

**AN EVALUATION OF THE HEALTH AND
NUTRITION PROGRAMMES OF WORLD VISION
GHANA. A CASE STUDY OF BONGO HEALTH
AND NUTRITION PROGRAMME**

BY

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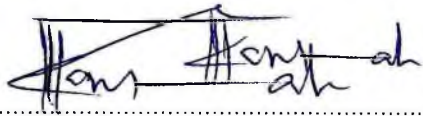
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DECLARATION

I declare that this work, with the exception of identified quotations, is written by me and I am responsible for the views expressed and for any errors in style of this dissertation.

A handwritten signature in dark ink, appearing to read 'Theophilus Nkansah', written over a horizontal dotted line.

Theophilus Nkansah

Approved as conforming to the required standard by

A handwritten signature in dark ink, appearing to read 'Dr. Michael Tagoe', written over a horizontal dotted line.

Dr. Michael Tagoe
(Supervisor)

DEDICATION

I dedicate this piece of work to my father, Mr. Jonathan Nkansah, and my mother, Madam Mary Akoto, who, out of their poverty, sacrificed everything to give me education. God richly bless you Paapa and Maame.

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To God be the Glory!

ABSTRACT

The study evaluated the World Vision Ghana's Health and Nutrition programme at Bongo in the Upper East Region.

Issues of health and nutrition are very crucial since they are closely related to the development of the individual and by extension, nations. There is widespread malnutrition and ignorance of health issues in most rural communities in Ghana. World Vision is operating in most of these rural communities in Ghana, and interventions in Health and Nutrition are undertaken in all these communities. The study therefore evaluated the World Vision programme at Bongo.

The study used the case study method. A sample of 24 respondents was purposively selected from eleven communities, and an officer of World Vision Ghana was selected for interview. The semi-structured interview was used as the data collection instrument.

The major findings of the study indicated that:

- Beneficiary communities were not involved in the design of the programme, although they participated actively in programme implementation.
- Even though World Vision is collaborating well with the District Health Management Team (DHMT), there is no official collaboration between World Vision, Catholic Relief Services, and Rural Health Integrated, who are also undertaking the same interventions in the district.

- Community education on health is not done regularly in the communities. It is however done in times of disease outbreak and during immunisation.
- Supplementary feeding is provided for Nursery and Primary School pupils, malnourished children, expectant and lactating mothers, resulting in reduction in malnutrition.
- There has been considerable reduction in maternal and child mortality due to increased immunisation coverage and health awareness in the communities.

Significant issues coming out of the study which health and nutrition implementation programmes need to take note of include:

- All health and nutrition programmes should take care of pre-school children, children of school going age, expectant and lactating mothers and the elderly since these are more prone to malnutrition.
- Poverty alleviation through the giving of credits to small-scale enterprises and ensuring food security through Agricultural Support should be integral parts of Health and Nutrition Programmes to ensure sustained impact.

Health and Nutrition education is an indispensable component of health and nutrition programmes.

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CHAPTER ONE

INTRODUCTION

1.0 Background to the study

In poor countries children are caught in a cycle of malnutrition and infection. Each year about 13 million infants and children die in the developing countries. The majority of these deaths are due to infections and parasitic diseases. In Africa, for example, more than 20% - on average – do not reach their fifth birthday. Even for those who survive, a significant number are malnourished. The “malnutrition – infection” complex remains the most prevalent public health problem in the world today, (Tomkins and Watson 1998, p.1).

Good health and proper nutrition are essential prerequisites for the growth and development of the individual.

A number of studies have acknowledged the need for good nutrition and health, and the close relationship that exists between nutrition, health and development. Proper nutrition provides good health, which in turn positively impacts on development. Such is the importance of the relationship between health and development that the World Health Report (1999) challenged the International Community to examine the difference health can make to the continuing progress and development of humanity.

Malnutrition and disease are issues that people grapple with in many communities in Ghana. The problem is more acute in rural Ghana, especially in the Savannah areas of

the country. The elderly, women and children are the ones who suffer most from malnutrition and disease.

The World Bank Health Sector review on Ghana (1989) noted that Ghana had made considerable progress in increasing life expectancy at birth and in reducing mortality. However, indicators pointed to the fact that the health status of the population remained rather poor, as evidenced by high prevalence of preventable infectious and parasitic diseases, and poor nutritional status between urban and rural areas, and among regions, as well as different disease patterns.

The review on nutrition noted that in Ghana as in other low-income countries, malnutrition takes its greatest toll on young children and pregnant and nursing mothers. The report identified the problem as being a combination of two interrelated phenomena: protein-energy malnutrition and associated micronutrient deficiencies among the vulnerable population groups, and pre-harvest hunger affecting predominantly the rural population.

The Ghana Demographic Health Survey (1989) revealed that for the period 1983 – 1987, the mortality rate for all children under five years of age was 155 per 1,000 births. The Northern, Upper West and Upper East Regions were the worst units (222 per 1,000 live births), followed by Central Region (208 per 1,000 live births). The report further revealed that over 60% of deaths among children under five were caused by preventable conditions and infectious diseases such as malaria, diarrhoea, low birth weight, anaemia,

kwashiorkor, tuberculosis, measles, diarrhoea diseases and acute respiratory infections. Ten percent (10%) of children die as a result of causes related to malnutrition and an equal number from low birth weight. The report estimated the maternal mortality rate at 214 per 1,000 live births.

The Ghana Community report (2000), touched on the status of health in the country and indicated that the crude death rate was estimated at about 12 per 1,000, having dropped from over 16 per 1,000 a few decades back. Infant and under-five mortality rates, however, still remained unacceptably high (55 and 108 per 1,000 respectively). Even though the report admitted that reliable figures on maternal mortality rates were not readily available, it estimated the rate at 214 per 100,000, stating that in the rural communities where health facilities were minimal, the rate could be as high as over 500 per 100,000. The report revealed that malaria is endemic in the country and is the single largest killer, especially of infants and children. Pregnancy-related problems were also identified as constituting a major health hazard in Ghana.

According to the report, there was limited information on maternal morbidity. Serious illness and disabilities caused by pregnancy complications were common but were not documented well enough to obtain trends.

Maternal morbidity was high in Ghana, primarily because of low accessibility to services, inadequacies in the quality of services as well as social, cultural and economic factors that inhibited progress in achieving results.

On malnutrition, which is widespread among women and children in Ghana, the National Nutrition Survey (1986) indicated that 40.3% of children 0 – 6 months old were below 80% of the US-NCHS weight-for-age standard while 51% were below 90% of the height-for-age standard. 36% of women were found to be severely underweight during the lean season and 19% during the rest of the year.

In the Upper East region where Bongo is situated the rate of malnutrition was high. According to the Ministry of Health Nutrition Survey report (1997) about 38% of children in the Upper East region were under weight. The peak age group was 30 – 35 months. The most affected districts are Bongo and Bawku East.

Wasting was found in 18.6% of children in the region. The 14 – 17 month's age group being the most affected.

Stunting which is a measure of chronic malnutrition was 31% in the region. The 30 – 35 month's age group was most affected. The morbidity rate for children (diarrhoea and fever) in the region was 48% and 76% respectively.

In the Bongo district, nutritional problems prevailed due to inadequate availability of food. Children as well as adults suffer from malnutrition. In 1995 the district had an average malnutrition rate of about 5%. The average malnutrition rate for 1996 was 24.4% and 28.0% for 1997. Between January and March 1998, out of 3330 children aged

between 0 – 59 months, an average of 33.3% were severely malnourished (Bongo ADP Generic Proposal document, 2000. P.17)

According to the population census (2000), the Bongo district, which has a population of 76,773, and covers an area of 459.5km², has the highest population density of the 110 Districts in the country – 194 persons per km², three times the national average.

This population pressure, added to the fact that the vegetation in the district is Guinea Savannah, has a large expanse of rocks covering two-thirds of the land area. These interlocking factors have led to excessive fragmentation of land and efficient farming systems, thus seriously degrading the soils. This has led to near desertification, declining crop yield and low household incomes.

In spite of this land situation, the main economic activity has been agriculture (crops and livestock), which constitutes 70 – 80% of the district's occupation. Hence, over the years there has been perennial food shortages in the district, which has affected the nutritional status of mainly children and women.

The district, comprising 137 communities, has only one Health Centre and six sub-district health posts. The doctor/patient ratio in this district is 1 per 100,000 inhabitants. In 1996 the infant mortality rate in the district was 150/1,000 and dropped to 105/1,000 in 1998. The maternal mortality rate is 136/1,000 live births. Infant morbidity rate (0 – 5 years) is 105/1,000. The malnutrition rate was 28.0% in 1997 and 34.1% in 1998, the rise

attributable to a drought in 1998.

The five top diseases in the district are malaria, skin diseases, diarrhoea diseases, anemia and snake bites (Bongo ADP Generic Proposal documents 2000).

It is against this background of acute health and nutritional problems in the northern regions of Ghana that the Government of Ghana and Non-Governmental organizations have focused their attention on that part of the country in an effort to mitigate the crisis.

Among the Non-Governmental Organizations, which have embarked on health and nutrition programmes to supplement the efforts of the Government of Ghana in Northern Ghana and other rural areas are: Action Aid Ghana, Oxfam, Water Aid, ADRA, and World Vision Ghana.

World Vision Ghana, a Christian relief and development agency has since 1979 pursued eight major programme areas to meet the needs of the poorest of the poor in Ghana. Paramount among these programmes is the health and nutrition programme.

World Vision has nineteen Area Development Programmes (ADPs) scattered throughout Ghana and the health and nutrition component runs through all of the ADPs.

In an effort to help address the health and nutrition problems in the Bongo district, the World Vision Bongo ADP embarked on the Health and nutrition programme soon after

its establishment in 1996, with the following objectives:

1. To reduce malnutrition in children (0 – 5 years) and expectant mothers.
2. To promote immunization of children against the six (6) childhood killer diseases.
3. To improve Primary Health Care activities and health infrastructure for effective health delivery services.
4. To facilitate the provision of treated water to control skeletal and dental flourosis among 35,000 children in endemic communities.

The components of the programme include:

- i. Supplementary feeding for children (0 – 5 years) and expectant mothers.
- ii. Training of mothers on exclusive breast-feeding, weanimix preparation, and Nutrition management.
- iii. Community education on pre and post -natal clinics, and importance of immunization.
- iv. Training of community health and Nutrition volunteers.
- v. Immunization of children in collaboration with Ministry of Health.
- vi. Purchase of equipment for the health centre and health posts.
- vii. Construction of health and Nutrition infrastructure.

The programme is implemented in collaboration with the District Assembly, the District Health Management Team (DHMT) and the Ghana Education Service (GES), in respect of the supplementary feeding programme.

The programmes at the community level are implemented in the beneficiary communities through health and nutrition volunteers who are required to:

- Organize the people for health education and other health and nutrition related activities.
- Identify and report promptly to either the DHMT or World Vision any disease outbreak in the community.
- Administer basic First Aid in the community.
- Give peer counseling on HIV/AIDS and other Sexually Transmitted Diseases (STDs)
- Advise community members on Family Planning.

The programme covers 42 communities in seven zones in the Bongo district.

1.1 Statement of the problem

Although the programme has been running for the past six years, no independent evaluation has been done of the programme to ascertain the level of its effectiveness.

Questions that need to be answered are:

1. To what extent were beneficiary communities involved in the design, planning and implementation of the programme?
2. How far are the objectives of the project being met?
3. What is the level of collaboration among participating agencies in terms of sharing of resources?

1.2 Objectives of the study

- a. To assess the level of collaboration among participating agencies in terms of sharing of resources.
- b. To find out whether the health and nutrition programme is achieving its set objectives.
- c. To find out in what ways the programme is meeting the needs of women, children and the elderly.
- d. To make recommendations for the improvement of the programme through dissemination of research results.

1.3 Research questions

- i. How was the health and nutrition programme designed?
- ii. How is it being implemented?
- iii. Have malnutrition and disease been reduced in the beneficiary communities?
- iv. What health and nutrition infrastructures have been provided in the communities?
- v. What has been the outcome of the programme between 1996- 2002?
- vi. What specific steps are being taken to address the health and nutrition needs of women, children and the elderly?
- vii. Is the programme meeting its set objectives?
- viii. What effects are the interventions having on the beneficiaries?
- ix. Are there any lessons worthy of replication in health and nutrition programmes being implemented in other ADPs in the country.?

1.4 Significance of the study

It is hoped that this study will be of immense benefit to the sponsors of the various World Vision Health and Nutrition Programmes, Bongo ADP in particular and World Vision as a whole. Beneficiary communities as well as individuals stand to benefit from the study. This is so because the study will bring to light weaknesses in the programme and suggest ways to improve upon them, to ensure the provision of quality service to the communities. The study will also be beneficial to practitioners in the field, in that, they can draw lessons from the disseminated results.

As is true of most evaluation studies, this study is going to be formative. It will provide opportunity for the implementers of the programme in Bongo ADP to know where they are going with regard to set objectives and to help them to re-focus or take corrective action.

World Vision as an organization will benefit because other ADPs undertaking the health and nutrition programme will learn from the results of the study and improve their performance.

