

**A STUDY OF COMMUNITY PARTICIPATION
IN THE SUPPLEMENTARY FEEDING
PROGRAMME IN THE TAMALE
MUNICIPALITY**



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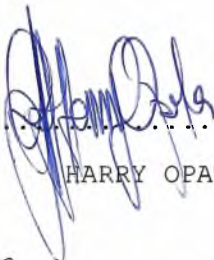
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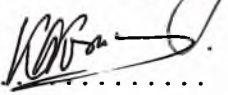
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Declaration

I hereby declare that, except for references to other people's works which have been duly cited, this work is the result of my own research and that this essay has neither in whole nor in part been presented for another degree.


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Executive Summary

This is a study of community involvement in the Supplementary Feeding Programme of the Ministry of Health in the Tamale District of the Northern Region, Ghana, at the request of the Tamale Municipal Health Management Team.

The Supplementary Feeding Programme involved the setting up of community feeding centres in poor communities in the Northern Region of Ghana. The main objective was to improve upon the nutritional status of pre-school children, pregnant and lactating women. It was envisaged that after three years of operation donor support was to be gradually withdrawn. In its place, community initiative and support were expected to have developed to a level that would sustain and expand the uses of the feeding centres.

A descriptive study was carried out to assess the extent to which the communities with feeding centres have reacted in the direction of the programme goal of community involvement. The main focus was on observing changes in the set-up and management of the feeding centres. Another aspect of interest was the communities' resource input.

This study was intended to serve as the basis from which further intervention could be modelled to foster

community participation in health. It may also serve as a resource for studies on the under-lying reasons of the dynamics of community participation in Tamale.

Findings of the study suggest that the communities have participated in the supplementary feeding programme to some extent. Even though some feeding centres have been in operation for relatively long periods community participation seems to be at the same level for all the communities. For community initiative and support for the feeding centres to develop towards the programme goal of self-sufficiency some changes will have to put in place. The programme settings will have to be modified so as to nurture further community participation.

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1 INTRODUCTION

SCOPE OF STUDY

Community participation and community involvement are concepts that have been defined in very many different ways, depending on the context of the discussion. It may be defined in the context of a means of achieving programme goals or, otherwise, as an end in itself. Oakley (1) suggests that health literature seems to be in doubt about which term to use in describing local participation in the design and delivery of health services:

Participation or involvement? Rifkin (2) gives a functional meaning to the definition of community participation by looking at the questions: Why participate? Who participates? How do people participate? For this proposal, however, the definition used by Bermejo and Bekui (3) for community participation is considered appropriate. They defined community participation as "...a process whereby specific groups, living in a defined geographic area and interacting with each other, actively identify their needs and take decisions to meet them." From this standpoint, community involvement is understood in this study as a measure of how deeply immersed the community is in participation in health.

Further, this study sees community participation as a means of achieving health goals rather than community

participation as a goal in itself. As an end in itself the concept faces social and political "stumbling blocks" (3).

The study used three variables (community initiative, community support, and utilisation) to measure the emergence and development of community participation in the Supplementary Feeding Programme of the Tamale Municipal Health Management Team. Rifkin's(2) classification of different levels of participation in health was used to assess the response of the communities. (See page 31 for elaboration on Rifkin's classification.)



BACKGROUND INFORMATION

Malnutrition among pre-school children is a major cause of morbidity and mortality in developing countries. Morley (5), stated that in developed countries a shift has taken place in the nature of morbidity. Childhood infections have shifted to a later time in life. He added that in developing countries the child is subjected to a continuum of infections from the age of six months until about the third birthday. This illness period is estimated to deprive the child of its food for one in every three or four days. The combination of malnutrition and infection should thus be seen in the light of their synergetic effect on the health of a child.

It is estimated that over 30% of Ghanaian children are malnourished and the highest prevalence of a poorly fed child occurs in the three northern regions (6).

