Child Survival, Protection and Development Programme in Mara and Singida Regions, Tanzania: A Focus on the Processes of Implementation

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ABSTRACT

What can we learn from the programmes which have attempted to improve the conditions of an estimated 190 million children around the world who are chronically undernourished ? It is evident from the literature that there is a dramatic increase in the risk of death amongst malnourished children, many of whom die from minor diseases which become fatal in the presence of malnutrition. Implementation of successful nutrition programmes seems to be an effective way of not only preventing the waste of human resources which are vital for development but also as an empowering process for communities to solve their own problems and ensure sustainable development. In addition, improved nutrition is viewed as a means to ensure the rights of children to life and an improved quality of life. At the same time it is regarded as a way of saving scarce resources which would have been spent on malnourished children and instead to spend the money in other sectors of the economy.

A review of different nutrition related programmes revealed that there is no "magic bullet" for solving nutrition related problems in different communities. However, there are basic elements which need to be considered if successful and sustainable implementation of nutrition related programmes is desired. This exploratory study aims at increasing the understanding of some of the elements which enhanced successful implementation processes of the Child Survival, Protection and Development (CSPD) programme in two regions of Tanzania, namely Mara and Singida. In order to accomplish the study a combination of qualitative and quantitative methods were employed. Districts and villages involved in the study were randomly selected.

The study revealed that there were eight main elements which enhanced implementation of the programme in the two regions. The elements included awareness, training, commitment, appropriate structures, an effective monitoring system, good leadership, adequate linkage with other programmes and positive outcomes within a reasonable time. Furthermore it was found that no single element was enough on its own to facilitate adequate implementation of the programme and hence the combination of the elements was an important factor.

Finally, recommendations are provided on how to incorporate the elements effectively into the implementation of the nutrition related programmes in order to ensure success and sustainability.

PREFACE

The study described in this thesis was undertaken in the Department of Geography and Department of Dietetics and Community Resources, University of Natal, Pietermaritzburg, from October 1996 to March 1998, under the supervision of Professor Robert Fincham and Miss Fiona Ross.

The thesis is original work by the author and has not otherwise been submitted in any form for any degree or diploma to any University. Where use has been made of the work of others it is duly acknowledged in the text.

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ACRONYMS

ACC/SCN	Administrative Committee on Coordination /Subcommittee on Nutrition
AIDS	Acquired Immune Deficiency Syndrome
ASNP	Alternative School Nutrition Programme
BIDANI	Barangay Integrated Development Approach for Nutrition Improvement of the Rural Poor
CBP	Community Based Programme
CFF	Child Follow-up Form
CP	Community Participation
CSPD	Child Survival, Protection and Development
DFC	District Full Council
DMT	District Management Team
DSC	District Steering Committee
DTF	District Task Force
EGMP	Embu Growth Monitoring and Promotion
FAO	Food and Agriculture Organization
FNP	Food and Nutrition Policy
GDP	Gross Domestic Product
GMP	Growth Monitoring and Promotion
HBI	Hongores de Bienstar Infantial
HESAWA	Health, Sanitation and Water
HFS	Household Food Security
ICDS	Integrated Child Development Scheme
IDA	International Development Agency
IDD	Iodine Deficiency Disorder
IFAD	International Fund for Agriculture Development
IMR	Infant Mortality Rate
INP	Iringa Nutrition Programme
INR	Institute of National Resource
JNSP	Joint Nutrition Support Programme
LBW	Low Birth Weight
MoCDWAC	Ministry of Community Development, Women Affairs and Children
MCH	Maternal and Child Health
MDGS	Mid Decade Goals Survey
MMR	Maternal Mortality Rate
MoA	Ministry of Agriculture
MoE	Ministry of Education
MoH	Ministry of Health
NAP	National Agriculture Policy
NCSP	National Child Spacing Programme
NFPP	National Family Planning Programme
NFS	National Food Strategy
NGMP	National Growth Monitoring Programme
NHP	National Health Policy
NPHC	Nutrition and Primary Health Care

