved environmental sanitation, proper maternal and child care, pre-natal care, family life education and a knowledge of the causes and treatment of diseases. As pointed out in chapters one and two, women suffer many health problems. This is especially so for rural women in developing countries. Maternal reproductive health problems of women accounts for the deaths of about half a million women each year. 89 percent of the deaths take place in Africa.

Rural women especially lack adequate knowledge of the causes and treatment of ailments that afflict them and their families. As the primary health care providers for their families and in view of their domestic roles of cooking and fetching water, they therefore pose a serious health threat to their health and that of their families. Their further lack of economic power contributes to some of the health problems in their lives. Lack of adequate nutritional diet is a major outcome of this. Some of the health risks of pregnant women and children resulting from improper diet are anaemia and low birth weight in babies.

It is a must therefore that any educational programme to the women should take cognisance of the above health problems. To this end the programme, as later discussions reveal, seem to be relevant to meeting the interest and needs of the women. The study also found that the involvement of women in the programme spanned a period of 1 to 8 years with the majority of them being involved for 5 to 8 years.

## 5.2 Programme Objectives, Activities and Content

Programme Objectives are needed to direct and guide programme activities. Knowles, (1980) has defined programme objectives as educational and operational outcomes towards which a total programme will be directed for a prescribed period of time. According to him, a list of programme objective provides a platform of specific goals toward which a programme should be directed in the period immediately ahead. It is on the basis of these objectives that decisions will be made as to what particular activities will be scheduled for what groups of participants.

The study revealed that the specific objectives of the health education programme as indicated by project staff were as follows:

- i. To promote environmental and personal hygiene.
- ii. To promote immunisation of children.
- iii. To promote maternal and child health.
- iv. To promote family planning and family life education.
- v. To develop appropriate infrastructure to support health education.

To obtain these objectives various educational activities were designed. The main educational activities as indicated by project staff were as follows:

- i. Educating the women to send their children for regular weighing and immunisation through health talks (90%).
- ii. Mobilising the women to participate in environmental cleanliness and practice of personal hygiene (100%).

- iii. Educating the women to attend ante-natal and post-natal clinics (70%).
- iv. Educating the women on the causes and treatment of diseases (60%).
- v. Demonstrations on how to prepare weanimix and nutrition education (80%).
- vi. Organising regular educational talks on the construction of pit latrines, KVIPs and hand dug wells (40%).

From the responses given it would seem that project staff placed an emphasis on the first two educational activities indicated above as compared to the others. The emphasis on these activities can be understood against the background of poor environmental sanitation of the study areas prior to the start of the WHO project. Indiscriminate defecation, improper disposal of refuse and inadequate supply of potable water had contributed to making poor sanitation a major problem of the inhabitants. This situation though is typical of rural areas in Ghana as the review of literature showed. A UNICEF supported survey on sanitation service coverage in 1992 showed a national coverage of 29 percent with 61 percent and 11 percent urban and rural coverages respectively. Water supply showed 76 percent urban and 46 percent rural coverages, which suggest that health and social service condition for the majority of the rural population were generally poor or lacking.

A further explanation for the emphasis on the above activities can be attributed to the important roles women play in maintaining health. As various studies and authors (eg. Arkutu, 1985, World Federation of Public Health Associations,

1986, WHO, 1995) have shown women are:

- i. The primary health care givers in the home.
- ii. The main users of immunisation services for themselves and their children.
- iii. Play a major role in the prevention and control of illness among family members that is, preventive treatments, early detection of symptoms and treatment of common illnesses and injuries etc.

Encouraging women to participate in the immunisation of their children as a main educational activity, is thus to enhance the chances of increasing child survival and development. This is especially important, in view of the prevalence of deadly diseases such as diarrhoea, malaria and measles that characterises the rural environment. (GDHS 1989, Okojie 1994).

Apart from the above educational activities involving women, they were also educated on the following:

- i. Family Planning.
- ii. Weaning practices.
- iii. Immunisation.
- iv. Pre-natal care, Maternal Care.
- v. Causes and treatment of diseases e.g Drug use, oral rehydration preparation.
- vi. Personal and Environmental Hygiene and
- vii. Teenage Pregnancy.

These health issues formed the main content of the programme. According to participants family planning, disease control, nutrition and immunisation were given immense emphasis. Surprisingly, Environmental sanitation which was reported by project staff as a major educational activity was not indicated.

It could be concluded that the women did not perceive environmental sanitation as a health issue emphasised.

Overall, an analysis of programme activities revealed that mobilisation for social action was given pre-eminence in the programme.

### **5.3 Methods Employed in Teaching Participants**

In health education people have to be equipped with the facts, ideas and attitudes they need to make decisions about their health. To do this successfully requires the adoption of effective communication skills or communication methods. The study wanted to find out the kind of methods used in the health education programme and how they could contribute to improving the health status of the participants.