Reasons for this situation could be derived from the socio-economic history of the Northern Region. It is the most sparsely populated region and, being almost one third of the size of Ghana, economic activity is thinly spread. The main source of income is agriculture but the extremely long dry season (October - May) puts a major strain on food reserves. Plant and animal food reserves run out and supplies are most scarce from May to July, when the last few grains have been sown and are growing. The rainy season is a labour intensive period and yet is the most ideal time for the proliferation of mosquitoes. The incidence of malaria fever, respiratory tract infection, diarrhoea diseases and other infections increases dramatically during the rainy season. These diseases pose a fatal threat to the already feeble and malnourished children. Then again, the disease burden imposes economic stress on families and continuously introduces well-breast-fed babies into the realm of mal-nourishment.

The already compromised health status of the rural population of the Northern Region was worsened recently (1994) by the armed conflict between the Konkombas and the Nanumba-Dagomba coalition of tribes. This war displaced

many communities from their farmlands and deprived them of their usual sources of income. The social and economic stress that is associated with displacement of people is known to have a sustained negative effect on the health of such vulnerable groups as children and pregnant women. Six months after this tribal conflict the nutritional status of a cohort of children in Saboba, Bimbila and Gushegu had not improved in spite of the food supplementation programme in these communities (7). In Nyohini, Tamale, 7% of children with normal nutrition in April 1994 were found to be malnourished in May, just a month later (7).

With the introduction of the Economic Recovery Programme in the mid 1980s it was planned that the poorest parts of the population of Ghana be compensated or helped out of the stress imposed by the reduction in value of the usual income from agricultural products. As part of the Programme of Action to Mitigate the Social Cost of Adjustment (PAMSCAD), the Supplementary Feeding Programme was initiated for poor communities. Starting from 1989, this programme carried out a baseline survey on nutrition of children in selected poor communities. This was followed by a programme of supplementary feeding and health education on nutrition for women and their children in some selected communities.

The general objective of the supplementary feeding programme of the Ministry of Health was to reduce the level of malnutrition in children under 5 years old in 120 communities by 20% in three years (8). The programme organised 12 community feeding centres (CFC) in each region of the country. About 200 malnourished children were to be given two balanced meals daily at each CFC except on weekends. The food was to be prepared by the mothers of the children. This part of the programme was designed to modify the 'child-feeding culture' of the women. Some cultural practices had been identified in the baseline survey as possible causes of malnutrition in children.

Expected outcomes of the first phase of the supplementary feeding programme included the following:

- Community members would be aware of their health and nutrition problems, and participate in solving these problems.
- Development agencies in the district will become aware of the importance of nutrition in national development and will participate in the PAMSCAD or similar projects.
- Communities would be able to mobilise resources for community development activities.

- A model programme will be developed and extended to other parts of the country.

After the three-year period of implementation (1990-1992) results of the programme varied from place to place. Over one half of the CFCs had ceased to function due to several reasons but most commonly, that the community had not supported the food input from their own sources. The withdrawal of the World Food Programme (WFP) food supplement in 1992 saw almost all the CFCs collapsing (9).

Another lesson learned from the Supplementary Feeding Programme is that the communities did not use the CFCs for other purposes. Separate day-care centres and under-5 clinics were organised by other social groups within the communities, leading to duplication of efforts and excessive strain on community resources.

The GDHS 1993 (6) states that "...since 1988, stunting in the Northern and Upper West Regions has declined, but wasting has increased considerably. Consequently, there has been little overall change in the percentage underweight since 1988."

In view of the persistence in the northern regions of the reasons why the Supplementary Feeding Programme was initiated, a second phase of food help was started in 1993. This phase planned for 120 feeding centres in the

five most northern regions. In addition to the objectives of the first phase it was envisaged that the following would be added.

- To support household food security of beneficiaries during the lean season.
- To maintain and improve upon the nutrition surveillance system for the children and pregnant and lactating women.