Moreover, the communities in which these programmes are implemented will be sure of getting quality service and also have the opportunity to participate in what concerns them. The study will have a lot to offer practitioners on the field since it will become a source of reference. The scholarly world is not left out since research students can reference the qualitative work that will be presented and build upon the results. Last but not the least,

the nation as a whole stands to benefit from the study. This is so because if the right impact is made by various health and nutrition providers as a result of the learning they acquire from this study, Government's responsibility of meeting the health and nutritional needs of the people would be enhanced.

1.5 Limitations of the study

The language spoken in the Bongo area is Frafra, a language the researcher did not understand. He therefore had to rely on interpreters during some of his interactions with the people. Some information may thus have been lost through interpretation. Moreover, the researcher was compelled by this constraint to concentrate more on people who could express themselves in English. Thus leaving out people who would have provided vital information.

Some of the units of the sample were not accessible and had to be replaced at the last minute. The researcher was even compelled to reduce the sample size.

1.6 Definition of terms

It is necessary to define terms used in the study right from the start. These terms are:

Health: The World Health Organization defines health as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity.

Nutrition: Galguillo (1999) defines nutrition as the way our bodies take in and use food. Foods that are great sources of nutrition are called nutrients.

Evaluation: Bhola (1979) defines evaluation as the process of judging the merit or worth of something.

ADP: Area Development Programme

CHAPTER TWO

REVIEW OF RELATED LITERATURE AND CONCEPTUAL FRAMEWORK

2.1 Review of related literature

In this section the researcher attempted to look at and discuss literature related to the dissertation, so that he can view the issue from other people's perspectives as well.

2.1.1 Nutrition

Various researchers have underscored the importance of good nutrition to growth and development and highlighted the devastating effects of malnutrition.

Tayie, et al, (2001) establish a relationship between food intake and socio-economic status. They identify elderly people as being more prone to malnutrition. They observe that elderly people do not eat adequately and attribute this to the following reasons: insufficient income, insufficient skills to select and prepare nourishing and well-balanced meals, dental problems, limited mobility, feeling of rejection and isolation that obliterate the incentive necessary to prepare and eat a meal alone.

They contend that such physiological, psychological, social and economic changes can cause malnutrition and further physical, mental and sensory deterioration. They observe further that elderly people with less education are likely to have lower incomes and fewer sources of information. The individual with limited reading ability has lesser opportunity for nutritional information. They recommend supplementation of vitamins and minerals

for elderly persons who are not consuming adequate nutrients. They are also of the view that community nutrition policies and programmes should promote better health among older people through health education, counseling, and the limited delivery of food services.

Tayie, et al, (ibid.) observe that many chronic disorders that occur in elderly people are influenced either directly or indirectly by earlier food selection. Encouraging the intake of appropriate amounts and types of food can prevent malnutrition in elderly individuals.

Manocha (1972) relates nutrition to growth and observes that good nutrition promotes the production and activities of the growth hormone which influences the metabolism of proteins, carbohydrates, fats, and minerals and permits nitrogen retention. A lack of adequate nutrition will hinder such a natural growth pattern, and physiological abnormalities or even retarded mental development may accompany a stunted physical growth.

Balderston et al., (1981) in support of Manocha's observation (1972) indicated that malnutrition is not just a simple deprivation of food, but a more complicated interaction of nutrient needs and health, based on the level of metabolic and activity processes and the presence of infection. They observe that stunting and wasting occur as a result of prenatal malnutrition, the mother's general health and nutritional state, her condition during lactation and the child's early diet.

The FAO report (1993), takes a broader perspective of nutrition to argue that under-nutrition is most common in pre-school children, women of child-bearing age, school age children, old people (confirming the assertion by Tayie et al (ibid.), refugees and deprived people living on emergency rations. The organization identified the causes of under-nutrition to include disease, pregnancy and childbirth

The report further revealed that under-nourished people have less energy to work, learn and enjoy themselves. Moreover, under-nourished children perform less at school and the emotional and social development of pre-school children may be retarded because under-nourished children are apathetic and miserable and so get less stimulated from and interaction with other people. Besides during the period of under-nutrition there is increased risk of complications and death to mothers and babies during pregnancy and childbirth

Green and Ottoson (1994) support the use of breastfeeding in ensuring infant nutrition when they argue that breast milk alone, without supplements, is the optimal choice for feeding full term infants for the first six months. Mothers' milk contains an ideal balance of nutrients, enzymes, immunoglobulin, anti-infective and anti-inflammatory substances, hormones, and growth factors that protect the infant and encourage growth.

From the literature, it is clear that it is important for any nutrition programme to pay attention to the elderly, the pregnant and nursing mother, infants and children. Supplementary feeding programmes in schools and nutrition education in schools and

communities will contribute greatly to the success of programmes.

2.1.2 Nutrition education

Nondasuta et al, (1983) identify nutrition education as being essential to village nutrition programmes. They advocate the need to concentrate on pregnant and lactating mothers in teaching basic nutritional knowledge to increase their management skills in the supplementary food programmes.

Saleh (1990) defines nutrition education as the teaching of nutrition knowledge in ways that promote the development and maintenance of positive attitudes and behavioural habits towards eating nutritious foods. This, to him, will ultimately contribute to the sustenance of personal health, well-being and productivity.

The World Bank report (1999) identifies nutrition education, Vitamin A supplementation, and breast feeding promotion as being among the most cost-effective public health interventions.

The programme's promotion and education of mothers on the use of exclusive breast feeding finds support with Green and Ottoson (1994) who support the use of breast feeding in ensuring infant nutrition. They argue that breast milk alone, without supplements is the optimal choice for feeding full term infants for the first six months. According to them mothers' milk contains an ideal balance of nutrients, enzyme

immunoglobulin, anti-infective and anti-inflammatory substances, hormones, and growth factors that protect the infant and encourage growth.

They call for nutritional counseling for women and their families during pregnancy. This to them, provides an opportunity to educate women not only about their own nutritional needs during pregnancy but also about the future needs of their infants, themselves and their families. They add those nutritional counseling needs to consider the recommended balance of food and should be sensitive to the cultural preferences and economic circumstances of the mother. This is particularly important and urgent in the Bongo district where in the words of interviewee 25 “there are some areas where school children are not allowed to take eggs, pregnant women are not allowed to take eggs, pregnant women are not allowed to visit clinics, and even to take injections, some are not supposed to cut their hair”

The identification of education as an integral component in health and nutrition programmes is very important. This is because so long as people's attitudes and habits remain the same the provision of health facilities and adequate food will not solve any problem

2.1.3 Health and nutrition service delivery

Kennedy (1991) writes on the factors contributing to the success of nutrition programmes in Africa. She observed that implementation issues appear to be critical in the success or failure of nutrition interventions throughout the world. She noted that the impact of any

nutrition programme depended on whether community participation is ensured or not. She stated further that effective community participation generally results in pooling of public, private and foreign aid resources for the project and the communities assuming responsibility for the project. To her community participation means active participation (fiscal responsibility, programme design, selection of personnel and or local level evaluation by the intended programme recipients) in the planning and implementation of programmes.

Colle (2002) advocates the use of paraprofessionals in health and nutrition service delivery. He defines the paraprofessional as the kind of village health worker who generally has less than a year of professional training, and who has a large amount of day-to-day autonomy in providing Health and nutrition services to rural low income populations.

He identified seven areas to consider when using paraprofessionals in service delivery. These are:

1. Legitimization: Convincing villagers that the village health worker who was once one of them now has the skills to handle matters of life and death.
2. Protecting role integrity: Helping define the limits of the demands that can be made on paraprofessionals.
3. Motivation: Sustaining enthusiasm for work when isolation and lack of rewards and compensation often make the original glamour of the job fade.
4. Monitoring and control: Checking on performance and collecting data related to

services.

5. Education and guidance: improving and expanding the service provided, technical assistance providing help for specific cases.
6. Linkage: Helping paraprofessionals establish and maintain contact with human and material resources vital to the task.
7. Evaluation: Making judgements concerning the performance of paraprofessionals.

Nondasuta, et al, (1983) supported the use of para-professionals in health delivery when he advocated the use of Village Health Communicators (VHC) and Village Health Volunteers (VHV) in health delivery Programmes. He touched on the aspect of motivation for the Volunteers when he cited the example in Thailand where the government provided them with free medical services and a certificate upon completion of their training.

The recognition of the need for community participation and the use of village volunteers in health and nutrition programme delivery is a step in the right direction. It will make community members more committed to the programme. However, the researcher thinks that both Colle and Nondasuta failed to realize that people cannot be made to volunteer for long and that there is the need for a well-spelt out motivation package for village volunteers.

2.1.4 Community health education

Health education in the community seeks to elicit, facilitate, and maintain positive health practices by assuring that people have the understanding, skills, and support needed for their voluntary adoption of activities conducive to their health. Health education concerns itself not only with current behaviour such as preventive actions, appropriate use of health services, health supervision of children from birth to adolescence, and adherence by adults and children to appropriate medical and nutritional regimens. But also with the development in children and youth of a foundation for future health (Green and Ottoson, 1994).

2.1.5 Maternal health promotion

Green and Ottoson, (1994) posit that prenatal care should be sought early in pregnancy, preferably during the first three months. Health education, early detection of abnormalities and identification of the high-risk mother and infant are the major purposes of prenatal care. They note that early care reduces infant mortality and low birth weight. Infants of women who receive no prenatal care have about 10 times the risk of dying in the first months of life.

They call for nutritional counseling for women and their families during pregnancy. According to them, this provides an opportunity to educate women not only about their own nutritional needs during pregnancy but also about the future needs of their infants, themselves and their families.

They add that nutritional counseling needs to consider the recommended balance of food and should be sensitive to the cultural preferences and economic circumstances of the mother.

WHO/UNICEF (1996) observe that the negative outcome of poor health and nutrition among women is high prevalence of maternal mortality nearly 600,000 women in developing countries die each year from pregnancy related causes.

In the rural communities in Ghana, due to the high level of ignorance and illiteracy, health and nutrition programmes need to attach a lot of importance to the counseling component.

In most rural communities in Ghana, the causes of most preventable diseases are attributed to supernatural sources. It is against this background that the researcher agrees with Green and Ottoson on the need for an effective health education package for women. The education should however, not be limited to the women, but should be extended to the men as well. This is important because men are the decision-makers in many homes in Ghana, and the women cannot do anything without their consent.

2.1.6 Child health

WHO (2002) report that children under five years of age account for more than 50% of the global gap in mortality between the poorest and the richest countries of the world's population. The report states further that more than 50% of all child deaths are due to

just five communicable diseases which are preventable: pneumonia, diarrhoea, measles, malaria and HIV/AIDS. Children are particularly vulnerable during early life.

Latham (1997) writes that 192 million children globally suffer from Protein energy malnutrition (PEM) and 2,000 million experience micronutrient deficiencies.

These revelations on maternal and child health call for a special attention to these groups in the delivery of health and nutrition programmes.

2.1.7 School health programmes

Green and Ottoson (1994) advocate for the institution of comprehensive school health programmes that educate children about parenthood, sexuality, personal hygiene, substance abuse and nutrition. To them the programme should be on a community -wide basis and should be supported by health services and environmental protection within the school setting and in the community.

2.1.8 Health education methods and theories

Green and Ottoson (1994) again write on health education methods and theories. They identify three basic types of educational strategies:

1. Direct Communications with the target population to predispose behaviour conducive to health. These include lecture - discussion, individual counseling or instruction, mass media campaigns, audio-visual aids, educational television, and programmed learning.

2. Training methods to enable or reinforce behaviour conducive to health. These include skill development, simulations and games, inquiry learning, small group discussion, modeling, and behaviour modification.
3. Organizational methods to support behaviour conducive to health. These include community development, social action, and social planning, and economic and organizational development.

2.1.9 Participation

Burkey (1993) notes that participation by people in the institutions and systems, which govern their lives, is a basic human right and also essential for realization of political power in favour of disadvantaged groups and for social and economic development. He adds that rural development strategies can realize their full potential only through the motivation, active involvement, and organisation at the grassroots level of rural people with special emphasis on the least advantaged. Conceptualizing and designing policies and programmes and in creating administrative, social and economic institutions, including co-operatives and other voluntary forms of organisation for implementing and evaluating them are also effective strategies in rural development. He adds that participation of the rural poor in their own development has been measured as a key factor in the success of projects.

Cohen and Uphoff (1977 cited in Burkey, *ibid.* p.56) cite a study by Development Alternatives Inc. based on an evaluation of over 50 rural development projects. The study found that local participation in decision-making during implementation was even more critical to project success than such participation in the initial design. They note that local action taken by farmers to complement outside measurement and resources accounted for half the variation in overall success rankings, and farmer involvement in decision-making in the implementation phase was one of the two factors found to be most significant in promoting overall project success.

Burkey (*ibid.*) notes further that participation is an essential part of human growth, that is the development of self-confidence, pride, initiative, creativity, responsibility, and co-operation. Without such a development within the people themselves all efforts to alleviate their poverty will be immensely more difficult, if not impossible. The process whereby people learn to take charge of their own lives and solve their own problems is the essence of development, he adds.

He notes again that unfortunately, participation, even when taken beyond mere rhetoric, is often felt to be sufficient, for example, when villagers turn out on request to dig irrigation channels or build roads merely to participate in the labour element of project implementation. Participation in project design and decision-making is all too often limited to a few village meetings where the project is explained and the people are asked to give their comments, and where a few comments made are by the school teacher in a language unintelligible to the majority. To him, participation, if it is to really release the

people's own creative energies for development, must be much more than the mere mobilisation of labour forces or the coming together to hear about pre-determined plans. Participation must be more than a policy statement – there must be genuine commitment to encourage participation in all aspects and at all levels of development work. He adds that it is becoming more and more apparent that the first step in achieving genuine participation is a process in which the rural poor themselves become more aware of their own situation, of the socio-economic reality around them, of their real problems, the causes of these problems, and what measures they themselves can take to begin changing their situation.