The results of the study as evidenced in table 8 showed that largely, traditional face to face, discussion and drama methods were used. The responses given, further showed that proverbs, role play and videos/films were methods that were less used in communicating health messages.

The prevalent use of face to face and discussion methods could be attributed to the approach adopted by personnel in disseminating information mostly through established women's groups. Organised community groups, serve as important outlets for the transmission of information. The use of the discussion method may further be attributed to the fact that it seemed to be more helpful than other methods in enabling participants to modify attitudes and opinions. According to Ghorde, (1988) participants are able to modify certain attitudes and opinions because it encourages them to examine them in an atmosphere from

which as much threat as possible has been removed.

In spite of this there is a need for personnel to maximise the use of proverbs, role play and adopt innovative approaches for example, puppets, films and displays. Audio visual aids for instance render more understanding in less time. Cinema vans as operated by the department of Community Development should be utilised more often to show films on health issues to the women.

On the whole, personnel are to be commended for the use of several methods in communicating health messages. This is because effective health communication is not achieved through the use of only one method but a combination of a variety of methods (WHO, 1988).

#### **5.4 Programme Resource**

Personnel who educated participants on health issues came from various professional backgrounds. There were Community Health Nurses, Community Development Officers, Community Health Volunteers, Environmental Sanitation Officers, Community Clinic Attendants, Literacy Facilitators, Church Leaders and visiting WHO Officials.

Some of them came from the local community and some others had been posted there for work. As indicated in the review of literature, health education can be carried out by a variety of health workers who may not have necessarily been specially trained in health education. Health education according to WHO, is really the duty of everyone engaged in health and community development activities (WHO,1988).

The study however showed that the first four health personnel indicated were largely involved in educating the

participants on health issues. The Community Clinic Attendants and Literacy Facilitators also educated a significant number of the participants. Church leaders and WHO officials were the least involved in the programme.

This finding may indicate that Community Nurses, Community Development Officers, Community Health Volunteers and Environmental Sanitation Officers are more active on the ground or that participants interact more with them than the others. Again, it also shows that not all the women are actively engaged in the functional literacy classes which also provides a very good media for disseminating knowledge and skills on healthy behaviour.

Personnel were also asked in what ways they had been equipped to carry out their tasks. To this question most of them indicated the use of manuals, training and hand books. A few others indicated drugs, vaccines, health equipments such as weighing scales, and an overhead projector.

Primary data further revealed that some of the personnel had benefitted much more from these above facilities as compared with their colleagues. This was particularly the case of personnel from the Non-Formal Education Division, especially with regards to training. Project staff from the Department of Community Development though had no special training organised for them unless it was absolutely necessary. The same also applied to the District Intersectional committee who complained of the lack of regular training.

In conclusion, there is more that the project can do to enhance the work of personnel by organising refresher courses for them. They should also be supplied with more written materials.

### **5.5 Logistic support**

The subject of logistic support was considered regarding the important role it played in enhancing the success of the programme as well as in sustaining it.

The result of the study showed that logistic support for the programme was mainly in the form of cash or financial aid. Other forms of support were personnel, vehicles, stationery, drugs and tools for communal work. There were some participants however who in spite of the above said that no support as such had been given to them. These constituted quite a significant number (40%). They explained that their involvement in the health education programme was carried out as part of their sectorial duties. It was also unfortunate to note that the District Focal person on the project did not have a project vehicle to facilitate work in the project areas.

It is suggested that adequate logistic support should be made available to facilitate the programme and enhance the goal of improving the health status of women in the study area.

### **5.6 Value of the programme**

The goal of health education as indicated already is to encourage behaviour that promotes health, prevents illness, cures disease and facilitates rehabilitation (WHO,1988). The success of any health education programme lies in the accomplishment of this goal. Thus for example, getting people to wash their hands before eating thereby reducing the risk of getting a diarrhoeal disease would be a story of successful behaviour change.

The health education programme in this light has proved quite successful from the data analyzed. One of the important

outcomes of the programme activities has been the involvement of respondents in health related activities that promote good health. The study found out that all the respondents had been involved in the healthy practice of sweeping their compounds.

This was done mostly on a twice daily basis as secondary data revealed. The involvement of women in this activity had been promoted through health talks, the 'fale fale' or environmental cleanliness programme and through setting aside a day for communal sweeping.

The construction of KVIPs was also another activity involving a majority of the participants. This was made possible through organised educational talks for women and the communities on the need for its construction. Other activities worth mentioning were the disposal of refuse in the ground, that is, by digging a hole and burying the refuse; boiling drinking water; weeding the environment and the construction of a community clinic.

All the respondents found the activities useful in several ways. Of the number, 51.2 percent said the activities helped to improve sanitation in the area, 45 percent said the activities helped to prevent the outbreak of disease while 28.3 percent said that they promoted good health. A few others 10 percent also said it reduced the presence of flies, helped to maintain proper hygiene and promoted a communal spirit among them (Ref. Table 11)

The promotion of participatory skills among respondents was another important value of the programme. They had participated in the planning of specific activities, assisting health workers, research and collection of data but mostly in fund raising activities. As the review of literature has shown,

participation is an important aspect of the health education process. By encouraging participation, participants would be more interested in helping themselves and become more committed to taking the necessary actions to improve their health.