The criteria for selecting communities to participate in this phase included the presence of an active, women's group. Other criteria were the presence of a dynamic chief and an active community development committee. The food support, as in the first phase, was expected to come from the World Food Programme through the Ministry of Health.

The second phase was expected to make its impact by concentrating all the 120 CFCs in the northern regions, where the problem of malnutrition was most severe. It was hoped that the addition of services like children's day care, treatment of minor ailments and the provision of antenatal and postnatal services would make the CFC idea more acceptable to the communities. Also, the second phase was expected to avail itself to the use of resources from other sectors concerned with community development.

Some questions remained unanswered about the Supplementary Feeding Programme, and these are:

- Whether the communities will provide food from their own sources to continue the CFC programme if the WFP support is withdrawn.
- Whether the idea of CFC providing other health services is feasible, acceptable to the community and will be patronised.
- Whether the anticipated intersectoral support (Government and Non Governmental Agencies) will be acceptable to these agencies, and thus avoid duplication of efforts by the communities.

STUDY AREA

Three community feeding centres (CFC) were found to be active in the Tamale Municipality during the study period. Two other communities were in the stage of constructing the buildings of would-be feeding centres. These were scheduled to commence feeding by the end of May 1997.

Yilonaayille is a farming community, situated 14 kilometres north of central Tamale, on the Bolgatanga highway. This community consists of 219 compound houses with a population of 1685. A community register is kept by the community health nurse, who is not resident in Yilonaayille. The people are predominantly Dagombas. Other tribes like Frafras and Moshies constitute less than 10%

of the population. Women of reproductive age number 347 (21%), and children younger than 5 years are 329 (20%).

Community based facilities include a primary school and a community standpipe. Social activity is co-ordinated by a community development committee, headed by the chief. One other member serves as a member of the Tamale Municipal Assembly, and is very influential in decision making.

There is a private chemical retailer in the community, who sells medicines like chloroquine and analgesics. A military medical reception centre is located about a half of an hour's walk from Yilonaayille. The Taha-Kamina sub-district health team provides child welfare, antenatal, postnatal and curative services monthly, at the feeding centre.

Chanshegu is located at about 6 kilometres south of central Tamale. It shares the CFC with two other communities because of its relatively small population. These communities are situated on opposite sides of Chanshegu, at a distance of about 20 minutes' walk. Currently, these two out-lying communities are not much involved in the activities of the CFC. This conclusion was based on the much smaller number of CFC children from these communities.

The population of Chanshegu is estimated at 600, all of them being Dagombas. It is a farming community living in a cluster of just over 80 compounds. Children below 59 months old numbered 122 (20%), and the number of women of child bearing age was 112 (19%). A hundred and one of these women were registered as pregnant or lactating mothers.

Chanshegu has a community development committee and an elderly and active enthusiast as a recently appointed chief. The only community based structure is a non-functioning primary school, which was started several years ago out of the abandoned Presbyterian chapel. A trench that resulted after earth was removed for house building serves as their source of water. A community register is currently being compiled.

The nearest health facility is the Industrial Area Clinic, situated at about four kilometres towards central Tamale. A team of community health nurses routinely visits Chanshegu for antenatal, postnatal, child welfare and curative services. The community feeding centre (CFC) was initiated in August 1996, when 61 (43%) of children under 5 years old were found to be malnourished (weight for age) by WHO standards.

Kunyanvilla is a farming community situated at the end of a dirt road about 6 kilometres south-west of

central Tamale. The population consists of 783 Dagombas living in 65 compound houses. The number of children below 59 months old stood at 168 (22%) and the number of women in fertility age was 157 (20%).

The community has a recently appointed, middle-aged chief and a community development committee. Apart from the CFC the only community based facility is a primary school. A team of community health nurses visits Kunyanvilla monthly to provide antenatal, postnatal, child welfare and curative services. The nearest health facility is the Industrial Area Clinic, situated at about one hour's walk towards central Tamale.