Axinn and Axinn (1997) note that by the middle of the 20th century, it was recognised in both agricultural extension and in community development that those affected by any development activity must participate in it if it was to satisfy their needs and endure over time. They note further that the extent to which the clientele participate in all aspects of planning and implementing the programme is directly related to its success.

It follows from the foregoing discussion on participation that beneficiaries of intervention programmes should not only be informed about pre-determined plans to provide solutions to their problems, and be asked to provide labour. They must be involved right from the design, through the implementation to the evaluation of the programme.

2.2.1 **Programming concepts**

The following programming concepts underlie this study.

i. **Programme design**

Development workers agree that for a programme to be successful it should not be imposed on the beneficiaries. The latter should be actively involved right from the design of the programme to feel committed.

Axinn and Axinn (1997) state that there is the need for collaboration between insiders and outsiders in all aspects of project planning, implementation and evaluation. They mention instances where people in North America and Europe who were involved with programmes designed to help enhance development in Asia, Africa and Latin America assumed that they had the answers to problems which needed attention, and the major strategy was one of delivery. This assumption led to the failure of the programmes.

They point out that programme development is essentially a planning process. Planning is a decision-making activity in which an individual or a group decides what to do. They argue that this clarifies the process so that all persons involved can know what the group is trying to do. They note further that programme design is also a process of deciding how to do what they have chosen to do, and when, where and by whom it is to be done. According to them, when two or more groups are collaborating, this joint decision-making is crucial to the process.

2.1.10 Collaboration

Axinn and Axinn (1997) define collaboration as a mode in which specialized professionals from any one field or discipline acknowledge that they need to work with and support specialized professionals from other fields. Thus the collaborative mode involves collaboration among insiders and outsiders at all levels, and also collaboration among individuals from various different specialized fields at every level.

According to them professional collaboration is built on each collaborator (person, organisation, or nation) having something to give to the relationship, and something to gain from it.

The decision by World Vision to work with the Bongo DHMT and other stakeholders in the implementation of the health and nutrition programme is therefore a step in the right direction. Through the collaboration all participating bodies will achieve their objectives as they supplement the efforts of each other.

2.2 Conceptual framework

A number of concepts have been developed on how to undertake successful intervention programmes and also how to evaluate programmes. These include:

ii. **Needs Assessment.**

There have been various definitions of Needs Assessment. These include:

1. “Activities that include surveys of various targeted populations, assessment of prevention resources within the state, studies of current outcome indicators, geodemographic analyses of Social marketing data, and household and School surveys”. (Ref: preventionpartners.samhsa.gov/resources_glossary_p2.asp).
2. “An analysis that studies the needs of a specific group (employees, clients, managers), presents the results in a written statement detailing those needs (such as training needs, needs for health services, etc), and identifies the actions required to fulfill those needs, for the purpose of programme development and implementation”. (Ref: www.nonprofitbasics.org/CompleteGlossary.aspx).

Okedera (1981) observes that agencies of Adult Education have to assess needs and interests because they are often not voiced out. Assessment may be done by observation, interviews, and questionnaires, studying written evidence or by calling a meeting (in conjunction with the leaders in an area or organization).

Ellis (2000) mentioned the use of Rapid Rural Appraisal (RRA) which seeks to achieve a quicker, more accurate, and less expensive means of gathering relevant local information for project purposes.

Chambers and Blackburn, (1996) talk of the use of Participatory Rural Appraisal (PRA) in assessing needs of rural communities. They describe PRA as a vehicle for empowering people to take control of their own lives, and ideally, many of its key components become institutionalised as ongoing processes of plural and democratic decision-making in rural communities. They add that the Primary role of the outsider in “true” PRA is as facilitator and equal sharer of ideas and information, it is not information acquisition, and it is not arriving with pre-packaged technical solutions to local problems.

iii Programme implementation.

Kennedy (1991) writes on the factors contributing to the success of nutrition programmes in Africa. She observed that implementation issues appear to be critical in the success or failures of nutrition interventions throughout the world. She noted that the impact of any nutrition programme depended on whether community participation is ensured or not. She stated further that effective community participation generally results in pooling of public, private and foreign aid resources for the project and the communities assuming responsibility for the project. To them community participation means active participation (fiscal responsibility, programme design, selections of personnel and or local level evaluation by the intended programme recipients) in the planning and implementation of Programmes.

Nondasuta et al, (1983) supported the use of professionals in bulk delivery when they advocated the use of Village Health Communicators (VHC) and Village Health Volunteers (VHV) in health delivery programmes. They touched on the aspect of motivation for the volunteers when they cited the example in Thailand where the government provided volunteers with free medical services and a certificate where their training was complete.

2.2.2 Concepts of evaluation.

a. Process studies and evaluation.

Patton (1990) notes that a focus on process is a focus on how something happens rather than on the outcomes or results obtained. Groups, programmes, even entire organizations may be characterized as highly “process oriented” if how members and participants feel about what is happening is given as much attention as the results achieved.

According to Patton (ibid.) process evaluations are aimed at elucidating and understanding the internal dynamics of how a programme, organization or relationship operates. Process evaluation looks not only at formal activities and anticipated outcomes but they also investigate informal patterns and unanticipated interactions. A variety of perspectives may be sought from people with dissimilar relationships to the programmes inside and outside sources. He adds that process data permits judgements to be made about the extent to which the programme or organization is operating revealing areas in which relationships can be improved as well as highlighting strengths of the programme that should be preserved. Process descriptions are also useful in permitting people not intimately involved in the programme for example, external sponsors, public officials and

external agencies, to understand how a programme operates. This permits such external persons to make more intelligent decisions about the programme. Formative evaluations aimed at programme improvement often rely heavily on process data. Finally, process evaluations are particularly useful for dissemination and replication of model interventions where a programme has served as a demonstration project or is considered to be a model worthy of replication at other sites. By describing and understanding the dynamics of programme processes, it is possible to isolate critical elements that have contributed to programme successes and failures.

b. Implementation evaluation

It is important to know the extent to which a programme is effective after it is fully implemented; but to answer that question it is important to know the extent to which the programme was actually implemented. Williams, (1976) states that in the lack of concern for implementation is currently the crucial impediment to improving complex operating programmes, policy analysis, and experimentation in social policy areas. A decision-maker can use implementation information to make sure that a policy is being put into operation according to design or to test the very feasibility of the policy. Unless one knows that a programme is operating according to design, there may be little reason to expect it to produce the designed outcome. Where outcomes are executed without knowledge of implementation the results seldom provide a direction for action because the decision-maker lacks information about what produced the observed outcomes.

One important way of studying programme implementation is to gather detailed descriptive information about what the programme is doing, he adds. Implementation evaluation includes attention to inputs, activities, processes, and structures. It tells decision-makers what is going on in programme, how the programme has developed, and how and why Programmes deviate from initial plans and expectations.

c. **Evaluation models**

Bhola (1979) defines evaluation as a process of judging the merit or worth of something. He presents many evaluation models. Among these is the Context Input, Process product (CIPP) model now context, Input Process, Output, Outcome (CIPOO) model propounded by Daniel L. Stufflebeam (1982), cited in Bhola (1984) The CIPP model considers four evaluation areas.

- **Context evaluation:** to provide information on the setting
- **Input evaluation:** to make programming decisions such as the alternative project design and personnel decision
- **Process evaluation:** to make decisions related to methodology and implementation
- **Product evaluation:** to evaluate impact and to make recycling decisions.

Bhola makes a distinction between formative and summative evaluation. While formative evaluation provides opportunity for learning and improving on programme performance, summative evaluation is about making end of term judgements about the success or failure of programmes. He contends that all evaluations are inherently formative in nature.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter gives information on the research design, the target population and sample size, and the sampling techniques. It also talks about the data collection procedures, issues of reliability and validity and how data were analysed.

3.1 The research design

The study used the case -study approach with the focus on the Bongo health and nutrition programme.

Yin (1994) defines a case study as an empirical inquiry that investigates a contemporary phenomenon within its real life context, especially when the boundaries between the phenomenon and context are not clearly evident.

Merriam (1988) defines a qualitative case study as an intensive holistic description and analysis of a simple instance, phenomenon, or social unit.

Miles and Huberman (1994) think of the case as "a phenomenon of some sort occurring in a bounded contest".

Looking at all these definitions the researcher agrees with Merriam (2001) that the single most defining characteristic of case study research lies in delimiting the object of study,

the case.

Smith's (1978) notion of the case as a bounded system and Stake's (1995) definition of the case as an "integrated system" helps one to see the case as a thing, a single entity, a unit around which there are boundaries.

3.1.1 The Target Population and the Sample size

The population for the study was made up of males and females- both School Children and adults- drawn from beneficiary communities of the Health and Nutrition Programme. In all, 24 respondents, made up of 14 males and 10 females, selected from 11 communities constituted the target population. Out of this number eight were Children.

3.1.2 The Sampling Technique

The non-random sampling strategy was used to draw out the sample size of 36.

Under this strategy, the purposive sampling method was used to select four out of the seven zones where the programme was being run. The selected zones were Soe zone, Beo zone, Namoo zone and Bongo zone. Three communities were then selected purposively from each of these zones.

Purposive sampling was again used to select 36 respondents according to the following criteria:

1. The selected person should be somehow associated with the health and nutrition programme and thus have information on it.
2. At least one interviewee in each community should be a woman
3. All respondents should be able to express themselves in English.

The sample traced is illustrated below:

3.1a **Sample population**

Zone	Community	Number of respondents
Beo	Kansingo	2
	Wagliga	3
	Adaboya	2
Soe	Yidongo	3
	Soboko	3
	Sanaabisi	3
Namoo	Ayopia	2
Bongo	Nayiri	2
	Borigo	1
	Tingre	2
	Atampisi	1
Total: 4	11	24

It is important to note here that a zone is a cluster of communities put together for operational purposes.

3.1.3 Data Collection procedures

Three means were used to collect data. These were the semi- structured interview, reports of World Vision Ghana and informal discussions with project staff.

3.2 Identifying themes and drafting interview questionnaire

Interview questions were focused on two major areas – process evaluation and product/outcome evaluation.

Under process evaluation ideas were developed around the following themes:

- Programme design
- Needs assessment
- Programme implementation
- Programme strengths and weaknesses

Under Product /Outcome evaluation, ideas were developed around these two themes:

- Programme output
- Programme effect on beneficiaries

3.3 Pre-testing of interview questions

The draft semi-structured interview questions were pre-tested at Anaafofobi, where the health and nutrition programme was being run. Some changes were made in the way the questions were initially put at the end of the pre-test.

3.4 Analysis of data

The analysis of the data was done simultaneously with the data collection. As the interview proceeded from one to another, issues, which had not previously been thought about, kept emerging which directed the following phases of the interview. The researcher ended up refining and reformulating interview questions, to get the most out of the respondents. There were times when it became necessary to move entirely out of the originally designed interview questions to get more insight into an emerging fact.

Having looked at the various strategies for analysing qualitative data, the content analysis and the constant comparative techniques were finally selected. In setting the interview questions, some categories or themes initially guided the researcher, but others, which had not previously been thought of, emerged in the course of conducting the interviews. The raw data collected through the interviews were coded, and various categories were simultaneously constructed. These categories were then organised by putting together all units of data that had something in common. From here, the data were analysed.

3.5 Coding and categorising of raw data

Before starting to code the data, the interview transcripts were read through several times till a picture of the overall idea began to form. Words, phrases, and sentences were then highlighted in the transcript, writing the codes ascribed to them against them in the margin of the interview transcript. At this stage categories had already begun to emerge.

3.6 Development of broad themes

Having identified the categories from the coded data, two major broad themes emerged from the categories – process evaluation themes and product/outcome evaluation themes.

The first broad theme – process evaluation, embraced the following categories:

1. Community participation in:
 - a. Programme design
 - b. Needs assessment
 - c. Programme implementation
2. Collaboration
3. Community education on health

The second broad theme, product/outcome evaluation, embraced the following categories:

1. Supplementary feeding for children and expectant mothers.
2. Health and nutrition education for mothers
3. Training of community health and nutrition volunteers
4. Programme outcome
5. Infrastructure development
6. Benefits for the elderly
7. Control of dental flourosis.

CHAPTER FOUR: PRESENTATION OF DATA

In this chapter raw data (Quotes) from interviews of programme staff and beneficiary communities are presented.

The table over leaf shows the various categories of themes that emerged from the responses given by the interviewers. The information given under the supporting data column are direct quotes from respondents. The only changes made are attempts at correcting the grammar. The information in the interpretation column is an attempt at giving meaning to the quotes from the respondents.