Participation also implies a notion of self reliance which could mean working together as a group or unit in order to overcome problems in the community as a whole. From the responses given in table 13, it appeared that participants had a good understanding of what their participation could bring them. Most of them indicated that participating in the programme would ensure a healthy environment and achieve greater improvements in their health.

Another specific outcome of the programme was the individual benefit derived by the participants. One of the objectives of this study was to find out what improvements there had been in the health of participants since participating in the programme. The end result of health education as the review of literature has tried to show is to have individuals take those actions that will be beneficial to their own and their communities health. The question one may ask therefore is: has the participation of the women in the programme led to the adoption of new practices that promote health and enhanced their health status.

Before participating in the programme participants and their families were found to have been suffering from certain health problems. These were mostly cholera, measles, poor environmental sanitation, poor personal hygiene and malaria. Other health problems included convulsion, guinea worm, gonorrhoea and malnutrition. Since their participation in the programme however, there had been a reduction of these health problems in

their lives. This had been achieved mainly through:

- i. Their acquired knowledge of how to prevent the incidence of diseases through such activities as boiling their drinking water and
- ii. Through an understanding of the causes and treatment of diseases affecting them.

Documented report on the project revealed that before the programme started, the women did not give proper attention to their clothing, feeding and care of their children. Sheep, goats and pigs were allowed to roam about freely and bathe in the same source of water they used among other negative practices. (Okunnor, Mpare. M, 1991). Today, the women can be said to have benefited from the programme. As table 16 shows, almost all the respondents had benefited in many ways. They included improved personal and environmental hygiene, healthier children, proper maternal care, improved nutritional diet and positive change in attitude. They had also derived the benefit of knowing how to prevent illness in their communities, improved health and enhanced their occupation. Also significant was the participation of one of them in an international conference on health. An unintended benefit not indicated but made known to the researcher was the establishment of a kindergarten at Akplabanya.

## 5.7 The Future

The significance of the study lies in obtaining results that may be found useful in strengthening and improving the performance of future programmes.

From the data analysed the general view would be for the programme to continue because of the individual and societal benefits derived. The programme has succeeded in attaining such notable achievements as the high creation of awareness on personal and environmental hygiene; improvements in the health status; improvement in environmental cleanliness and communal sweeping; and construction of KVIPs, wells etc.

The potential benefit of the programme can be evidenced from the responses of participants who would want the programme to continue to:

- i. Improve their health
- ii. Ensure a clean and healthy environment
- iii. Because it had brought about improvement in their health.

In spite of these achievements there is a need for the programme to focus its attention on the improvement of certain health aspects. The main areas indicated by a majority of respondents were family planning, environmental sanitation and immunisation. It is a fact that sanitation continues to be a problem in the communities despite the achievements noted (1995 progress reports). At the time of the study the KVIPs in the Akplabanya were for instance full and in disuse. Definitely the people would have to look for other places of convenience such as the beaches further worsening the problem.

Participants indicated an improvement in family planning and immunisation for the main reason of checking population growth and preventing infant mortality in their communities. Yet, progress report on the project shows that family planning practice has been very low. The main reason given by the

participants for these discouraging reports was lack of interest (Progress Report 1995). Project staff interviewed also revealed that the women complained that their husbands did not encourage them to practice family planning. Apart from this some of the women found it prestigious to give birth to many children because they will gain recognition and be given many gifts. The programme should intensify education on the benefits of family planning and immunisation and provide more KVIPs for the communities use. Furthermore there is a need to strengthen institutional support for the programme.

The study found that project staff had been facing many institutional difficulties. The major difficulties indicated by majority of project staff were lack of funds; apathy in some members of staff; transport to the project site; lack of incentive for health volunteers and staff and lack of personnel and administrative support. The personnel of the department of the Community Development for instance were housed in a dilapidated building and lacked the necessary administrative support as well. Infact there was great discontent among the staff. Addressing these difficulties will go a long way to ensuring the sustainability of the programme.

## **CHAPTER SIX**

### **SUMMARY OF RESULTS AND CONCLUSION**

#### **6.0 Introduction:**

This chapter gives a brief summary of the results and the conclusions arrived at. Included in this is the summary of the organisation and results of the field work conducted in the study areas which is treated in the first section. The second section gives the conclusions derived from the analysis of the data.

The major concern of the study was to identify the health education programme being provided to four communities in the Dangme East District and to find out how it had contributed to bringing about improvements in the health status of women in those communities.

Specifically the study attempted:

- i. To find out the socio-economic background characteristics of the participants.
- ii. To identify the health education activities and issues covered by the health education programme.
- iii. To identify the methods and techniques used in the programme.
- iv. To find out if there have been improvements in the health of the participants since participating in the programme.