The community feeding centre has been in existence for the past eight years. It was established during the first phase of the supplementary feeding programme in 1989. However, records on how it functioned are not available in Tamale. During the tribal conflict this CFC is said to have continued to feed the children because the supply of food supplement was not disrupted. The current CFC management committee asserts though, that for a period of 3 months the CFC did run out of food supplies. Feeding was then continued with money and food collected from the community.



2 LITERATURE REVIEW

The World Food Programme (10) identifies four main themes in its 1989 review of food aid to sub-Saharan Africa:

1. Understanding of Africa's continuing agrarian crisis is central to any analysis of food aid in the region.
2. If food aid programmes are to contribute to strengthening of national food systems they must confront the problems of reliability, commodity selection and disincentives
3. The targeting of food aid at the poorest people has been hampered by severe logistical constraints, high delivery costs and the prevalence of superior commodities, rather than local staples, in food aid baskets.
4. The level of planning, management and data collection demanded for the effective use of food aid in sub-Saharan African countries has frequently strained local administrative capacity.

Supplementary Feeding is one of the major activities covered by the social welfare programmes (Integrated Child Development Service - ICDS) in India. Three rounds of survey of these programmes indicated that the package of

ICDS needed to be restructured, giving priorities to community interventions in improvement of hygiene and sanitation as well as in social attitudes of the people (11).

The above arguments point to the need for a planned and systematic introduction of food supplementing and health programmes. The socio-political environment of the communities must be scrutinised in the light of the experience of the WFP and PAMSCAD. The broader framework as suggested by the Indian Social Welfare Programme will necessitate the use of the intersectoral approach and social mobilisation to attain better results.

So far, assessments of the vitamin-A supplementary programme in northern Ghana have demonstrated that this intervention has had a rather limited effect on morbidity of children in northern Ghana. Vitamin A supplementation was found not to influence morbidity and mortality due to malaria fever, one of the biggest causes of children's death in northern Ghana (12). This underscores the point that a more complete and adapted approach is essential if better health is the final goal of food supplementation. It is therefore, necessary to monitor and to some extent, 'steer' the CFCs toward the health goal.



3 PROBLEM STATEMENT

Currently, three CFCs are active in the Tamale District. It is planned to increase their number with the aim of promoting the health of vulnerable groups with the support of the Supplementary Feeding Programme. A fundamental question remains to be answered; whether the CFCs will continue to function after the anticipated withdrawal of donor support. The District Health Management Team deemed it necessary to assess the communities' reaction to the programme.

4 OBJECTIVES

MAIN OBJECTIVE

The main objective of this study is to assess the extent of community involvement in the supplementary feeding programme in the Tamale District so as to establish the basis of monitoring and influencing the dynamics of community participation in the community feeding centres.

Initial aspects of community involvement that were considered at the onset of the study could be separated as: community support for the CFC, utilisation of the CFC and community initiative in the management and functioning of the CFC.

SPECIFIC OBJECTIVES

Community support

1. List and, where possible, assess the value of community contributions to community feeding centres in the Tamale district. Comment on the qualitative and quantitative changes, with reference to the situation at onset of the Supplementary Feeding Programme.

Utilisation of the CFC

2. Describe trends in the utilisation of each community feeding centre over the period of operation.



Community initiative

3. Describe changes in the administrative and structural set up of each community feeding centre as compared to the situation at the start of its operation.
4. Make recommendations towards improvement of the set-up of the Community Feeding Centres.

5 METHODOLOGY

A descriptive study of the community feeding centres in the Tamale municipality was conducted over a period of six weeks.

The variables studied were derived as follows:

1. Contributions of the community to the functioning of the CFC. Contributions in kind and cash were specified at the start of the CFC in each community and as such their qualitative and quantitative changes reflected the dynamics of community support.
2. The utilisation of the CFC. Figures on patronage of the services of the CFC were used to assess trends.
3. Community initiative in the functioning of the CFC. This variable was indicated by the extent to which the community had modified the functions of the CFC. This was assessed from changes to the number and quality of services provided. Community initiated changes in administrative procedure were considered as positive.