CATEGORY (of theme)	SUPPORTING DATA	INTERPRETATION
Community participation in programme design	“At the Regional Coordinating Council meeting it was realized that the problem of Bongo was health and Nutrition after giving their profile. And Bongo was also identified as the poorest among all the six districts. So they chose Bongo.” Quote from interview of project staff.	Bongo selected for the project because Health and Nutrition was a problem there. Also because of the high rate of poverty. Design of programme began at the Regional level.
	“At Bongo there was a start-up meeting in 1996, where we invited all the District Assembly members and the heads of the decentralized departments and opinion leaders of all the communities in Bongo, precisely the 137 communities. At that meeting we decided to divide the interventions into three phases.” Quote from interview of project staff.	Start-up meeting at the district level brought all stakeholders together to plan the project.
CATEGORY	SUPPORTING DATA	INTERPRETATION
Programme Design	“From the meetings that we held with them, we came out with some common programmes and interventions that we were supposed to carry out. DHMT, which is our main collaborator in health and Nutrition, had their own programmes that they were to carry out. But because of lack of funds, they were not able to do them.”(project staff)	Programmes and interventions of World Vision and DHMT were spelt out.
	“When we meet them at our Annual Review Workshops, they give us a presentation on what they intend to carry out in the coming year. Based on that when we are writing up our budget we embody it in the budget.” Quote from project staff.	Ministry of Health presents yearly programme to World Vision for incorporation into World Vision budget for the year.

CATEGORY	SUPPORTING DATA	INTERPRETATION
Programme design	“They organized the way that they can help us. But in our little way, the way they are helping us we think it is good. But at least we would have liked that in addition to the food, they supplied the center with other things like medicine, to at least from time to time administer to the children.” Quote from a beneficiary community member.	Community not involved in the design of the programme.
	“Before World Vision came out with that programme, we the Unit Committee members met with World Vision to discuss the idea. So we were sent by World Vision to talk to our people.” (community member)	Programme discussed with Unit Committee members.
CATEGORY	SUPPORTING DATA	INTERPRETATION
Programme design	“They called the community and sensitized them on the programme. So they agreed.” (community member)	World Vision discussed programme with community
	“The Workshop they run, they invited the health workers, and even all the departmental heads – the Agric people and all the rest. They did not discuss only the health, but all what their plans were and how they could go about it” (community member)	World Vision discussed programme with stakeholders.
CATEGORY	SUPPORTING DATA	INTERPRETATION
Community participation in programme Design	“Before they started the programme, they came to the community and talked to them so that the community would know what World Vision was going to do.” (community member)	Community informed about programme
	“We went to World Vision that we needed a health and nutrition programme and they responded to our request” (community member)	Health and Nutrition programme was an initiative from the community.

	“The World Vision people came and talked to the community about the programme.” (community member)	Community was informed about programme.
	“The idea has been a long-standing one with District Assembly. It was embodied in the five-year development plan of the District Assembly. So when they came in, they looked at the document and knew that this was an area people needed.” (Local management committee member)	Programme embodied in the development plan of the District Assembly.
	“They came and we listed the activities.” (community member)	Community involved in listing activities to constitute programme

CATEGORY	SUPPORTING DATA	INTERPRETATION
Community participation in needs assessment	“Most at times they came and called the community to sit down and try to find out what our needs were” (community member)	Community involved in needs assessment.
	“They came from time to time to educate the community and to discuss their problems with them” (community member)	The project did occasional assessment of community needs.
	“We lacked health facilities so we asked for a clinic but that has not been done yet.” (community member)	Not all the needs expressed by the community are met.
CATEGORY	SUPPORTING DATA	INTERPRETATION
Community participation in needs assessment	“There was a project committee in place here to assist World Vision in bringing out problems that people faced in the community.... So they organised a meeting at the community level. They came to discuss what we were to carry out, and prioritized them, so they knew where to start from.” (community member)	Needs assessment done at the community level.
	“You know they have this Annual Review of World Vision Programmes, and they invited we the Area Council members. We went for a meeting first and we listed what we needed, then we met all the other areas and tried to prioritize, because they could not cover all the needs.” (Area Council Member)	Need assessment was done with Area Council members and prioritized.

CATEGORY	SUPPORTING DATA	INTERPRETATION
Community participation in needs assessment	“They called us to a meeting to discuss our problems with us and how they could help us.” (community member)	Needs assessed at community level.
	“They sat down with them to discuss what they needed.” (community member)	Needs assessed at community level
	“They discussed the problems of the community with them and they talked about building the Nutrition Centre.” (community member)	Needs assessed at community level
	“They never sat with us before they came out with the construction of the Centre. They just initiated the idea that it was good they did this for the community.” (community member)	Community not involved in decision to put up the Nutrition centre.

CATEGORY	SUPPORTING DATA	INTERPRETATION
Community participation in needs assessment	“They spoke to the community and we came out. We even asked them that we needed a Nutrition Centre for the children.” (community member)	Needs assessed at the community level.
	“We moved to the communities and had meetings with the community members. They came out with their needs.” (project staff)	Needs assessed at community level.
	“They had done the needs assessment already and therefore knew the problems of the communities. So through that we were able to draw the components of the programme.” (project staff)	Needs assessment carried out by M.O.H. in the communities used by World Vision.
	“They realized that most of the communities in the district were malnourished. Because of that they identified certain areas where the situation was more serious and they asked World Vision if they could put a Rehabilitation Centre for the World Food Programme to assist in providing food.” (staff of DHMT)	Nutrition division of the DHMT guided by data available to them in deciding programme and beneficiary communities.

CATEGORY	SUPPORTING DATA	INTERPRETATION
Community participation in programme implementation	“On the part of the Nutrition Centre the people supplied the labour.” (staff of DHMT)	Community contributed labour for the construction of the Nutrition centre.
	“They formed a project committee and the community contributed some money to open an account and World Vision paid money for the project into the account. The community also contributed labour.” (community member)	Community contributed money and labour to help with the implementation of the project.
	“They came and sat with the community to discuss the construction of the Nutrition Centre.” (community member)	Project discussed with the community before being carried out.
	“The Ministry of Health people came and asked for volunteers so the community selected them.” (community member)	Community involved in the selection of Village Health Volunteers.
CATEGORY	SUPPORTING DATA	INTERPRETATION
Community participation in programme implementation	“Then at the district level the community leaders interacted during workshops to convey what was happening in the community so that they could discuss them and come out with solutions.” (project staff)	Community leaders participated in workshops where issues in the community were discussed.
	“The community carried sand, collected stones, provided water and offered labour.” (member of a local project committee)	Community provided local materials and labour during construction of the Nutrition centres.

CATEGORY	SUPPORTING DATA	INTERPRETATION
Community participation in programme implementation	“We had to contribute to open a bank account before World Vision gave us assistance. And from time to time we had local contributions to support. This included hiring a vehicle to collect sand to augment what the people were doing.”(member of a local project committee)	Community contributed financially towards the construction of the Nutrition Centre.
	“They were selected by contacting opinion leaders to find out who was capable and prepared to assist.” (community member)	Village Health Volunteers selected with the help of opinion leaders.
	“The community helped by sending their children to school and organising the people to bring out their children for weighing when the Ministry of Health people came to work here. ” (community member)	Community participated in the Health and Nutrition project by sending their children to the Nutrition centres and also making them available for weighing.

CATEGORY	SUPPORTING DATA	INTERPRETATION
Community participation in programme implementation	"The chief, Unit Committee members, and the opinion leaders helped the World Vision people to bring us together." (community member)	Key people in the communities supported the implementation of the programme.
	"And they would get some committees so that they would be taking care of the food in order that we would not use them aimlessly or misuse them." (Worker in a community Nutrition centre)	Community involved in the management of the supplementary feeding programme.
	"Every child contributed thousand cedis and they used that to buy ingredients, the firewood and all the nutrients." (Worker in a community Nutrition centre)	Community contributed financially towards the supplementary feeding programme.
	"So the community was able to come out to also participate with communal labour." (community member)	Community contributed labour in the construction of the Nutrition Centre.

CATEGORY	SUPPORTING DATA	INTERPRETATION
Community participation in programme implementation	“Anytime when they came, they called the people and talked to them about what they had for the community. Then they would ask them to select people to do it.”(Village Health Volunteer)	Community involved in selecting Village Health Volunteers.
	“Yes, they talked to us on several occasions and even when they were going to build the Nutrition Centre, they talked to us about it so people understood.” (community member)	Community sensitized on project before it took off.
	“Mostly whenever the food was going to them, the Assemblyman organized a vehicle to convey it and pay the driver.” (community member)	Assemblyman organized transport to convey food to Nutrition centre.
CATEGORY	SUPPORTING DATA	INTERPRETATION
Community participation in programme implementation	“They took the programme as they had been told. When they were taught how to prepare the food for the children, the women tried to implement that.”(Village Health Volunteer)	Women from the communities prepared food for the children at the Nutrition Centres on the suggestions made by Ministry of Health workers.
	“The contributions were from communal labour, fetching water and sand and helping in the construction.” (community member)	Community participated in the construction of Nutrition Centres by providing communal labour.
	“World Vision was responsible for the building. They were to purchase the materials and the community gave communal labour. That was their contribution towards the building of the Centre.”(DHMT Worker)	Community contribution towards building of Nutrition Centre took the form of communal labour.

CATEGORY	SUPPORTING DATA	INTERPRETATION
Community participation in programme implementation	“They agreed that they would give volunteer workers who would be at the centre, to help the children and their mothers.”(DHMT Worker)	Volunteers helped workers at the Nutrition Centres provided by communities
	“They periodically visited the place and any problem there the people knew the Assemblyman was the one they would contact.” (community member)	The Assemblyman assisted in the management of the Nutrition Centre.
	“They cooked in groups on rotational basis. If some women cooked this week, next week they changed to other women.” (community member)	Community women cooked for children at the Nutrition Centre in turns.
	“They organized communal labour to come and help them do the work.” (community member)	Community participation in the construction of Nutrition Centre took the form of communal labour.

CATEGORY	SUPPORTING DATA	INTERPRETATION
Community participation in programme implementation	“We organised the women to convey stones and water for the workers.” (community member)	Women conveyed stones and water in the construction of Nutrition Centre.
	“Any time there was work to be done; the community came out to do it.” (community member)	Community provided communal labour in projects.
	“The community helped by carrying mortar and stones for them to put up the building. We came out to mould the bricks.” (community member)	Community provided labour in the construction of Nutrition Centre.
	“The whole village selected them because they knew very well they could do the work”. (community member)	Community participated in selecting Village Health Volunteers.
CATEGORY	SUPPORTING DATA	INTERPRETATION
Collaboration	“We went there but we did not waste much time because already DHMT had the data, the statistics of the communities.”(project staff)	World Vision used data collected by DHMT to design the project
	“World Vision does not have health personnel as at now, but with the help of the DHMT, we are able to implement our programmes on health issues.”(project staff)	World Vision used personnel of DHMT to implement the Health and Nutrition Programme
	“World Vision per se, we do not have our own programmes, it is the programmes of DHMT that we are helping to implement.”(project staff)	World Vision’s Health and Nutrition Programme was in line with that of DHMT
CATEGORY	SUPPORTING DATA	INTERPRETATION

Collaboration	“The project collaborated with Ghana Education Service, Department of Community Development, Local Council of Churches, besides the District Assembly which was our main collaborator, the Area Council and the Communities themselves.”(project staff)	Institutions that World Vision collaborated with in the Health and Nutrition Programme.
	“Our collaborators felt that they were doing our work but not that we were helping them to carry out their programmes, so they wanted us to even pay them for the work that we were helping them to do.”(project staff)	Collaboration was not well understood.
CATEGORY	SUPPORTING DATA	INTERPRETATION
Collaboration	“We assisted the communities with the ingredients. The World Food Programme came with the raw food.”(project staff)	Collaboration between World Vision and The World Food Programme.
	“Although we were not collaborating at the highest level, when they had meetings they invited us, and vice versa, so as to avoid duplication.” (project staff)	Nature of collaboration between World Vision and Catholic Relief Services.

CATEGORY	SUPPORTING DATA	INTERPRETATION
Collaboration	“World Vision and CRS did not come to do the same project, but they worked together. When World Vision was doing one project, CRS did another.” (community member)	There was no duplication of work between World Vision and CRS
	“Sometimes Word Vision and ADRA organised health and nutrition programmes together.” (community member)	There was some collaboration with ADRA
	“The Ministry of Health collaborated with World Vision.” (community member)	World Vision collaborated with Ministry of Health.
	“Yes, they did collaborate because this school feeding programme for instance, World Vision came in to support schools that CRS was not supporting. That was the collaborative aspect. There was no duplication.” (community member)	World Vision collaborated with CRS at the local level.
CATEGORY	SUPPORTING DATA	INTERPRETATION
Collaboration	“World Vision put up the building but the food came from World Food Programme.” (community member)	Talking about the Nutrition Centres.
	“World Vision actually supported the Health Centre so most of the programmes they ran were done with World Vision.” (community member)	Collaboration between World Vision and Bongo Health Centre.

CATEGORY	SUPPORTING DATA	INTERPRETATION
Community education on health.	"They organised it once a year and came and talk to the people." (community member)	Health education was organized by Bongo Health Centre in the community once yearly.
	"Yearly. Also if there was an outbreak they came and educated the people on how to protect themselves from catching it." (community member)	Health education was undertaken when there was outbreak of disease.
	"They talked to the community about how to clean the environment. They also educated the women on how to take care of their children as well as the women themselves." (community member)	Content of health education.
CATEGORY	SUPPORTING DATA	INTERPRETATION
Community education on health	"It was done through the outreach staff who came here to do child welfare clinic. So they educated mothers before they gave treatment. Seminars were organised but they were not regular." (community member)	Staff of Ministry of Health educated women on health issues during their outreach programmes. Sometimes education was done through seminars. But these were not regular.
	"The Ministry of Health people from Bongo. Even at times the doctor himself came." (community member)	He was talking about who did health education in the community.
	"They told us to immunize our children. They educated us on how to keep our children." (community member)	Content of health education.