#### **6.1 Research Procedure**

The field work was conducted in Akplabanya, Goi, Anyaman and Lolonya in the Dangme East District in the Greater Accra Region. These were communities selected by the project based on a

mutually acceptable criteria of vulnerability. Women included in the study sample of 60 were hand picked from each of the four communities using a purposive non-probability sampling technique. The choice of this method was due to certain conditions but especially because some of the women involved in the programme had emigrated to other coastal communities and neighbouring countries to work.

The basic research technique used for the fieldwork was the interview schedule. In addition self administered questionnaires were used to collect information from personnel on the project (this included project officials at the field level and those in the main implementing office in Accra).

## **6.2 Results of the field work**

The major results of the study are summarised as follows:

1. Majority of respondents were married and in their reproductive years. They were also of low educational status.
2. Project staff appeared to attach more importance to the following programme objectives:
  - i. To promote environmental and personal hygiene and prevent the outbreak of diseases.
  - ii. To educate women to participate in immunisation of children, ante-natal and post-natal activities.
  - iii. To decrease population growth and promote the health of women and children through family planning.

3. The main health education activities indicated by a majority of the project staff were as follows:
  - i. Educating women to send their children for regular weighing and immunisation through health talks.
  - ii. Mobilising women to participate in environmental cleanliness and to practice personal hygiene.
4. Health issues covered by the programme were:
  - i. Family Planning
  - ii. Nutrition/weaning Practices
  - iii. Immunisation
  - iv. Pre-natal Care, Maternal Care
  - v. Causes and Treatment of Diseases
  - vi. Personal and Environmental Hygiene and
  - vii. Teenage Pregnancy

Only a few of the participants (6.7%) however indicated that they had been educated on Teenage Pregnancy.

5. A variety of health workers and personnel from other professional backgrounds were involved in the programme. Those who were regular tutors were:
  - i. Community Health Nurses
  - ii. Community Development Officers
  - iii. Community Health Volunteers
  - iv. Environmental Sanitation Officers
  - v. Community Clinic Attendants

Personnel who were occasionally utilised were church leaders and visiting WHO Officials.

6. Largely, traditional face to face discussion and health talks methods were used in communicating health messages to the participants.
7. Participatory skills, especially in programme planning processes, fund raising activities, research and data collection and assisting health workers were being promoted among participants.
8. It was observed that logistic support for the programme was inadequate.
9. The majority of the women had derived important benefits from their participation in the programme. These were mainly in the areas of maternal and child health, improved personal and environmental hygiene and improved health status.
10. Major achievements of the programme indicated by a majority of the project staff included:
  - i. A greater awareness on personal and environmental hygiene (90%)
  - ii. Improvement in the health status of women (90%).
  - iii. Improvement in environmental cleanliness and communal sweeping (80%).
  - iv. Construction of KVIPs and wells (80%).
  - v. Reduction of malnutrition and control of diseases (80%).
11. Family planning, immunisation and environmental sanitation are health issues requiring much improvement or impact in the lives of beneficiaries.

### 6.3 Conclusion

The study set out largely to find out the health education activities being provided in the Akplabanya cluster of villages and how these activities had contributed to improving the health status of women.

The results of the field work show that the women have benefited from their participation in the programme. The goal of health education as stated is to encourage behaviour that promotes health, prevents illness, cures diseases and facilitates rehabilitation (WHO 1988). The health education programme in this sense has succeeded in making participants take actions that are beneficial to their own health.

Practical benefits derived from the programme have been the application of the knowledge gained in taking such actions as the daily sweeping of their compounds, weeding their environment and preparing more nutritious weanimix diets for their children. What is especially commendable is that the women now have a good understanding of the need to take these actions. Majority of the women indicated that these activities helped to prevent the outbreak of diseases, improved the sanitation in the area and promoted good health in their lives.

In addition, the women have derived individual benefits from the educational activities provided quite apart from the societal benefits also. Most importantly, the health status of majority of the women have been enhanced.

There is however room for improvement in the programme, especially the health and institutional aspects. The study revealed that most of the participants wanted to see more improvements in the area of family planning and immunisation.

Obviously not much impact had been felt by the women in these areas. Regarding the institutional aspects of the programme most of the project staff complained about the lack of funds, apathy in some members of staff, and others that were affecting their work. These aspects of the programme must be carefully looked at to see how best improvements can be made.

#### 6.4 Recommendations

The following are recommended as ways for improving programme performance.

- i. There is a need to intensify the health education component of the programme especially in the areas of family planning, immunisation and environmental sanitation in order to achieve greater results in the health of women and children.
- ii. There is a need for the provision/construction of more KVIPs to ease the sanitary problem in the communities.
- iii. Personnel should maximise the use of proverbs, role play and adopt other indirect and innovative approaches such as photographs and displays, in communicating health messages to the women. These, together with traditional methods like discussions will pave the way for the desired changes in behaviour.
- iv. Personnel should also be well equipped to deal with the tasks at hand. They should all be exposed to organised training programmes and refresher courses at regular periods to enhance their performance.