The target population was defined for this study as the Tamale Municipality, the study population being the communities with feeding centres.

Data collection was carried out by reviewing the records of the CFCs with a checklist. Other information was obtained from a structured questionnaire administered to the CFC management committee. To confirm the

information given by the committee, six ordinary community members were interviewed with a short questionnaire. The questions were structured on community contributions to the CFC, services provided at the CFC and attendance. To select respondents, the interview team sat at an open place in the community and invited one passer-by at a time for questioning.

Data collection started with a two-day training of two data collection assistants. A pre-test of data collection tools and interpretation was carried out at Yilonaayille. This community was chosen for the pre-test because it was more easily accessible than the others. After the pre-test it was found necessary to modify the checklist on attendance and add a question on CFC's plan for the year. Final data collection was carried out over the following three weeks. Work proceeded in one community at a time.

Ethical considerations: Permission was sought from the Municipal Assembly and the communities' chiefs for community entry and conducting the interviews

Sources of error: The most probable error will originate from the fact that information about the functioning of the CFC management committee was taken from the committee members in group. As such, differences in opinion of the members could not be easily elicited. The

committees kept no records of meetings and so the answers were subject to recall bias.



6 RESULTS

FINDINGS

A flexible interview of the CFC management committees was carried out with the aid of a pre-trained translator. A typical interview lasted for about ninety minutes. Six other community members were selected (see: methodology) and interviewed with a structured questionnaire. Findings from the three communities are as follows.

Yillonaayille:

Management. After the initial survey of the children's nutritional status in June 1996, supplementary feeding was started in August, two months later. Currently the CFC operates under the management of the community management committee that was set up in August 1996. This committee has met six times during the first three months of this year. The last meeting was held on 21 March 1997, with seven out of the nine members in attendance. No records of the meetings were kept.

Services. Daily activity of the CFC is supervised by a CFC attendant, who is responsible for the children while they are in the CFC compound. Services provided include supplementary feeding and day-care of the children, sales of iodised salt to the public, antenatal, postnatal, and child welfare clinics. Health education durbars are

organised through the community development committee and the chief.

Attendance. At the onset, 172 malnourished children were registered for supplementary feeding. The criteria for selection were based on the recommendations as per WHO document on 'Anthropometric reference values for use in the African region' (13). Although the programme limit is 200 children, more than 230 children are recorded daily for feeding and day-care. The most probable reason why a regularly attending child may be absent is that the parents have travelled out of town with it. Inability to pay the 100 cedis weekly fee was not admitted as a reason for non-attendance.



Initially, 120 pregnant and lactating mothers were registered as antenatals and postnatals that received dry ration of food aid. Although this number represented the programme ceiling, 159 women are currently being given dry rations. Logistically, this has been possible because other CFCs have not reached their ceiling number.

Contributions. Children pay 100 cedis weekly for supplementary feeding and day-care, while pregnant and lactating mothers pay nothing for services. All community members are subject to levies imposed by the community development committee as and when necessary, for use in the work of the CFC. Ten thousand cedis was collected from

the whole community by the community development committee for the purpose of constructing the new CFC building in December 1996.

The female folk of one household are appointed weekly to be in charge of preparing food and feeding the children. Fuel wood is provided from a community woodlot by communal labour. The cost of other inputs for cooking is about 20,000 cedis monthly.

Infrastructure. A new CFC building is being constructed by the community. Work started in December 1996, and so far 71,000 cedis has been spent on it. No inputs have come from outside the community. In March 1997, an amount of 12,000 cedis was spent on new notebooks for the registration of children's attendance.

Asked about the future plans, the committee mentioned that the community intends to make a community farm during this rainy season, for the CFC. Another wish was to solicit help from the Municipal Assembly to complete the new CFC structure. Finally, the community plans to introduce first aid service at the CFC.