CATEGORY	SUPPORTING DATA	INTERPRETATION
Community education on health	"It was done yearly." (community member)	Talking about the frequency of health education in the community.
	"They came twice in a month." (community member)	World Vision staff did health education in the community twice in a month.
	"They received abundant education on these sicknesses, and things are now getting better." (Village Health Worker)	Talking about education given on diarrhea, fever and malaria, which were common in the community.
	"They talked to them on how to take care of themselves, so as to prevent sicknesses, and the need to go to the clinic if they fell ill." (community member)	Health education on disease prevention, and sensitization to go to clinic when sick.
CATEGORY	SUPPORTING DATA	INTERPRETATION
Community education on health	"The World Vision people also educated the people on health issues." (community member)	World Vision staff also did health education.
	"Not all the time but any time they had a meeting. They talked to us about how to handle ourselves so that we would not have sicknesses attacking us." (community member)	Health education done by World Vision staff not frequent. They talked about disease prevention.
	"They talked about elephantiasis and guinea worm. They talked to us about how they affected people and how they could be treated." (community member)	Content of health education – elephantiasis and guinea worm.

CATEGORY	SUPPORTING DATA	INTERPRETATION
Community education on health	“At times the Ministry of Health went round with their van in times of outbreak to educate the communities. At times too from rural radio the communities were educated on health issues. When it was time for immunization then the health people also came round to give their health education.” (community member)	Health education during disease outbreak, from rural radio and during immunization.
	“They took opportunity where there were gatherings, when there was an outbreak to educate the people.” (community member)	Health education was undertaken when there were gatherings and during disease outbreak.
	“They came but not always.” (community member)	Asked whether the Ministry of Health people went to the community to do health education.

CATEGORY	SUPPORTING DATA	INTERPRETATION
Community Education on health	“They talked about how the women should care for the children.” (community member)	Ministry of Health staff talked about childcare during health education.
	“It was last month that they came and talked about the ringworms. So they brought us some ointments.” (community member)	Community educated on ringworm infestation.
	“About once a year.” (community member)	Health education was done about once a year.
	“At the clinic sessions, we did growth monitoring, if there were lactating mothers, pregnant or malnourished women, we gave them health talks.” (Village Health Worker)	CRS health volunteers gave pregnant women and lactating mothers.

CATEGORY	SUPPORTING DATA	INTERPRETATION
Community education on health	“If there was an outbreak or something, they came to educate the people on how to prevent the disease.” (community member)	Health education was done during outbreak of diseases.
	“We have groups like mothers supporting groups. They educated them. They even selected their group leaders to educate them on health issues.” (community member)	Women’s groups educated on health issues.
	“They educated them on exclusive breast-feeding. They also educated them on the need for antenatal care.” (community member)	Mothers educated on exclusive breast-feeding and the need for antenatal care.
	“They came every month.” (community member)	Ministry of Health staff visited the community every month.
CATEGORY	SUPPORTING DATA	INTERPRETATION
Community education on health	“When any disease was coming, they used to come here, gather us and talk to us.” (community member)	Community educated during disease outbreak.
	“Every month. I mean the women, but the community it was once in a while.” (community member)	Women were educated on health issues every month, but the whole community once a while.
	“We advised them to do it every quarter. But it looked as if they lacked personnel so they did it may be three or four times in a year.” (project staff)	Health education was undertaken in the communities three or four times in a year.

CATEGORY	SUPPORTING DATA	INTERPRETATION
Community education on health	“Firstly, they talked about immunization. They also talked about antenatal care and personal hygiene.” (project staff)	Community educated on immunization, antenatal care, and personal hygiene.
	“They gave them education on how to take care of themselves, and how to keep the environment clean.” (project staff)	Mothers were educated on how to take care of themselves, and how to keep the environment clean.
CATEGORY	SUPPORTING DATA	INTERPRETATION
Supplementary feeding for children and expectant mothers.	“They provided food for the children once in a blue moon. When they gave out a number of times and the bags were finishing, then we waited for some time. But in the lean season the food came regularly.” (a worker at a Nutrition centre)	School feeding programme was only regular in the lean season.
	“World Vision did not give them food. It was CRS, which gave them food.” (community member)	CRS also provided food for the school children in some of the communities.
	“At least five to six thousand children were given lunch everyday in school.” (project staff)	Number of children who benefited from the school-feeding programme daily.

CATEGORY	SUPPORTING DATA	INTERPRETATION
Supplementary Feeding	“They wanted to motivate the children in their attendance. Most of the parents could not afford. At times a child would get up and would not have a meal to take as breakfast. So when the parents told the children to go to school, they would be crying of hunger and refuse to go to school. But when the food came to the community and the children were fed, they were happy to go to school.” (community member)	Supplementary feeding motivated children to go to school.
	“World Vision provided food for the children at the Nursery. Formerly they were giving them breakfast and lunch. But now they give them only lunch.” (community member)	World Vision provided lunch for nursery children.

CATEGORY	SUPPORTING DATA	INTERPRETATION
Supplementary feeding	“World Vision gave food to the school children in the community.” (community member)	Supplementary feeding was provided for school children.
	“Because when the food was there the attendance of the school children went up and decreased when the food finished.” (community member)	Supplementary feeding increased school attendance.
	“They fed those schools that were not in the CRS programme.” (community member)	There was no duplication between World Vision and CRS in the supplementary feeding programme.
	“Those in the nursery ate twice a day, but those in the primary once a day.” (community member)	Frequency of feeding.
	“Now it is better but getting to the lean season it is always hard for parents to feed their children.” (community member)	Supplementary feeding, a relief for parents.
CATEGORY	SUPPORTING DATA	INTERPRETATION
Supplementary feeding	“When they went to the clinic they gave them food.” (community member)	World Vision gave food to pregnant women.
	“The pregnant women and the lactating mothers went to the Wagliga Nutrition Centre every month and they were given food.” (community member)	World Vision gave monthly food rations for pregnant women and lactating mothers.

CATEGORY	SUPPORTING DATA	INTERPRETATION
Supplementary feeding	“They weighed the children every month and gave food to the mothers.” community member)	Ministry of Health staff weighed children and gave food to mothers every month
	“Yes they give them food. Formerly it was very regular but now it may take up to four to five months.” community member)	Food rations for pregnant women and lactating mothers not regular.
	“They have put up a structure and we are accommodating some children there and someone is taking care of them.” community member)	Nutrition centre constructed for taking care of malnourished children.
	“Presently the Nutrition Centre is completed so we have children there. And we have two attendants managing it who take care of the children.” community member)	Children taken care of at the Nutrition Centre.

CATEGORY	SUPPORTING DATA	INTERPRETATION
Supplementary feeding	“So DHMT was able to start the feeding programme for the malnourished children.” (community member)	Feeding programme for malnourished children.
	“Quite apart from that they de-wormed the school children every year so that they could feed better.” (community member)	School children de-wormed every year.
	“Every month the Ministry of Health people came here to weigh the children.) (community member)	Monthly weighing of children.
	“World Vision gave lunch to malnourished children. They also gave the children medical care.” (community member)	World Vision gave lunch and medical care to malnourished children.
	“At first they used to make porridge for them and they would take lunch. But now they only give them food in the afternoon”. (community member)	Malnourished children fed at the Nutrition Centre.

CHAPTER FIVE

FINDINGS/RESULTS AND DISCUSSION

In this chapter the findings of the study are presented and discussed. Data are drawn from interview transcripts, analysis of documents, informal discussions, and personal observation.

In all twelve (12) categories, grouped under the two broad themes of process evaluation and product/outcome evaluation are discussed in this chapter.

5.1 Summary of findings/results

Category	Findings/Results
1. Programme design	1. Beneficiary communities were not involved in the design of the programme. It was designed by the implementing agencies and the communities were informed. Their inputs were not taken.
2. Needs assessment	2. Needs assessment was done both by the DHMT and World Vision.
3. Implementation	3. Beneficiary communities participate in the implementation of the health and Nutrition Programme: a) Programmes were implemented at the

Implementation	community level through trained Community Health and Nutrition Volunteers. b) Communities contributed labour local materials and some funds during Construction projects. c) Nutrition centres were constructed through the initiative of Project Management Committees at the community level. d) The Community Health and Nutrition Volunteers were not well motivated. e) Projects were discussed with communities before they were carried out. f) Communities were involved in the selection of Village Health Volunteers.
4. Collaboration	1. The Health and Nutrition Programme was a collaborative Venture between World Vision and the District Health Management Team.

6. Supplementary feeding for Children and expectant mothers.	It was done once a year. 2. Health education was mainly done in times of disease outbreak or during the period of immunization. 3. Communities were educated on pre and post natal clinics, disease prevention environmental cleanliness and the importance Of immunization. 1. Supplementary feeding was being undertaken at two levels: (a) A school feeding programme in which nursery and primary school pupils were given lunch everyday. Between 5000-6000 children were given lunch everyday.
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Category	Findings/Results
Supplementary feeding	b) Supplementary feeding was given at nutrition centres where malnourished children, expectant and lactating mothers were taken care of. c) Orphans and children of poor parents were taken care of at the Nutrition centre.

	d) Pregnant women were given food rations every month. 2. The provision of food to the school children was not very regular. 3. Catholic Relief services was also undertaking a supplementary feeding programme in the Bongo district.
7. Health and nutrition education for mothers.	1. Health and nutrition education for mothers begins during the period after childbirth. 2. Mothers were educated on topics like responsible parenthood, HIV/AIDS, child care, wean mix preparation, preparation of balanced diet, and exclusive breast-feeding. 3. Pregnant women were not taken through Nutritional Counseling
8. Training of community health and nutrition volunteers.	1. Community health and nutrition volunteers, community – based distributors, peer educators and

	traditional birth attendants were trained in the communities.
9. Programme outcome.	2. The content of the training included the administration of Basic First-Aid how to make referrals to the hospitals and how to identify common diseases. 3. Refresher courses were not done for the volunteers regularly. 1. There has been considerable reduction in maternal and child mortality rate. 2. There has been increased immunization coverage. 3. People in the beneficiary communities were enlightened on health issues leading to improved disease prevention and management in the communities. 4. Children in the communities looked well nourished and healthy.

10. Infrastructure development	1. Four nutrition/Rehabilitation centres have been constructed in four communities – Bongo, Soe, Beo and Sanaabisi.
11. Benefits for the elderly.	1. The benefits of the elderly in the programme was indirect. There was no direct package for the elderly.

5.2 Discussion of findings

5.2.1 Programme design

From the interview with the World Vision Officer in charge of the health and nutrition programme, it came out that the Ministry of Health had already designed the health and nutrition programme but had not been able to carry it out due to lack of funds. World Vision also had programmes they needed to run in the same area of health and nutrition, so components for the programme were drawn.

The Bongo district was selected for the intervention because it was identified as the poorest of the six districts in the Upper East Region. In the words of the World Vision officer, “at the Regional Coordinating meeting it was realised that the problem of Bongo is health and Nutrition after giving their profile, and Bongo was also identified as the poorest among all the six districts, so they chose Bongo”.

Another respondent also revealed that the idea of undertaking a health and nutrition programme had been a long- standing one with the District Assembly. He said it was embodied in the five-year development plan of the District Assembly. So when World Vision came in, they looked at the document and knew that health and nutrition were priority areas of the people.

After Bongo was selected at the Regional level, there was a start-up meeting at the district level where all stakeholders were invited – District Assembly members, Heads of decentralised departments and opinion leaders.

An interviewee with these words reinforced this fact: “the workshop they ran, they invited the health workers, and even all the departmental heads – the Agric. people and all the rest. They did not discuss only the health, but all what their plans were and how they could go about it.”

From then on, the Ministry of Health became the owner of what programmes were to be run, while World Vision provided the funding. This is seen in the words of the World

Vision officer interviewed, “when we meet them at our Annual Review Workshops, they give us a presentation on what they intend to carry out in the coming year. Based on that when we are writing up our budget we embody it in the budget.”

The beneficiary communities were then informed of the intervention programme. Comments from two respondents allude to this fact. The first said “the World Vision people came and talked to the community about the programme”, while the other also put it this way. “Before they started the programme, they came to the community and talked to them so that the community would know what World Vision was doing ”.

It is clear from the foregoing that the programme was designed at the top, leaving out the community members who were going to be the direct beneficiaries. There were meetings at the Regional and District levels to plan the programme, only to go down and inform the communities. This is seen in the words of a respondent when he says, “they organised the way they could help us. But in our little way, the way they are helping us we think it is good but at least we would have liked that in addition to the food, they supplied the centre with other things like medicine for them to at least from time to time administer to the children”.

In other areas, World Vision discussed the programme with Unit Committee members and sent them to go and talk to their people. Thus there was no direct interaction between World Vision and the community members.

Participation in programme design was therefore not complete. The programme was planned and taken to the people. No wonder almost all the people that were interviewed did not know what the components of the programme were. It is believed the programme would have been more successful if World Vision had discussed it thoroughly with the community members to gain their input and support.

It is however good that World Vision consulted the district development plan before deciding on what intervention to undertake, and also that they involved all stakeholders in the district.