NPP	National Population Policy
NWP	National Water Policy
ORS	Oral Rehydration Salts
PC	Planning Commission
PEM	Protein Energy Malnutrition
PHC	Primary Health Care
PMO	Prime Minister's Office
RDC	Regional Development Committee
RMT	Regional Management Team
RTF	Regional Task Force
RtHC	Road to Health Card
SFPP	Supplementary Food Production Programme
SIDA	Swedish International Development Agency
SM	Social Marketing
SSC	Social Service Committee
TANU	Tanganyika African National Union
TB	Tuberculosis
TBS	Tanzania Bureau of Statistics
TDHS	Tanzania Demographic Health Survey
TFNC	Tanzania Food and Nutrition Centre
TINP	Tamil Nadu Integrated Nutrition Programme
UFMR	Under Five Mortality Rate
UMATI	Planning Association of Tanzania
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population
UNICEF	United Nations Children's Fund
UNP	University of Natal, Pietermaritzburg
UPGK	The Family Nutrition Improvement Programme
URTI	Upper Respiratory Tract Infection
VAD	Vitamin A Deficiency
VEO	Village Executive Office
VG	Village Government
VGA	Village General Assembly
VHC	Village Health Committee
VHD	Village Health Day
VHW	Village Health Worker
VR	Village Register
WFWP	Women Family Welfare Programme
WHO	World Health Organization
WIC	Women, Infant and Children

CHAPTER 1

INTRODUCTION

Preamble

In 1990 more than 1.1 billion people in developing countries were living in poverty and half of them in extreme poverty while nearly 190 million children below five years of age were underweight for age (Andersen et al, 1995a). The situation in Tanzania is similar, about one million children are underweight for age (TBS/UNICEF, 1996). As a consequence of malnutrition, children are dying from minor diseases which become fatal due to reduced immunity. Those who survive may suffer long-term reduction in their learning and working capacity.

The contemporary situation indicates that there is great concern among governments and international institutions about nutrition as an important aspect of development. Nutrition is important in the development process as it is viewed as an investment in human capital and also as a saving for other sectors of the economy. Efforts at improving the nutrition status of children are also viewed as a means to exercise rights for children, rights for a better life and rights to survival. These concerns are reflected by a number of nutrition related programmes which are implemented by different communities. Programmes have been implemented in some communities more successfully than in others (Andersen, 1991; ACC/SCN, 1991; Jonsson et al, 1993; Balachander, 1993; Andersen et al, 1995b). Lessons from these programmes show that there are no "magic bullets" that will provide appropriate solutions for every community.

The determinants of malnutrition are many and they differ from one community to another and sometimes from one household to another in the same community. Furthermore, the determinants of malnutrition are influenced by time, individual behaviour, the socio-economic, cultural and political environment which usually differ from one place to another (Andersen, 1991; Pelletier, 1994; Jonsson, 1995). Any efforts to deal with malnutrition should take into consideration the type of community involved and the set of circumstances responsible for influencing the determinants of malnutrition in the particular community.

The remainder of this chapter consist of six sections. The first considers background information for the Child Survival, Protection and Development (CSPD) programme in Tanzania, followed by the motivation for the study, limitations, expectations, aim and objective of the study. The final section outlines the structure for the remainder of the thesis.

1.1 Background Information on the Child Survival, Protection and Development (CSPD) Programme

The CSPD programme is a community based programme implemented in several regions of Tanzania including Mara and Singida regions. The programme uses community participation as an important pillar for its implementation. This approach is evident through the emphasis of the programme on supporting communities to take a leading role in solving their own problems (UNICEF, 1989). The main goal of the programme is to empower communities to assess, analyse and take appropriate actions aimed at

improving their own conditions, especially those related to health and nutrition (UNICEF, 1989; Jonsson et al, 1993).

The implementation of the CSPD programme in Mara and Singida regions officially started in 1990. One of the objectives of the CSPD programme is to improve the nutrition status of children. Data from the CSPD areas suggest that there has been a reduction in the rate of malnutrition in all areas implementing the programme (see Figure 2 page 56). For example in Mara and Singida regions, malnutrition has dropped from 32 to 17 percent and from 34 to 29 percent in the respective regions over a period of five years (1990 - 1995).