Chanshegu:

Management. The CFC is managed by a Chanshegu based committee, with representation from the other two

communities. This committee has met four times over the past three months. All the 8 members are said to have attended all the meetings. No documents are kept as records of meetings and decisions taken. A young, junior secondary school graduate works as the CFC attendant. He is aided by two young females, one from Chanshegu, and the other from Banvim-Dorhin, a community that shares the CFC with Chanshegu.

Services. Services provided include supplementary feeding, day care, child welfare clinic, antenatal and postnatal care. Iodised salt is sold to the public. No new services have been added since the onset of the CFC in August 1996. As to what new service was intended, the CFC management committee mentioned curative service. Suggestions from community members included the need for a trained day care attendant to provide better day care services for the children.

Attendance. Daily attendance at onset was 189 children. Currently, the attendance is 146. This drop in attendance was attributed by the CFC management committee to the withdrawal of the children from Banvim-Dorhin to attend another day care centre. This other centre is situated between Banvim-Dorhin and central Tamale and is asserted to be more attractive because better care and teaching are offered to the children. During a visit to



Chanshegu on 22 April, the only child from Banvim-Dorhin that was at the CFC happened to be the child of the female help from that community. Seventy-seven pregnant and lactating women were registered for maternal health care and the distribution of dry ration food aid. Their number has increased to 101 while the number of women in fertility age is estimated as 112.

Contributions. Attending children paid 100 cedis weekly. Pregnant and lactating women paid no money for services received at the CFC. The CFC management committee has not instituted any new levies. When the need arose for the construction of the new CFC structure all community members were made to pay some amount of money; the amount was decided by the development committee. Males paid a higher levy than females. During the first three months of the year 180,000 cedis was collected in this manner for roofing the new building.

The females of each household are appointed weekly to prepare the food for the children. Such a household is charged with the responsibility of providing firewood for cooking. No CFC farm has been made, and all other ingredients for cooking are purchased with money from the children's weekly fees.

Infrastructure. The community is currently roofing the new CFC building with communal labour and metal



roofing sheets that cost 180,000 cedis. This year the management committee intends to organise a farm to support the supplementary feeding and pay some compensation to the young man whose compound has been used as the CFC since August 1996. Other plans include the initiation of curative services in the community and the training of a day care attendant.

Kunyanvilla:

Management. The current CFC management committee was formed in 1993 and consists of 15 members. Over the past three months it has held two meetings. The last meeting was held on 14 April and was attended by ten members. No documents are kept as records of meeting procedure or of decisions taken. Daily activity at the CFC is supervised by a young adult male attendant who is fluent in English.

Services. Services provided include supplementary feeding, day care, child welfare clinic, antenatal and post natal services. Iodised salt is sold to the public. A 40-year old female mentioned during the individual interviews that the young females are taught how to cook for the children at the CFC. As to what new services may be introduced, the individual interviewees mentioned

curative services and the need for a trained nursery attendant to teach the children.

Attendance. Two hundred children were enlisted at the onset of the programme. Currently the attendance is 168. The CFC management committee blames the drop in attendance on emigration of families to central Tamale. The number of women that receive food aid has remained at 120 over the past four years.

Contributions. Children's weekly payments have been adjusted to 100 cedis from the 1993 figure of 50 cedis. Currently, females that use the services of the CFC pay an amount of 200 cedis monthly to the CFC. This payment was originally set at 100 cedis.



A vegetable farm is made annually for the CFC by the community. In 1993 a bicycle was purchased by the community for the CFC attendant and benches were made for the antenatal clinic. The compound whose weekly turn it is to do the cooking at the CFC is charged with the responsibility of providing fuel wood.

Infrastructure. The CFC building was constructed by the community in 1993; the PAMSCAD secretariat provided the roofing sheets. For this year, the committee plans to build a toilet facility for the CFC and make a 2-acre cereal farm. Another wish is to buy and mount a grinding

mill. This is expected to raise funds for other development activity as well as reduce the time spent and toil by the women in getting flour prepared.