5.2.2 Needs assessment

The District Health Management team had already done the needs assessment in the communities before World Vision came on the scene. They did not therefore undertake any new intensive assessment of needs in the communities. The World Vision officer interviewed put it this way “They had done the needs assessment already and therefore knew the problems of the communities, so through that we were able to draw the components of the programme”.

Nutrition centres were therefore constructed in selected communities and feeding programmes instituted for malnourished children according to the need there. A respondent said, “they realised that most of the communities in the district were malnourished. Because of that they identified certain areas where the situation was worse

and they asked World Vision if they could put a rehabilitation centre for the World Food Programme to assist in providing food.”

From the statements of the interviewees, it came out that even though the DHMT had done the needs assessment already, World Vision also did some assessment in the communities. One person said “they came to discuss what we were to carry out, prioritising them, so they knew where to start from.” Another respondent observed that “they discussed the problems of the community with them and they talked about building the nutrition centre.” Yet another person interviewed reinforced this fact when he said that “they spoke to the community and we came out. We even asked them that we needed a Nutrition Centre for the children.” It appears however, that the assessment of the needs was not done in all the communities. This is evidenced by the comment of an interviewee “they never sat with us before they came out with the construction of the centre. They just initiated the idea that it is good they do this for the community”

It is important that the needs of the communities were assessed before the programme took off. Because as Okedera (1981) observes, agencies of Adult Education have to assess needs and interests because they are often not voiced out.

Besides, not assessing needs before embarking on intervention programmes can result in interventions not responding to the needs of the people. In this programme, all the comments by the interviewees pointed to the fact that their needs were being met.

5.2.3 Programme implementation

According to documents made available to the researcher at the World Vision Office, the health and nutrition programme was implemented in collaboration with the District Assembly, the District Health Management Team (DHMT) and the Ghana Education Service in respect of the supplementary feeding programme.

Health and nutrition volunteers in the beneficiary communities were trained to:

- i. Organise the people for health education and other health and nutrition related activities.
- ii. Identify and report promptly to either the DHMT or World Vision any disease outbreak in the community.
- iii. Administer Basic First Aid in the community.
- iv. Give advice to community members on Family Planning.
- v. Do peer counseling on HIV/Aids and other Sexually Transmitted Diseases (STD)

From the interviews, it came out clearly that the programme was being run in collaboration with the Ministry of Health. An interviewee knew that World Vision was sponsoring the Ministry of Health to undertake health programmes in the communities. In his words “I know World Vision sponsors most of Ministry of Health’s programmes. Even immunization, World Vision supports this and people go round.”

During the construction of the nutrition centres, World Vision worked through Project Management Committees, which they formed in the beneficiary communities. Each

committee comprised five members selected by the community. These committee members served as the liaison between World Vision and the community. As interviewee 25 points out “when we came the Area Councils were not functioning, so we formed what we called Project Management Committees. Each community selected five people to manage the project. These committee members were supposed to be the leaders of the various communities, so whenever we had an intervention we contacted these leaders”.

For health education and other health-related issues, the DHMT worked through trained health and nutrition volunteers at the community level. Comments from many of the interviewees brought home this fact. Interviewee 1 says that “the Ministry of Health people came that they needed some people to help them when they come here to work and also to report to them when there are some diseases in the community”. Thus the community volunteers were to assist DHMT staff in the community and to report any outbreaks in the community.

Interviewee 9 also said “they have also trained some people in the community to talk about the six killer diseases and give reports to the health people.” The community volunteers are thus trained to do health education and to report to the DHMT.

DHMT also trained and used peer educators for their health education programmes. A respondent brought out this fact when he said “they have chosen one person (myself) as

peer educator to go round in the community, to reach all the youth and educate them about HIV/Aids, drug abuse, abortion, and teenage pregnancy.”

The functions of the trained volunteers at the community level included organising the community people when DHMT staff were going to work in the community. In the words of a respondent “they normally organise the people when they want to come and do some work here.” Interviewee 6 noted that “when they are coming to talk to us about health they will contact them to give us the information so that we will come out to wait for them.” Interviewees 5 and 2 added respectively, “when there is weighing he organises the people and when he finds any sickness in the community he reports to the Ministry of Health”. . This shows that the work of the community health volunteers was not only to organise the people but also to report any outbreaks in the community. “Anytime the Health workers are coming here to weigh the children they organise the people”, said a respondent. The community health volunteers organise the people for weighing.

Apart from organising the people for health education and other health-related issues, the community health volunteers reported disease outbreaks, assisted during immunisation and Vitamin A supplementation. Interviewee 1 brought this out vividly “they go from house to house and give some information. If there is some disease somewhere, they will take note and report. Also during immunization and giving of Vitamin A to the children, they help the Ministry of Health people”. The fact that community health volunteers report disease outbreaks in the community is further brought out by these words from two respondents.

“ In my area if there is any outbreak of a particular disease, either guinea worm infestation, C.S.M. or any other disease, I will just go and make a report that this disease has broken out here. Let’s say when there is measles we report to them and they bring people here to come and help”

The community health volunteers were also trained to administer First Aid in the community. According to interviewee 23 “the World Vision people came out with the idea that they wanted some people like that in the community to help so that they can give First Aid on the minor sicknesses in the community before they are referred to the hospital”. Statements from interviewees 1, 11 and 25 buttressed this point respectively; “I was specially trained to treat malnourished children, malaria, headache, minor injuries, diarrhea, so we were given chloroquine, aspirin, paracetamol, iodine, dettol and G.V. paint. They give the medicine to the children. As I said they have knowledge in medication so they help to distribute the tablets to the children. The community volunteers give medication to the malnourished children at the Nutrition Centres. One respondent noted that most of the community volunteers had been given kits containing condoms, basic drugs like paracetamol and chloroquine, and that they had been trained to administer the drugs.

Moreover, the community health volunteers did health education and gave advice on Family Planning. Interviewee 19 stated that they educated people on health and nutrition and taught the mothers how to take care of their children so that they would not become

malnourished. Interviewee 18 added that “the Village Health Volunteers organise the women and talk to them about health and Nutrition”.

The community health volunteers educated the people on health issues at community gatherings. According to interviewee 25 “they have some days, especially when they are going to weed around the boreholes and the water sources, then the community volunteers will get some thirty to forty minutes to talk to them.”

Interviewee 2 revealed that the community health volunteers gave education on Family Planning. He said “at times we talk to the people on Family Planning and spacing their birth”

Community health volunteers also did peer counseling and other Sexually Transmitted Diseases (STD). According to interviewee 9, “the peer counselors are in the community, talking to their peers on how to control themselves on certain issues like the STD’s and HIV/AIDS”.

From all that has come out of the interviews, it is clear that there was no contradiction between the way the programme was being implemented in the communities and what was in the documents at the office. World Vision has succeeded in going by how the programme was initially planned to be implemented. There has not been any deviation.

The use of volunteers at the local level was in line with what were advocated by Colle (2002) and Nondasuta *et al.* (1983)

Colle advocated the use of paraprofessionals in health and nutrition service delivery. He defined the paraprofessional as the kind of village health worker who generally has less than a year of professional training, and who has a large amount of day to day autonomy in providing health and nutrition services to rural low income population. This agrees with the local volunteers who have been given some training and allowed to operate in the communities. Nondasta et al (1983) also advocated the use of Village Health Communicators (VHCs) and Village Health Volunteers (VHVs) in health delivery. The use of local volunteers at Bongo was therefore in line with normal practice in health and nutrition delivery programmes.

However, as Colle points out there is the need for monitoring and control and education and guidance, to ensure the effectiveness of the volunteers. Even though the volunteers gave monthly reports to the DHMT, there was the need for both DHMT and World Vision to visit the communities to get first hand information on how the volunteers were faring. This was because it looked like the only source of feedback from the volunteers was through the monthly reports they sent to World Vision and DHMT and this was not enough.

Colle (ibid.) further talked of the need to consider the issue of motivation when using paraprofessionals in service delivery.

There is the need to sustain enthusiasm for work when isolation and lack of rewards and compensation often make the original glamour of the job fade. Also touching on the issue of motivation Nondasuta *et al* (ibid.) cited the example in Thailand where the government provided volunteers with free medical services and a certificate upon completion of their training.

In the Bongo health and Nutrition programme, the volunteers were given some sort of motivation as evidenced in statements made by some of the interviewees. Interviewee 25 said “they have given them bicycles and I think the drugs they sell they have some small commission.” Interviewee 9 and 10 had these to say respectively:

“Whenever there is a programme, like this Polio Immunization, they give them money after the project.” “Sometimes when they go out they are given some honorarium, but they do not pay them salaries”.

However, comments from most of the interviewees pointed to the fact that they expected a lot more motivation for the volunteers. Interviewee 22, who is a village health volunteer put it this way, “we are not paid. After training we asked them that they should do something to encourage us. You know going from house to house is far. But they said they cannot help”.

On his part interviewee 11 said, “I cannot say they are paid. Because actually what they take is not worth what they are doing. Because they are there washing these children,

carrying them and doing all that. You know it is not easy handling such children". He was talking of the volunteers who assisted at the nutrition centres.

Asked whether the village health volunteers did the health education in the communities, interviewee 3 replied, "they are supposed to do, but you know when these volunteer programmes start, they almost die if you don't come from time to time to give them training and motivate them, it never works". Thus lack of motivation could affect the effectiveness of volunteers. This is in line with what Colle said that "lack of rewards and compensation often make the original glamour of the job fade".

Interviewee 3 advocated for monetary reward for volunteers when he said, "if from time to time they have some monetary reward or any reward in kind, it will motivate them to function effectively". Interviewee 11 reinforced this view when he noted that "to the best of my knowledge they should be motivated. I know they will put in their best and even more will come." What he meant was that if the volunteers were well motivated, they would perform well and more people would join them.

From the foregoing it is clear that the Village health volunteers were not well motivated, and therefore, they were not giving of their best. Better results would be achieved if the volunteers were adequately motivated. However, care should be taken not to over-do it, since that would attract people who do not have the work at heart but are only interested in the reward. There is the need to put in place a package of motivation to sustain the interest and commitment of volunteers.

The beneficiary communities participated in the health and Nutrition programme at various levels. In the first place, projects were discussed with the communities before they were carried out. Interviewee 2 noted that “they came and sat with the community to discuss the construction of the Nutrition centre”. The comment of interviewee 7 supported this fact “Yes they talked to us on several occasions, and even when they were going to build the nutrition centre, they talked to us about it so the people understand.”

The community was also involved in the selection of village health volunteers. According to interviewee 2 “the Ministry of Health workers came and asked for volunteers so they were selected by the community.”

In other communities the village health volunteers were selected with the help of opinion leaders in the community. According to interviewee 3, the village health volunteers were selected by contacting opinion leaders to find out who was capable and prepared to assist.

During construction projects, the communities contributed in the form of labour. This was the case when the nutrition centres were being constructed. Interviewee 1 says, “on the part of the nutrition centre the people supplied the labour.” This point is supported by comments from almost all the interviewees. Interviewee 11 for instance stated that “World Vision was responsible for the building”. They were to purchase the materials and the community gave communal labour. That was their contribution towards the building of the centre”

Besides contributing in the form of labour, the communities also contributed financially towards projects. These words from interviewee 2 confirm this assertion “they formed a Project Committee and the community contributed some money to open an account and World Vision paid money for the project into the account”

Interviewee 3 supported this point when he said that “we had to contribute to open a Bank Account before World Vision gave us assistance, and from time to time we made local contributions to support maybe hiring a vehicle to collect the sand to augment what the people were doing.”

The community also provided local materials in the construction of the nutrition centres, “the community carried sand, collected stones, provided water...” said a respondent.

Moreover, women from the communities helped by preparing food for the children at the nutrition centres. “They are taking the programme as what they have been told. When they are taught how to prepare the food for the children, the women try to implement that”. Interviewee 16 also pointed out that the women cooked at the nutrition centre in groups and rotated after one week.

During workshops too community leaders participated to discuss issues in the community. “Then at the district level, the community leaders interact during workshops to convey what is happening in the community so that they can discuss them and come out with solutions”, noted a respondent.

Also the Assemblymen assisted in the management of the nutrition centres. Interviewee 11 noted that “they periodically visit the place and any problem there the people know the Assemblyman is the one they will contact.”

World Vision has succeeded in ensuring the participation of the beneficiary communities at all levels of programme implementation. This explains the success they are chalking in the programme. The picture we are seeing here proves the observation made by Kennedy (1991) that implementation issues appear to be critical in the success or failure of nutrition interventions throughout the world. He noted that the impact of any nutrition programme depended on whether community participation was ensured or not.

5.2.4 Collaboration

The health and nutrition programme was a collaborative venture between World Vision and the DHMT. The latter provides the expertise, while the former provided the funds. As the World Vision staff interviewed put it “World Vision per say, we do not have our own programmes, it is the programmes of DHMT that we are helping to implement”

Even though World Vision did not have health personnel with the help of the DHMT, they were able to implement their health programmes.

In the implementation of the programme, World Vision was collaborating with a number of institutions apart from the DHMT. These include: the Ghana Education Service, the

Department of Community Development, the Local Council of Churches, the District Assembly, the Area Councils and the beneficiary communities.

World Vision was also collaborating with the World Food Programme (WFP) in the operation of the nutrition centres. In the first place, World Vision put up the structures and W.F.P. provided the food to the centres.