Implementation of the CSPD programme draws a great deal on experience from the Iringa Nutrition Programme (INP). The INP was initiated as a pilot project in 1983 by the government of Tanzania with funding from UNICEF, WHO and the Italian government. Evaluation of the INP suggested that the philosophy used in the implementation of the INP could be used elsewhere in the country (UNICEF, 1989). To date more than 10 regions are implementing the CSPD programme based on the experience obtained from the INP (TBS/UNICEF, 1996).

In order to facilitate monitoring and coordination in terms of resources and technical support from donors, central and local governments, the programme is categorized into several components. These components are: community mobilization; adequacy of food intake; child development; community based education; health; water and sanitation;

income generating activities; and management of information systems. The activities under each component are mainly decided by the community members themselves using their own decision making structures.

1.2 Motivation for the Study and Choice of the Study Area.

As a nutrition advisor working for a parastatal organisation, the researcher was involved in the conceptualisation, writing of the proposal for, and implementation of the CSPD programme in the two regions. The researcher was involved in the programme in the two regions between 1989 and 1996. The experience accumulated during initiation and implementation of the programme motivated the researcher to undertake an in-depth study on the basic processes which are involved in the implementation of the programme in the two regions.

The questions which the researcher had in mind included: are there any basic processes which are involved in the implementation of the CSPD programme across different social settings and economic activities ? If there are, which are they ? It was observed that all regions which were implementing the programme showed a decline in malnutrition (see figure 2 page 56). From the experience of the researcher working in the areas, it appeared as if there were basic processes needed for the implementation of the programme irrespective of cultural and social settings.

The study was undertaken in order to elucidate and understand the basic processes which were involved in the programme and how they were implemented. This understanding is important to improve implementation of the programme, not only in the study area, but throughout the country. In addition, understanding of processes can be used to improve health and nutrition related policies and strategies in the country in general. The fact that there has been little emphasis on the processes involved in the implementation of nutrition related programmes also motivated the researcher to contribute to information available to implementors.

The regions involved in the study were selected to represent two sets of regions namely those which displayed a low rate of malnutrition reduction and those which showed a high rate of reducing malnutrition as a result of implementing the programme (see figure 2 page 56). Singida represents the first category while Mara represents the second. In addition, the two regions were selected because implementation of the programme in the two regions started in the same year, 1990. The experience and prior knowledge of the researcher about the two regions were also reasons for selecting the regions. It was also thought that in order to optimise information regarding the processes involved during implementation of the programme in different areas and social groups, selection of more than one region was needed. The selection procedure described above would enable the researcher to see a range of processes under different circumstances and to determine which processes are basic to all the areas. The reason as to why there is a difference in the rate of reducing malnutrition in the two areas is beyond the scope of this study.

1.3 Expectations of the Study

It is anticipated that the outcome of the study will be to further the understanding of fundamental processes involved during the implementation of the programme in the two regions. That understanding will be vital input to those who are involved in the implementation of the programme and other community based programmes elsewhere in the country.

1.4 Limitations of the Study

The main limitations of the study were time and funds available and the size of the sample involved in the study.

❑ Time and funds

In order to understand thoroughly the processes which take place in the community there should be adequate time to participate physically in the processes. This was not possible due to the limited time and funds available. As a result it was necessary to depend on individual and group discussions, household interviews and personal experience in order to obtain adequate information. The study was conducted from 20th of May to 12th of June 1997.

❑ Sampling

There are more than 10 regions in Tanzania which are implementing the programme. It was only possible to involve two regions in the study. In the two regions there are more than six districts which are implementing the programme. Using the available resources,

only two districts could be covered in the study. However, the two districts were randomly selected from the districts implementing the programme. This limited coverage of districts might have contributed to some bias in the selection of districts and villages involved in the study. Any conclusion therefore can not be made for the whole country.

1.5 Aim and Objectives of the Study

1.5.1 Aim of the Study

The central aim of the study is to examine the processes involved in the implementation of the CSPD programme in Mara and Singida regions, Tanzania.