COMMENTS

Community support. Moneys collected for the CFC by the community development committees and inputs like firewood do constitute a qualitative and quantitative initiative in supporting the work of the CFC. The Yilonaayille CFC management committee answered in the negative to the question whether the user fees should be increased.

Utilisation of the CFC: Changes in proportions of users as against the numbers of pre-school children and pregnant or lactating women were not assessed as suggested in the study proposal. The programme has a limit of number of people that could receive the supplementary feeding and this target was usually met, making utilisation almost always equal to 100%. The attraction of the food aid at the minimal fees must be responsible for the high utilisation figures for the services offered by the CFCs. With attendance in excess of 230 at Yilonaayille and the larger number of children younger than 60 months, the programme's limit of 200 children is obviously very low.

The combination of supplementary feeding and day care makes it ethically impossible to feed only the malnourished children.

The availability of food for the children did not prevent the parents of Banvim-Dorhin from withdrawing their children from the Chanshegu CFC. In this instant the factor that made the difference seems to be the need for good day care services.

Community initiative: Judging from the frequency of meetings, the CFC management committees have been very active. Since the CFC management committees kept no records of their meetings the real situation may be different. There have not been any changes in the administrative structure. The number of services offered has increased by one at Yilonaayille; apart from supplementary feeding and day care the CFC management committee provides health education for the community. The first aid services have not yet begun. Although a separate compound for the CFC was part of the initial programme demands, the supplementary feeding was started in borrowed compounds. The new buildings represent structural changes; an indication of community initiative. Notwithstanding the longer history of existence, Kunyanvilla has gone farther by providing a bicycle for the CFC attendant.



7 CONCLUSIONS

Taking Rifkin's (2) classification of levels of community participation into consideration, the response from Yilonaayille and Chanshegu may be placed at the third level. This level may be characterised as a stage where apart from committing land and resources, the community is involved in implementation, and "...local people assume managerial responsibilities in a programme and decide how activities are to be conducted".

The summit of community participation is described as the stage where, apart from programme monitoring and evaluation (the fourth stage), the people actually decide what health programmes they think should be undertaken and solicit expert knowledge or resources from health staff or government to enable the activities to be pursued. This challenge will be faced by the CFCs as they intend to train or acquire teachers to care for the children and as they introduce curative services to the CFC.

The CFC at Kunyanvilla has been working for about 8 years and yet, community involvement has not gone beyond the stage reached by the younger CFCs. This gives the impression that the programme's environment is not fostering the further development of community participation. That is to say that the supplementary

feeding programme has achieved what community participation it anticipated, with reference to Brownlea (14).

There could be other reasons for the stall in community involvement at Kunyanvilla. The socio-economic situation and the resultant emigration of the population may have influenced community development. Generally, however, the communities are clearly not at the stage where the resources for the supplementary feeding could be immediately, locally provided.



8 RECOMMENDATIONS

Suggestions that may be implemented in the very near future:

For ethical and practical reasons, the programme's limit for the number of children that could receive food aid should be reviewed or even abolished. It has not been practicable to enforce that limit in Yilonaayille, where the number of children is large. This change will increase the cost of running the programme but will have the advantage of maintaining the hitherto healthy children above the threshold of malnutrition.

The CFC is more likely to generate a more broad based community response if all children are admitted. As at now, a substantial number of people who are not pregnant or lactating and do not possess a malnourished child will seem not to benefit from the community effort in the CFC. Mostly, these will be the more, relatively well off and influential adult males. Thus, apart from losing their contributions to community development the process will expose itself to the negative effects of divisions in the community.

The CFC management committees from different communities will need to be encouraged and organised to meet and compare notes and exchange experiences so as to enhance the rate of development of their feeding centres.

The CFC management committees will have to be introduced to the functions of a community health committee. Though this will demand their gradual personnel build-up in the direction of programme monitoring and evaluation, it will immediately facilitate the introduction of curative services, a community drug store and other services. Documentation of CFC management activity must be introduced as soon as possible. The CFC attendants have the ability to perform this task.