World Vision further collaborated with W.F.P.^{*} by providing ingredients at the Nutrition Centres while W.F.P. provided the raw food.

There was no official collaboration between World Vision and Catholic Relief Services (CRS) which is also undertaking supplementary feeding programmes in the district. There however seemed to be understanding between the two organizations. Interviewee 25, who is an officer of World Vision stated that “Although we are not collaborating at the highest level, when they have meetings they invite us, when we have meetings we invite them for us to know where each of us should go to avoid duplication.” Interviewee 11 also said, “they do collaborate because this school feeding programme for instance, they came in to support schools that CRS is not supporting. That is the collaborative aspect. There is no duplication.” “World Vision and CRS do not come to do the same project, but they work together. When World Vision is doing one project CRS does another”, observed another interviewee.

There were Community-Based Distributors (CBDs) in the communities, trained by another NGO, Rural Health Integrated. There was however no formal collaboration between World Vision and Rural Health Integrated or between World Vision volunteers and volunteers trained by Rural Health Integrated in the community. Asked whether World Vision recognised her role as a C.B.D. interviewee 2 said “I have not really talked to them but they know that I am a CBD. But it is because I am a women’s leader that when they come, they come to me”.

From the comment of interviewee 25, it appears that the parties involved in the collaboration did not understand it very well, “our collaborators feel that they are doing our work but not that we are helping them to carry out their programmes, so they want us to even pay them for the work that we are helping them to do.”

Several issues need to be commented on here. First is the lack of official collaboration between World Vision and Catholic Relief Services and Rural Health Integrated. World Vision had programmes in common with each of these two organizations, and they were working in the same area. Even though there had not been any conflicts and duplications between them, I believe a greater impact could be made if there was collaboration between them.

Secondly, I think that the collaborators of World Vision demanded payment from World Vision because they had not been educated enough to understand the nature of the collaboration. For effective collaboration to be realised there was the need for more

sensitization.

5.2.5 Community education on health

The DHMT undertook health education in the communities. However from the interviewees it appeared that this was not done regularly. Interviewee 1 said that the education was done yearly. To use his own words “they organise it once a year and come and talk to the people.” On his part interviewee 2 said the community health education is done monthly. Still on the frequency of the health education in the communities, interviewee 5 said yearly, interviewee 8 said “not very often”, interviewee 10 said, “it is not regular, interviewee 12 said “no they don’t”, interviewee 16, “they come but not always”, interviewee 19, “about once a year”. It can therefore be concluded that health education was not regularly undertaken in the communities by the DHMT.

In times of disease- outbreak however, they gave the communities health education. Interviewees 1, 20 and 22 talked about this. According to interviewee 1, “If there is an outbreak they come and educate the people on how to protect themselves from catching it.” Interviewee 22 said, “when any disease is coming, they used to come here, gather us and talk to us.”

The content of the health education covered areas like environmental cleanliness, child and maternal care. They also educate the communities on the importance of immunization. In the words of interviewee 11, “when it is time for immunization, then the health people also come round to give them health education.” Interviewee 20 noted

that “they educate them on the need for Ante-Natal Care”. The statement of interviewee 25 supported this when he said, “firstly they talk about immunization. They also talk about antenatal care. They also talk about personal hygiene.”

According to interviewee 24 the communities were also educated on Family Planning, breast-feeding, malnutrition and communicable diseases

It is clear from what has been said that not much health education was done by the DHMT in the beneficiary communities. Education is done about once a year, during disease outbreaks and during the period of immunization.

This perhaps was a weakness in the programme considering the importance of health sensitisation. Even though volunteers have been trained in the communities, to do health education, it came out during the interview sessions that this was not effective in most communities.

The importance of community health education was underlined by Green and Ottoson (1994) when they stated that health education in the community sought to elicit, facilitate and maintain positive health practice by assuring that people have the understanding, skills and support needed for their voluntary adoption of activities conducive to their health. They added that health education concerned itself not only with current behaviour such as preventive actions, appropriate use of health services, health supervision of children from birth to adolescence and the adherence by adults and children to

appropriate medical and nutritional regimes, but also with the development in children and youth of a foundation for future health.

Viewed against this background it was clear that the programme was not giving health education the importance it deserved in the life of the community. There is the need therefore to step up the aspect of health education in the communities. It should be regular because people do not easily change.

The education that the programme gave on pre and postnatal clinics was good and should be intensified. Green and Ottoson (1994) indicate that pre natal care should be sought early in pregnancy, preferably during the first three months. To them health education, early detection of abnormalities and identification of the high-risk mother and infant are the major purposes of pre natal care. They note that early care reduces infant mortality and low birth weight. Infants of mothers who receive no pre natal care have about 10 times the risk of dying in the first months of life, they add.

Green and Ottoson (ibid.) identify three basic types of health educational strategies. Among these are:

1. Direct communications with the target population to predispose behavior conducive to health: These include lecture, discussion, individual counseling or instruction, mass media campaigns, audio-visual aids, educational television and programmed learning. The DHMT sometimes uses the mass media campaign strategy as evidenced by the words of Interviewee 11 “at times the Ministry of

health goes round with their Van in times of outbreak to educate the communities. At times too from rural radio (The FM station at Bolgatanga) the communities are Educated on health issues”, says a respondent. This is good but should be done more often.

2. Training methods to enable or reinforce behaviour conducive to health: These include skills development, simulations and games, influencing learning, small group discussion, modeling and behaviour modification.

The programme’s training of women in weanmix preparation, preparation of balanced food and childcare practices were also in line with this strategy and should be kept up.

5.2.6 Supplementary feeding for children and expectant mothers

Under the Health and Nutrition programme supplementary feeding was undertaken at two levels – a school feeding programme in which school children were given lunch everyday, and feeding at nutrition centres where malnourished children and expectant mothers were given food and taken care of.

According to interviewee 25 “at least five to six thousand children are given lunch everyday in school.” Interviewee 6 confirmed this when he said “they give food to the school children in the community.” Interviewees 8 and 1 added to the fact that World

Vision provided food for school children. Those at the nursery and those in the primary schools were given lunch everyday.

However, statements from some of the interviewees pointed to the fact that the provision of food for the school children was not very regular. According to interviewee 19 “they provide food for the children once in a blue moon. When they give out a number of times and the bags are finishing, then we wait for some time. But in the lean season the food comes regularly.”

Apart from providing the nutritional needs of the children, the school-feeding programme also motivated children to go to school. As interviewee 9 put it “they want to motivate the children in their school attendance. Most of the parents cannot afford. At times a child will get up and will not have meal to take as breakfast, so when the parents tell the children to go to school, they will be crying that they are hungry and refuse to go to school. But when the food comes to the community and the children are fed, they are happy to go to school.” Interviewee 5 reinforces this assertion when he said, “when the food is there the attendance of the school children goes up and decreases when the food finishes.”

Many of the interviewees made statements to drive home the fact that expectant mothers, lactating mothers and malnourished children benefited from supplementary feeding. Interviewee 17 said they gave monthly food rations to pregnant mothers when he said “they give them wheat, Tom Brown and salt every month.” Similarly interviewee 5 said

“the pregnant women and the lactating mothers go to Wagliga Nutrition Centre every month and they are given food.”

Interviewee 11 pointed out that “World Vision gives lunch to malnourished children. They also give them medical care.” Thus the children were not only given food but their health was also taken care of.

Orphans and children of poor parents were also taken care of at the Nutrition Centres. As interviewee 23 put it, “some of the children have lost their parents. Some too due to poverty sometimes not all can afford the nutritious food to take care of their children so that they grow up nicely”.

At the nutrition centre the children were weighed regularly and fed. The mothers were also taught to take care of the children. Moreover, the children at the nutrition centres are given medical care. Interviewee 22 brought this out in the words “also they use to give medicine to the children and the health people used to come there for weighing children”

During antenatal care, children identified to be malnourished were recommended to be taken care of at the nutrition centres.

It is significant that World Vision identified school children, malnourished children and expectant mothers to provide them with supplementary feeding.

5.2.7 Health and nutrition education for mothers

Health and Nutrition education for mothers began during the period of pregnancy and extended to the period after childbirth. Interviewee 6 pointed out that “when they are pregnant they teach them that they should always be going to the clinic until they give birth”. Furthermore, seminars were organised for pregnant women and lactating mothers, where topics like responsible parenthood, HIV/Aids and childcare were talked about.

The mothers were given education on how to take care of their malnourished children at the health centres. Moreover, the women were taught how to prepare balanced diet. In the words of interviewee 6 “they also come with the Health workers to talk about how we should cook the food. What kind of nutrients we should add to it so that when the children take the food they will get blood and it will also build their body”. The words of interviewee 5 confirmed this fact, “They also talked about the necessary ingredients you can take to prepare food so that the body will get all what it needs”.

The mothers were trained on weanimix preparation, childcare, personal hygiene, how to prepare a balanced diet for a child and exclusive breastfeeding. Interviewee 6 confirms this fact by saying that “they educated them on how to take care of their children, how to handle the child when the child was going to suck the mother’s breast, the way they were to hold the child, and how to hold the breast for the child to suck. They also educated them on exclusive breast- feeding”.

Giving health and nutrition education to the mothers and educating them on exclusive breast-feeding was a step in the right direction.

5.2.8 Training of community health and nutrition volunteers

As has already been indicated, community health and nutrition volunteers were trained in the communities to assist the DHMT in the implementation of the health and nutrition programme. Interviewee 10 talked about the training of peer educators when he said that “they have been trained and resourced by the Ministry of Health” Interviewee 9 also talked about the training of Community Based Distributors, saying that “through World Vision the Health workers came out and trained them.” Interviewee 7 also stated that community – based volunteers were trained to educate people on tetanus and other health issues and in his own words, “if a child is born and dies, they have to find out what happened and the child died”. Apart from the CBDs trained by World Vision, others were trained by the Rural Health Integrated; an NGO based in Bolgatanga. Interviewee 25 talked about the content of the training for the community health and nutrition volunteers. He said the volunteers were trained in the administration of basic First Aid, how to make referrals to the hospitals, and how to identify common diseases.

CRS also trained some volunteers in the communities on how to weigh the lactating children, growth monitoring, and how to go about home visits.

Some Traditional Birth Attendants (TBAs) were also trained in the communities as evidenced in the words of interviewee 19 “World Vision has trained three Traditional Birth Attendants who help women during child birth.”

Asked about how competent the trained volunteers were, interviewee 25 replied, “well as at now averagely but their capacities need to be built.”

It is good that World Vision is training volunteers in the communities. There is however, the need for refresher courses and monitoring of their performance to ensure their effectiveness.

5.2.9 Programme outcome

The interviews conducted revealed that the health and nutrition programme has yielded some outcomes. First is the reduction in maternal and child mortality rate. This is evidenced in the words of a number of the interviewees. Interviewee 2 said, “now women or their babies rarely die through childbirth”.

But previously they were dying.” In the words of interviewee 7 “before they came here our children were suffering. Even when they were sick, people could not afford to send them to hospital. They have saved the lives of most of the children.” Interviewee 23 also notes that the programme has helped to reduce child mortality in the communities. According to him “the good thing is that child mortality rate has really come down. Because formerly there were a lot of malnourished children in the community. Now it

has reduced drastically. Measles was very rampant here but now even if it gets a child, it is very mild”.

Interviewee 7 further observed that “the programme is helping our children very well. We used to have problems, like children dying at tender ages and all that. But because of the programme, it has now improved our standard of living”.

Another outcome of the programme was increased immunization coverage. According to interviewee 3, “a lot of awareness has been created so people now immunise their children.”

Interviewee 11 stated that “before the programme, most children used to be denied of it (talking about immunization) because of their hide and seek. But now that the centre is there many children are brought out so in times of immunization, more children get the opportunity to be immunized”. Adding to this interviewee 25 noted that, “now immunization coverage is high as compared to the previous years”.

Documents analysed revealed that between 1996 – 1998 2,850 children fewer than five years were immunised against six childhood killer diseases. 2, 041 women – received tetanus immunization. Besides, people in the beneficiary communities were enlightened on health issues. As interviewee 9 pointed out, “because for the previous years people did not take these health issues to be important to their lives. But because of this

nutrition programme, most of the people in the communities are enlightened and whatever they advise them to do, they also try to do”.

Viewed against the objectives set by the programme, the outcome of the programme was quite remarkable. The supplementary feeding for children and women no doubt addressed the objective of reducing malnutrition in children (0 – 5) and expectant mothers.

Additionally the improvement in immunization coverage addressed the objective of promoting immunization of children against the six- (6) childhood killer diseases.

With the enlightenment of people on health and nutrition issues, primary health care activities would definitely be improved.

5.2.10 Infrastructure development

World Vision has facilitated the construction of four Nutrition and Rehabilitation Centres in four communities – Bongo, Soe, Beo and Sanaabisi. Statements from a number of the interviewees confirm this fact. Interviewee 24 said, “they have built a primary school and a Nutrition Centre.” Talking about the Nutrition Centre interviewee 23 said “ a Centre that is built by World Vision for the community to bring up their malnourished children for care.” Interviewee 22 also said “World Vision built a Nutrition Centre at Sanaabisi and we send our children there.”

From the interviews, it came out clearly that the Nutrition Centres constructed were really being of benefit to the communities. They were especially meeting the needs of expectant women, lactating mothers, and malnourished children. The construction of these facilities addressed World Vision's objective of improving Primary Health Care activities and health infrastructure for effective health delivery services. The beneficiary communities were involved in the construction of the centres.