1.5.2 The Objectives of the Study

To achieve the aim, the objectives are:

- to determine the basic processes which were involved in the implementation of the programme in Mara and Singida regions.
- to determine how the processes were implemented in the two regions

1.6 Structure of the Thesis

The thesis is comprised of a further five chapters. Chapter two is a review of the relevant literature which is needed to contextualise this particular study. Chapter three describes the study area while chapter four outlines the methodology used to carry out the study. Chapter five provides the results and discussions which have materialized as result of the fieldwork. Chapter six provides the conclusion and recommendations, based on both the contextualisation of the study and the experience of working with the community in the field.

CHAPTER 2

LITERATURE REVIEW

Preamble

Solving the problem of under-nutrition is one of the most challenging tasks continuing to face developing countries. Nutrition interventions that have been employed in the past mainly concentrated on food (Pemberton and Harris, 1988). As a result, the solutions for the problem basically dealt with food issues especially increasing food production. The lessons gained from these programmes indicate that increasing food supplies alone was not enough. An explicit incorporation of nutrition goals into the overall development plans of a country seems to be necessary in order to realise both rapid national development and a sustainable solution for malnutrition (Melville, 1988; Pemberton and Harris, 1988; Jonsson, 1995; Andersen et al, 1995b). The reason for this is that both social and economic variables are responsible for the problem of malnutrition.

Poverty is one of the basic determinants of malnutrition in a society (Melville, 1988; Kavishe and Mushi, 1993; Andersen et al, 1995b; Jonsson, 1995). Among the more conspicuous features of poverty are poor conditions of health and nutrition, poor housing and environmental sanitation. (Sai, 1981; Jonsson, 1995). Improvement of these aspects is the objective of many nutrition related and development programmes. It appears that people now understand that in order to improve standards of living, nutrition programmes can not be separated from development programmes. This section attempts to examine the implementation of nutrition related programmes in relation to development processes by answering two main questions. The questions are:

- Why are nutrition programmes important for the development process?
- What lessons are available regarding the implementation of successful

nutrition programmes?

2.1 Importance of Nutrition to the Development Process

The ultimate goal of development is to bring about sustainable improvement in the well-being of the individual. Development is regarded as efforts concerned with human beings as ends rather than means (Qizilbash, 1996). The well-being of an individual is characterised by access to food, health, education, shelter and social welfare. These are elements which meet the basic needs of human beings. Therefore for any development programme to be meaningful it must include adequate consideration of these elements.

Poverty and malnutrition are linked (Monckeberg, 1983; Jonsson, 1995). Therefore efforts to eliminate poverty and malnutrition will be meaningful only if significant and parallel economic and social development takes place in a society. This implies that instead of looking at economic development as a necessary prerequisite for human development, investment in human development should be recognised as a key intervention for economic development.

The economic importance of improving nutrition status can be viewed in two ways. First it can be viewed as investment in human capital as it influences the future economic productivity of an individual and secondly as resources saved in other sectors of the economy (Selowsky, 1983). The two viewpoints justify why a country should allocate limited national resources to improving the nutrition status of people in the country.

2.1.1 Investment in Human Capital

The ultimate objective of nutrition programmes is to promote the health of individuals and hence their living standards. The improvement of an individual's health results in improved quality of life which is manifested through, among other things, increased life expectancy. The fact that people will live longer means that the productive years of individuals will increase. However, at national level the effective use of human resources will depend on the ability of each country to absorb the available human capacity while at the individual level, it will depend on other resources that an individual can exploit, such as land.

- **Nutrition and human productive capacity**

Chronic under nutrition in adults results in adaptive behaviour necessary for an individual to survive. However, this ability to adapt can result in serious effects on social and economic aspects in the long term (Scrimshaw, 1994). Adaptation is associated with reduced physical activity and therefore individuals become less productive. In addition, there is a loss of body mass which is associated with tiredness, muscle soreness, irritability, loss of ambition, concentration, and depression which in turn affects the productivity of an individual (Scrimshaw, 1994). Under-nutrition also affects the learning capacity of children in school such that their school performance becomes low and hence affects their productive capacity in terms of intellectuality when they enter the labour force. Therefore for countries with high levels of malnutrition the capacity of the people to do productive work is likely to be significantly reduced. In the absence of deliberate efforts to protect the health of individuals, loss of human resources occurs due to reduced working capacity and premature death.