- v. Adequate logistic support should be made available to facilitate work on the programme. In particular, the procurement of a project vehicle for the local implementors of the programme should be speedily addressed.
- vi. Allowances and incentives should be given to project staff and health volunteers. A committee should also be set up to investigate and address the problem of apathy among some members. This is because the commitment of staff to the programme is important for increased output.

## B I B L I O G R A P H Y

- Adjei, S. 1989. Assessing the Effect of PHC on Mortality in Ghana. Journal of Biosocial Science, supplement No.10, Cited in UNICEF/Ghana, 1990. Children and Women of Ghana: A Situation Analysis, Accra.
- Ampofo, D.A. 1988. Maternal-Child Health and Family Planning in Ghana. University of Ghana. Population Impact Project.
- Antwi, P. 1995. Consolidating Africa Front for Positive Changes in Women's Status. Paper Presented at an Accra Consultative Meeting Towards the Fourth World Conference on Women.
- Antwi, P. et al. 1989. Retrospective Analysis of Maternal Mortality Data from Three Major Maternity Hospitals in Greater Accra Region, 1986-1988. Unpublished, cited in Government of Ghana Report, 1992. The Child Cannot Wait. Accra.
- Arkutu, A. 1995. Healthy Women, Healthy Mothers: An Information Guide, New York, Family Care International, Inc.
- Benneh, G. 1990. Population Growth and Development in Ghana. University of Ghana, Population Impact Project.
- Cohen, J. and Uphoff, 1980. Participation's Place in Rural Development: Seeking Clarity Through Specificity in World Development, vol. 8, no.3 (March).
- Dangme East District, Five Years Development Plan, 1996-2000. The Psalm Consult, Accra.
- Dangme East District Profile, 1994. Cited in Dangme East District Five years Development Plan, 1996-2000. The Psalm Consult, Accra.
- Population Impact Project (PIP), 1996 Demographic Projection Model, 1996. Unpublished.
- Dixon-Mueller, et al. 1991. The Culture of Silence: Reproductive Tract Infections Among Women in the Third World, International Women's Health Coalition cited in Mcdermott et al. 1993. The Health of Women: A Global Perspective. Boulder, West View Press.

- Donerty, S. 1984. Educational Objectives and Their Role in Teaching Project Planning. Project Planning Centre for Developing Countries, Teaching Materials Series, No.4. Bradford.
- Ewles, L. and Simnett, I. 1992. Promoting Health: A Practical Guide, 2nd ed, London, Scutari Press.
- Ghana Statistical Service, (GSS) and Macro International Inc(MI). 1994. Ghana Demographic and Health Survey (1993). Calverton, Maryland:GSS and MI.
- \_\_\_\_\_, 1995. The Pattern of Poverty in Ghana, 1988-1992. Commercial Associates ltd, Accra.
- \_\_\_\_\_, 1984. Population Census of Ghana, Accra, Rural Communities in Ghana. Report of National Rural Community Survey Carried out as part of the Third round of the Ghana Living Standards Survey 1991/92.
- Ghorde-Team, 1988. Discussion Method as a Teaching Aid Journal of Adult Education and Development, No.30.
- Government of Ghana Report, 1992. The Child Cannot Wait.
- Gyekye, O.L. 1988. Functional Literacy and Health Education for Women. Institute of Statistical, Social and Economic Research. University of Ghana.
- Hall, B. 1978. "Man is Health: Mtu Ny Afya". Clearinghouse on Development, Communication Academy for Education Development, Washington, D.C. Cited in World Bank, 1984. Better Health in Africa: Experience and Lessons Learned. Washington, D.C.
- Hammad, A. 1995. Improve our Health, Improve the World. World Health Magazine, WHO, Geneva.
- Holmes, C.A. 1964. Health Education in Developing Countries, London. Thomas Nelson and Sons Ltd.
- Jacobson, Jodi L. 1993. Women's Health: The Price of Poverty, in Koblinsky, M. et al. eds. The Health of women: A Global Perspective. Boulder, West View Press.
- Kane, P. 1991. Women's Health: From Womb to Tomb. Great Britain, Macmillan Press.
- Knowles, M. 1980. The Modern Practice of Adult Education: from Pedagogy to Andragogy. New York. The Adult Education Company.