A well-planned programme of weaning the CFCs from external food aid must be quickly initiated. This seems most urgent since the five year programme period ends in 1998.



Suggestions that may be implemented as long-term measures:

Madan (15) states that community participation is made, not borne. With the argument above, that the supplementary feeding programme's summit of community participation may have been attained, further involvement should be induced by a properly planned intervention. "Participation, if it is to be done well, has to be adequately and appropriately resourced; otherwise it is simply tokenism and does nothing to alter knowledge balance, the skill's balance and the power balance in the community" (14).

Creating the environment for further community involvement in health will have to start from a critical assessment of the existing support mechanisms in the Tamale Municipality, the training of health staff and community structures in planning, implementation and evaluation of health and other programmes (1). Due regard must be given to the need for intersectoral collaboration especially, the rich experience of the agricultural extension service.

The communities have expressed their need for curative service, better day care for the children and for income generating activities. This could be the basis for initiating community entry. Later, strategically, health interventions could be infused into the process of interaction with the people. Stone (16) commenting on the difficulties of the Nepal PHC programme states that "...health and nutrition education can be more effectively introduced after village people experience the modern participatory process in areas that address their more immediate and pressing needs, namely income generation and food production."

Further, external support for food aid should be considered in the light of the recommendations made by the World Food Programme (10): That local cereals and other resources be used instead of "superior" donor food



components. This will remove a major disincentive to local food production.

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Appendix 1

QUESTIONNAIRE ON COMMUNITY INVOLVEMENT IN COMMUNITY FEEDING CENTRES TAMALE APRIL - MAY, 1997.

Questionnaire # : Interviewer:
Date:

A Demographic Information

Community :Compound #:

Name :

1. Age 2. Sex
3. Marital status..... 4. Occupation.....
(Housewife, farmer, trader, tradesman, Office worker)
5. Do you have children(yes/no).....
6. Age of last child (In months)

B General CFC questions

7. Do you know that there is a CFC in your community(y/n).....
- 8.* Name three services provided by the CFC:.....
.....
.....
- 9.* Name one new service you wish the CFC does.....

C Contributions to CFC

10. Have you ever been to the CFC(y / n).....
11. What service of the CFC have you benefited from.....
12. What did you pay for the service (in 11)?
13. Can you pay more money if a new service(like in 9)is started(y/n)...
14. Have you ever contributed to the CFC(y/n).....
15. (If 14. is yes) Name one contribution.....
16. Thank you for the reception.

* services like feeding of children, day-care for children, ante-natal, post-natal curative care or first aid clinic, sales of drugs or any other.

Appendix 2

CHECKLIST ON COMMUNITY INVOLVEMENT IN THE COMMUNITY FEEDING CENTRES TAMALE APRIL - MAY, 1997.

INSPECTOR :
DATE :
CHECKLIST #:.....
NAME OF COMMUNITY.....

A Community initiative

A1 Management committee:

1. Date of last meeting.....
2. Number of members present.....
3. Total number of members of committee.....
4. Number of meetings over past 3 months.....

A2 Functioning of CFC

5. Is CFC working this week.....
6. Number of services provided.....
7. Name the services provided apart from supplementary feeding.....
8. Number of new services.....

C Attendance

9. Average daily attendance of children for last whole week.....
10. Average daily attendance of children best week in month of onset of CFC.....
11. Monthly attendance of women at onset of CFC.....
12. Current monthly attendance of women.....



1D Contribution to CFC

13. list contributions per attending person against type of service

type of service	initial per child	current per child	initial per woman	current per woman
sup feeding				
cwc				
antenatal				
postnatal				

14. List other levies or contributions; cost and source.

15. Was a farm made for the CFC last farming season.....(Y/N)

16. Name and write value of structural changes.

17. List activities planned for this year.