Project Management Committees were formed at the local level to oversee the construction of the Nutrition Centres. Communities also provided labour and local materials. The involvement of the communities was good in that it would create a sense of ownership in the minds of the people. There was the need however to educate the communities so that the structures would be maintained and not left to deteriorate with time.

5.2.11 Benefits for the elderly

Most of the interviewees felt that the elderly in the beneficiary communities were indirectly benefiting from the programme since their children were benefiting. The following statements from interviewees point to this fact, "once their children are benefiting, it means they are also benefiting." "Because of the training they are giving to the women, they are now able to care for the old men and women in their homes" "Well, if somebody feeds your child it means the person has fed you also." "If the whole community is benefiting from the programme, it means the old men and women are also benefiting".

Countering this view, two interviewees felt that the programme was not catering for the elderly. In the words of interviewee 13, "I think they are not catering for the aged. I have never seen the aged put into a group or organised in a way that at least this is where they want to give them some sort of assistance or education or something of the sort. They are not taking care of the aged. I do not know if they have forgotten about the aged or they are included". Interviewee 3 thought that some of the elderly would live longer if they had proper health care and attention. According to him some of them could go through a whole day without eating because of poverty, living only on cola.

Interviewee 13 suggested that the elderly should be organised according to their needs, and that those who were found to be needy should be assisted with food and clothing.

Looking at the objectives and components of the health and Nutrition programme, it was obvious that the programme had no direct package for the elderly. It could however not be denied that the elderly were enjoying some indirect benefits from the programme as has already been pointed out by some interviewees. The supplementary feeding was targeted on children and expectant mothers.

Tayie, et al, (2001) establish a relationship between food intake and socio-economic status. They identify elderly people as being more prone to malnutrition. They observe that elderly people do not eat adequately and attribute this to the following reasons:

- a) Insufficient income
- b) Insufficient skills to select and prepare nourishing and well-balanced meals
- c) Dental problems
- d) Limited mobility
- e) Feeling of rejection and isolation that obliterate the incentive necessary to prepare and eat a meal alone.

They are of the view that community nutrition policies and programmes promote better health among older people through health education, counseling, and the limited delivery of food services. The vulnerability of the elderly to malnutrition was confirmed by the Food and Agriculture Organization report (1993) when it listed old people among the groups of people among whom under-nutrition was common.

Against this background, it can be argued that a health and nutrition programme, which does not take concrete steps to address the nutritional needs of the elderly, is not very complete.

There is however a danger in embarking on food delivery services for the elderly or instituting free medical care for them. These may not be sustainable, and will at the same time create a dependency.

The approach of World Vision in trying to reach out to the elderly by creating awareness among women would provide an answer, but only a partial one.

Poverty and food insecurity would cripple any good intentions a woman may have of taking care of her older folks as a result of her sensitisation. To fully solve the problem of malnutrition in the elderly, children and expectant mothers therefore, steps must be taken to ensure food security through agricultural support and combat poverty through the giving of credits.

5.2.12 Control of dental flourosis

The interviews revealed that dental flourosis was not a problem in all the communities in the Bongo district. Dental flourosis is the situation whereby the teeth of children become brownish as a result of chemical substances in the water they drink. It came out through the interviews that not all the people in the endemic communities knew the causes of the problem. An old man who was interviewed in an endemic community believed that the problem of dental flourosis came from two sources: (1) an act of God (2) An attack from man. He believed that if someone got it from God, then nothing could be done about it. If however, it was from man, then it could be treated. The majority of the people however knew the cause of the problem.

The problem of dental flourosis appeared to be quite serious as was evidenced in the words of interviewee 11, “Even at present we have some of our boreholes that were dug but because of this problem they have closed them. So that problem is there. Even the whole nation is aware of it. It is affecting our children and any time they go for interviews, they at times try to disqualify them because of the colour of their teeth. My own daughter was nearly disqualified, but for the timely intervention of the nurse who

brought about this flourosis in water. And according to them they said we have gold content in the water, that is causing it, so it is a big problem”.

The programme had however not addressed this problem. In the words of the World Vision officer in charge of the health and nutrition programme, “we have not done much there. We have started the survey. We hope to find a lasting solution to this problem”.

The objective to facilitate the provision of treated water to control skeletal and dental flourosis among 35,000 children in endemic communities had therefore not been achieved.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

This chapter attempts to provide a review of what have been learnt in relation to the aim and the theoretical ideas and propositions that emerged from the study.

It also touches briefly on the contribution the study makes to knowledge in the area of implementing health and nutrition programmes.

The researcher further makes a critical reflection on the limitations of the study and then concludes the chapter with recommendations to World Vision and any organizations that might be undertaking health and nutrition interventions.

6.1 Review of what has been learnt

From the study it became clear that participation of the communities in the programme has been quite commendable. The only set-back is in the area of the design of the programme where, even though discussions were made at the regional and district levels, the communities who were the direct beneficiaries of the programme were not involved. Needs assessment was however done before the programme took off and the communities were involved in the implementation of the programme at many levels.

Viewed against the initial objectives set by World Vision for the programme, the outcome of the programme has so far been impressive. There have been no deviations from the original purpose and most of the objectives have already been achieved. The only objective that has not yet been addressed is the control of dental fluorosis in children. The programme has been of immense benefit to pregnant women, lactating mothers, children, and indirectly to the elderly. Having been identified as the most vulnerable groups in society so far as health and nutrition is concerned, it is in the right direction that the programme is addressing the needs of these groups. The issue of malnourishment in expectant, lactating mothers and children was being addressed through the school-feeding programme and feeding at the nutrition centres.

Expectant and lactating mothers were further given health and nutrition education to equip them for taking care of their children.

Even though it is not being done regularly, communities are educated on health and nutrition issues and this has resulted in improved immunization coverage and increased health enlightenment in the communities. What perhaps needs to be introduced is nutritional counseling for pregnant women and lactating mothers, since the culture of some communities in the district impacted negatively on the nutritional status of women and children. The supplementary feeding programme and the health and nutrition education for mothers have helped to reduce malnutrition and maternal and child mortality.

World Vision collaborated with the District Health Management team, the Ghana Education Service, the Local Council of Churches and other governmental agencies in the district in the implementation of the health and nutrition programme. There is however, no official collaboration between World Vision and Catholic Relief Services and also between World Vision and Rural Health Integrated, even though they were all working in the same area and undertaking the same interventions.

Besides, the nature of the collaboration between World Vision and the agencies she is collaborating with. has not been very well understood by the rank and file of these agencies. Staff of these agencies often expected monetary reward from World Vision for work done in the name of the collaboration.

6.2 Contribution of study to knowledge in implementing health and nutrition programmes

One thing that has come out clearly in this study which all implementers of health and nutrition programmes should take note of is the fact that there are vulnerable groups in society which should at all costs be taken care of when designing and implementing health and nutrition programmes. These are pre-school children, children of school-going age, expectant mothers, lactating mothers and the elderly.

Moreover, it has become evident that in order to arrest the issue of malnutrition in the above-mentioned groups, there is the need to overcome poverty through the giving of credits for small scale enterprises, and to ensure food security through agricultural support for farmers.

It has also been stressed in this study that any health and nutrition programme that does not include health and nutrition education is not complete since lasting impacts can only be made when people's attitudes change in the area of health and nutrition.

6.3 Recommendations

1. Community participation

Beneficiary communities should be involved in the design implementation and evaluation of health and Nutrition programmes.

Community Health and Nutrition volunteers should be given a periodic package of motivation to encourage them. This should include monetary reward.

- There should be effective and periodic monitoring of the work of Community Health and Nutrition Volunteers at the community level.

2. Collaboration

- World Vision should work out an official collaboration with Catholic Relief Services and Rural Health Integrated to ensure a greater impact in the communities.
- The role of each collaborator in the implementation of the health and nutrition programme should be clearly spelt out and documented. The rank and file of the staff of each of the collaborating organizations should be educated on the collaboration.

3. Community education on health

- There should be regular health and nutrition education in the beneficiary communities.
- Health education should be undertaken in schools in the beneficiary communities.

4. Supplementary feeding for children and expectant mothers

- Efforts should be made to ensure that provision of food to the Nursery and Primary Schools in the beneficiary communities is regular.

5. Health and nutrition education for mothers

- A Nutritional Counseling Programme should be put in place for pregnant women.

6. Training of community health and nutrition volunteers

After initial training refresher courses should be organised for the Community Health and Nutrition Volunteers from time to time.

7. Benefits for the elderly

Health and nutrition programmes should make conscious efforts to address the needs of the elderly since they have been identified as being prone to malnutrition.

8. Control of dental flourosis

- World Vision is encouraged to step up its efforts at finding a solution to the problem of dental and skeletal flourosis.

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Research topic: An evaluation of the health and nutrition programmes of World Vision Ghana. A case study of Bongo health and nutrition programme

Semi-structured interview schedule for beneficiary communities

Process evaluation themes

a. Programme design

1. The health and nutrition programme has been running in your community for the past six years, can you tell me how the programme began here?
2. Was the community involved in selecting the programme?
If yes, how was it done?

b. Needs assessment

3. Do you know the components of the health and nutrition programme?
If yes, what are they?
4. How were the components of the programme selected?
5. What health and nutrition needs is the programme addressing in your community?
6. Can you mention any health and nutrition needs in the community that the programme is not addressing

c. Programme implementation

i. Community participation

7. In what ways does the community contribute towards the Implementation of the health and nutrition programme?
8. What has been the financial contribution of the community for the programme?
9. Do you have village health volunteers? If yes, how were they selected?

10. What do the village health volunteers do?
 11. Are the village health volunteers trained? How were they trained?
 12. Which other people in the community play active roles in the implementation of the programme?
- ii. Community education/Training
13. How often is the community educated on health and nutrition issues?
 14. What specific health and nutrition issues have the community been educated on?
 15. What for does the education take?
 16. Who does the education?
 17. Have women in your community received any training? What were they trained on?
- iii. Collaboration
18. Which health workers play roles in the implementation of The programme in your community?
 19. What specifically do these health workers do?
 20. Can you mention any other organisations that have contributed to this programme?

Product outcome evaluation themes

- a. Programme output
- i. Infrastructure
21. How many health and nutrition infrastructure have been constructed in your community?
 22. Which people constructed these facilities?
 23. Do you know of any other health and nutrition infrastructures constructed by World Vision in other communities?

24. Can you name the facilities and where they were constructed?
- ii. Supplementary feeding
25. Have women and children in your community received any supplementary feeding? If yes, how many of them?
26. In what way do you think the health and nutrition programme has affected immunisation in your community?
- iii. Improvement in primary health care activities
27. What primary health care activities are being undertaken in your community?
28. Which people are undertaking the primary health care activities?
- b. Programme effect on beneficiaries
29. What benefits has your community derived from the health and nutrition programme?
30. In what specific ways has the programme benefited children and expectant mothers in your community?
31. How has the programme helped to control dental flourosis among children in your community?
32. How has the programme helped to reduce child and maternal mortality in your community?

Appendix 2

Research topic:

An evaluation of the Health and Nutrition Programmes of World Vision Ghana. A Case Study of Bongo Health and Nutrition Programme.

Semi-structured interview schedule for project staff.

(A) Process evaluation themes

(a) Programme design

1. How was the health and nutrition programme designed?
2. What role did the beneficiary communities play in:
 - a) Identification of issues to be addressed?
 - b) Selection of issues?

b. Needs assessment

3. How were the components of the health and nutrition programme arrived at?
4. What processes did you go through in identifying and selecting beneficiary communities?
5. How were the priority needs of the beneficiary communities identified?

(c) Programme implementation

i) Community participation

6. In what ways are the beneficiary communities participating in the implementation of the programme?

ii) Community education

7. How often is the community educated on Health and Nutrition issues?

8. What specific health and nutrition issues have the beneficiary communities been educated on?
9. Who does the education?

iii) Collaboration

10. Can you explain the nature of the collaboration between World Vision and the Ministry of Health?
11. What role has the Ministry of Health played in the implementation of the programme in the communities?
12. What other agencies is World Vision collaborating with in the implementation of the health and nutrition programme?
13. What specific roles do these agencies play?

(d) (B) Product Outcome Evaluation Themes

a) Programme Output

I) Infrastructure

14. How many Health and Nutrition Infrastructure have been constructed in the communities since the programme took off?

ii) Training

15. How many mothers have been trained in the beneficiary communities?
16. What was the content of the training?
17. How many community health and nutrition volunteers have been trained?
18. How were the volunteers selected for training?
19. Who did the training?
20. What was the content of the training?
21. Would you say the trained volunteers are competent enough to handle health and nutrition issues in the communities?

iii) Supplementary feeding

22. How many women and children have benefited from supplementary feeding?

iv) Immunization

23. How has the programme helped to promote immunization in the beneficiary communities?

v) Improvement in primary health care activities

24. What primary health Care activities are being undertaken in the communities?
25. Would you say much is being done now in the area of primary health care than before the programme took off? Please explain.

(b) Programme effect on beneficiaries

26. Can you say the health and nutrition programme has helped to reduce malnutrition in children and expectant mothers? Justify your answer.
27. How has the programme helped to control dental fluorosis among children in the beneficiary communities?
28. How has the programme helped to reduce child and maternal mortality in the community?