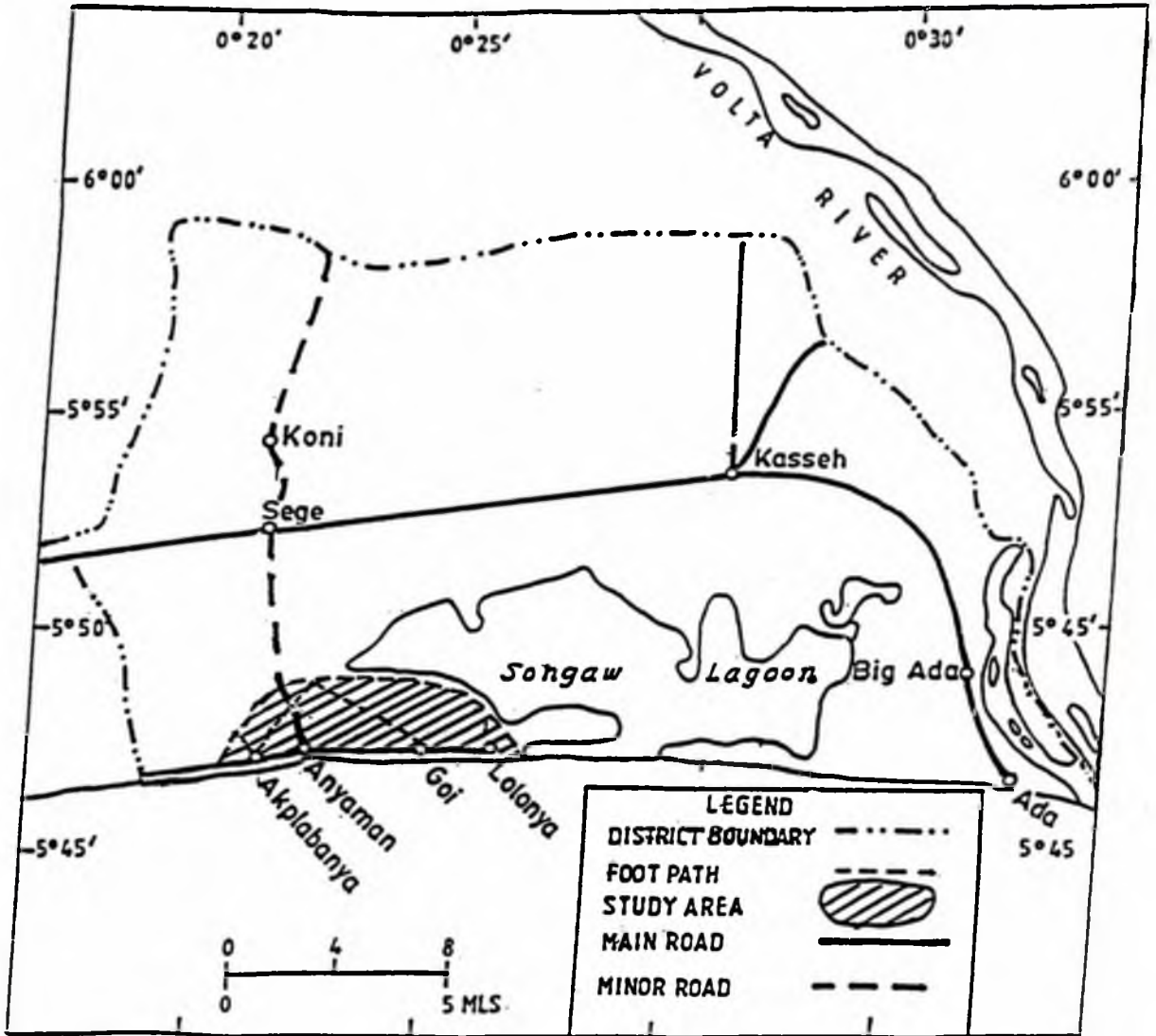
- Koblinsky, M. Campbell, O. and Harlow, S. 1993. Mother and More: A Broader Perspective on Women's Health in Koblinsky. M., et al. eds. The Health of Women: A Global perspective. Boulder, West View Press.
- Krishnagwamy, K.S. & Ramakrishna, V. 1958. Health Education and Environmental Sanitation. Swash Hind 2, 284.
- Kumasi Metropolitan Assembly, 1991-1994. Health Education Experiments in the Kumasi District. The Kumasi Health Education Project.
- Manu, T. and Others. 1992. Report on Women and Other Vulnerable Groups and the Family Planning Programme, in Indepth Assessment of the Ghana National Family Planning Programme: 1970-1990. Report of National Workshop held 3 4 April, 1992, Social Sector Policy Unit, Accra. Max Associates Ltd.
- Maternal and Child Health and Family Planning, 1994. Annual Report, Ministry of Health, Accra.
- Mcdermott et al. 1993. Infection: Social and Medical Realities in Koblinsky et al. eds. The Health of Women: A Global Perspective. Boulder, West View Press.
- National Population Council, 1994. Government of Ghana, National Population Policy, Ghana, Advent Press.
- Okojie, C. E. 1994. Environmental Hazards and the Health Status of Women and Children in a Riverine Community in Nigeria: Nikrowa in Edo State. Journal of Social Development in Africa. No.1, 25-35.
- Okunor V., Mpare M., eds. 1991. This is the Way, Promoting Health through Women's Functional Literacy and Intersectoral Action. WHO/Ghana.
- Pappoe, M.E. "Health Education Principles and Methods". Unpublished Mimeograph.
- Payne, S. 1991. Women, Health and Poverty- An Introduction. London, Harvester Wheatsheaf.
- Population Reference Bureau, 1991. Family Planning Saves Lives 2 ed. Washington.
- Pigozzi, M. 1982. Participation in Non-Formal Education Projects: Some Possible Negative Outcomes, International Journal of Adult Education. Vol. XV, No.3.

- Progress Report, 1995. Promoting Health Through Women's Functional Literacy and Intersectoral Action.
- Rasmuson, M. 1985. Report on the 1982 'Happy Baby Lottery'. Field notes, Communication for Child Survival Project. Academy for Educational Development, Washington D.C., quoted in World Bank. 1994, Better Health in Africa. Experience and Lessons Learned. U.S.A.
- Safe Motherhood Initiative, 1994. Newsletter, July-Oct. New York, Family Care International.
- Schultz, T. 1989. Returns to Women's Education PHRWD Background Paper 98/001. World Bank, Washington D.C., Cited in Better Health in Africa. Experience and Lessons Learned. World Bank, Washington D.C.
- Scotney, N. 1976. Health Education, A manual for Medical Assistants and other Rural Health Workers. Kenya, African Medical and Research Foundation.
- Sheriff, K. and Levison, P. 1996. Women's Health: A Model of an Intergrated Curriculum in Women and the University Curriculum: Towards Equality, Democracy and Peace (eds) Kearney Mary-Iouise and Ronning, Anne (eds). UNESCO.
- Standard, K. and Kaplun, A. 1983. Health Education. New Tasks, New Approaches. WHO Chronicle, Vol.37, No.2.
- Tengey, W. 1991. A Guide to Promote Rural Self-Reliant Development. [A Ghana Experience]. Ghana, Assemblies of God Literature Centre Ltd.
- Tim Yan, J. et al. 1993. Access to Care: More Than a Problem of Distance in Koblinsky, M. et al. The Health of Women: A Global Perspective. Boulder, West View Press.
- Titmus, C.J. ed. 1989. Life Long Education for Adults: An International Handbook. Oxford, Pergamon Press.
- UNICEF, 1993. Girls and Women. A UNICEF Development Priority. New York.
- \_\_\_\_\_, 1996. The State of the World's Children, Oxford University Press.
- \_\_\_\_\_/Government of Ghana, 1996-2000. Master Plan of Operations and Programme Plans of Operation.

- \_\_\_\_\_/Government of Ghana, 1990. Children and Women of Ghana: A Situational Analysis.
- United Nations, 1995. The World's Women. Trends and Statistics. New York: United Nations.
- \_\_\_\_\_. Economic Commission for Africa 1990/91 African Socio-Economic Indicators.
- Van der Kwaak, 1991. Women and Health. Vena Journal 3(1): 2-33, Cited in Koblinsky et al (eds), 1993. The Health of Women. A Global Perspective. Boulder, West View Press
- Wasserheit, J. 1993. Report on Women's Health and Nutrition. Seminar sponsored by the World Bank, Bellagio, Italy.
- WHO, 1995. Women and Health. World Health Magazine, Geneva.
- \_\_\_\_\_, 1988. Education for Health. A Manual on Health Education in Primary Health Care, Geneva.
- \_\_\_\_\_/Ghana, 1988. Promoting Health Through Female Functional Literacy and Intersectoral Action.
- World Development Report, 1993. Investing in Health. World Development Indicators, Oxford, University Press, New York.
- World Bank, 1994. Better Health in Africa: Experience and Lessons Learned, Washington D.C. Citing Mcquire, J. and Austin, J. 1986. Beyond Survival: Children's Growth for National Development. Cambridge, Mass, James E., Austin Associates.
- \_\_\_\_\_, 1994. Better Health in Africa. Experience and Lessons Learned. Washington D.C.
- \_\_\_\_\_, 1989. Ghana: Population Health and Nutrition Sector Review, Vols. I and II. Cited in UNICEF/Ghana, 1990. Children and Women of Ghana: A situation Analysis, Accra.
- World Federation of Public Health Association, 1986. Women and Health, Information for Action Paper, WFPHA, Washington D.C.

### APPENDIX A

MAP OF ADA TRADITIONAL AREA SHOWING THE STUDY AREA



**APPENDIX B****A STUDY OF THE WORLD HEALTH ORGANISATION (W.H.O)/GHANA  
GOVERNMENT HEALTH EDUCATION PROGRAMME FOR ENHANCING THE  
HEALTH STATUS OF WOMEN IN THE DANGME EAST DISTRICT****INTERVIEW SCHEDULE****SECTION A**

1. Age:
 

1. 15 - 19 [    ]	2. 20 - 24 [    ]
3. 25 - 29 [    ]	4. 30 - 34 [    ]
5. 35 - 39 [    ]	6. 40 - 44 [    ]
7. 45 - 49 [    ]	8. 50+ [    ]
2. Marital Status:
 

1. Single [    ]	2. Married [    ]
3. Widowed [    ]	4. Divorced [    ]
5. Separated [    ]	6. Consensual [    ]
3. Level of educational attainment:
 

1. No formal schooling	[    ]
2. Non-formal education (Adult literacy)	[    ]
3. Primary incomplete	[    ]
4. Primary complete	[    ]
5. Vocational	[    ]
6. Others (Specify).....	
.....	
4. Number of children, if any
 

1. 1 - 2 [    ]	2. 3 - 4 [    ]
3. 5+ [    ]	
5. What is your main occupation?.....



11. How do the Resource personnel communicate health messages to you?

1. Face-to-face interaction [     ]
2. Proverbs [     ]
3. Group meeting/discussion [     ]
4. Health talk [     ]
5. Demonstration [     ]
6. Drama [     ]
7. Others (Specify).....  
.....

12. What health related activities have you been involved as a result of your participation in the programme?

1. Construction of KVIP [     ]
2. Sweeping compound [     ]
3. Others (Specify).....  
.....

13. Do you find these activities useful?

1. Yes [     ]     2. No [     ]

(a) If yes, in what ways do you find the activities useful?

List.....  
.....

14. In which of the following aspects of the health education programme have you been involved?

1. Planning of specific activities [     ]
2. Fund-raising activities (Resource Mobilisation) for specific activities [     ]
3. Assisting health workers with programmes (e.g. weighing, nutrition demonstrations) [     ]
4. Research and collection of data [     ]
5. Others (Specify).....  
.....

15. Do you think community people should be involved more actively in all aspects of the health education programme?

1. Yes [     ]                      2. No [     ]  
 3. Don't know [     ]

(a) Give reasons for your answer.....

.....  
 .....

### SECTION C

16. What kind of health problems did you and your family have, before participating in the programme ?

.....  
 .....

17. Has your participation in the programme helped you to solve some of these problems?

1. Yes [     ]                      2. No [     ]

(a) If yes, how.....

18. What gains have you derived from your participation in the programme?

1. Improved personal hygiene [     ]  
 2. Healthier children [     ]  
 3. Proper maternal care [     ]  
 4. Improved nutritional diet [     ]  
 5. Positive change in attitude towards  
    health related diseases [     ]  
 6. Illness prevention [     ]  
 7. Better health for myself [     ]  
 8. Enhanced my occupational activity [     ]  
 9. Others (Specify).....

19. Do you think the health education programme should continue?

1. Yes [ ]      2. No [ ]

(a) Give reasons for your answer.....

.....

20. Is there an aspect of the health education programme you would like to see improved?

1. Yes [ ]      2. No [ ]

(a) If yes, mention which aspect you would like to see improved?

.....

.....

(b) Give reasons why this aspect should be improved?

.....

.....

**APPENDIX C**

**A STUDY OF THE WORLD HEALTH ORGANISATION (W.H.O)/GHANA  
GOVERNMENT HEALTH EDUCATION PROGRAMME FOR ENHANCING THE  
HEALTH STATUS OF WOMEN IN THE DANGME EAST DISTRICT**

**QUESTIONNAIRE FOR PROJECT STAFF**

1. Occupation.....
2. Place of work.....
3. Position in relation to project.....  
.....
4. What is the W.H.O Functional Literacy Programme?  
.....  
.....  
.....
5. What are the aims and objectives of the project?  
.....  
.....  
.....
6. What are the aims and objectives of the health education programme?  
.....  
.....  
.....  
.....
7. What health educational activities are provided for the women?  
.....

.....  
.....

8. What health topics are dealt with?

- 1. ....
- 2. ....
- 3. ....
- 4. ....
- 5. ....
- 6. ....
- 7. ....
- 8. ....

9. Does the project place emphasis on any particular health topic(s)/areas?

- 1. Yes [    ]
- 2. [    ]

(a) If yes, which area(s)/topics.....  
.....  
.....

(b) Give reasons why these area(s)/topics are emphasized.....  
.....  
.....

10. What health related activities do you involve the women in?.....  
.....  
.....

11. What educational methods are used in delivering health messages?.....  
.....  
.....
12. Which kind of personnel are involved in health education?.....  
.....  
.....
13. In what ways are the personnel equipped to deliver health messages?
- 1. Training [     ]
  - 2. Use of manuals [     ]
  - 3. Handbooks [     ]
  - 4. Others (Specify).....  
.....  
.....
14. How often are the personnel trained?.....  
.....
15. What logistic support has been put in place to enhance the health education programme?.....
16. What are the major problems you have been facing so far, in implementing the programme?.....
17. What are the major achievements?.....  
.....  
.....