2.1.2 Resource Saving

Good nutrition status of children can save resources which would have been used in other sectors such as health and social welfare to deal with the consequences of malnutrition and related diseases. In economic terms this can be illustrated as follows:

> "... better infant nutrition can save resources presently being invested in related sectors. Governments are already devoting economic resources to achieve particular minimum social targets (which may be called outputs) in sectors such as health and education. If infant nutrition is one of the several inputs determining these 'outputs', the economic question becomes what is the optimal combination of inputs that will maximise the cost of reaching these 'outputs' or social targets. If the total cost of achieving a particular target goes down with improved children's nutrition status a 'resource savings' benefits arises. Improved nutrition has released resources ...." (Selowsky, 1983: 24).

The "released resources" is viewed as a saving due to the improvement of nutrition and can therefore be used in other sectors. Practically the idea can be illustrated by the Women, Infant and Children (WIC) programme of United State of America and the Tamil Nadu Integrated Nutrition Programme (TINP) of India.

An evaluation of the WIC programme indicated that the programme was associated with a lower incidence of preterm births and a longer gestation period (ACC/SCN, 1991). It was observed that there was a saving in terms of medical costs during the first two months after birth for both mothers and new borns. This implies that investment in nutrition related programmes can save medical costs in the long run. The implementation of the TINP resulted in a significant decline in hospitalisation for diarrhoeal diseases (Balachander, 1993). This again indicates that there was a saving in terms of hospitalisation costs.

Another aspect of cost can be viewed in terms of saving costs related to death. Mild and moderate protein energy malnutrition may raise the mortality risk by 2 percent and 3 percent respectively while vitamin A deficiency alone may increase mortality by more than 20 percent (Jonsson, 1995). Although it is not easy to quantify the cost associated with the death of a child at an individual level, one could include time and money required to complete mourning and funeral services. In addition, there are also emotional and opportunity costs. Opportunity cost involves expectations of the parents and other people in relation to the child if he would have survived. In addition, at the community level there are some costs which can be associated with deaths such as time spent in supporting the affected families. Therefore by preventing deaths related to malnutrition, savings are made in terms of costs related to the death which would have otherwise occurred.

2.1.3 Nutrition as a Human Right

Ethically every human being is entitled to life as evidenced in the constitutions of various countries. The majority of children who die in the developing world die from diseases which are nutrition related and could be prevented if appropriate measures had been taken (Grant, 1987; Andersen, 1991; UNICEF, 1993). Therefore improving the nutrition status of children will reduce the risk of children dying from malnutrition and hence ensure their right to life. According to human rights law, governments are required to devote the maximum available resources to realising the right to nutrition along with other economic, social and cultural rights (Robertson, 1996). It should be noted that the majority of governments acknowledge that resources are scarce but this is not an excuse for not devoting resources to nutrition programmes. Allocation of resources in many cases

reflects the priorities of governments therefore whether or not nutrition is a priority can be determined by the way a government allocates resources to different sectors.

In December 1986, the United Nations (UN) general assembly made a declaration on development as a human right, the pillar of which is found in the universal declaration of human rights, article 28, which proclaims that:

> "... everyone is entitled to social and international order in which the rights and freedom set forth in this declaration can be fully realised ..." (Eide, 1996: 25).

With regard to "social order" the declaration on human rights to development provided in article 8(1) proclaims that:

> "... state shall undertake, at national level, all necessary measures for the realization of the right to development and shall ensure, *inter alia*, equality of opportunity for all in their access to basic resources, education, health services, food, housing, employment and the fair distribution of income ..." (Eide, 1996: 25).

The inclusion of health services and food implies that nutrition is also included. It should be noted that one potential advantage of applying a human rights approach to development, including nutrition, provides a means of enforcement (Jonsson, 1996). Enforcement mechanisms include legislation which ensures preservation of individual health. Such legislation includes those which promote breastfeeding, ensure production and consumption of iodised salt and general food legislation which protects human safety. Another advantage of using a human rights strategy is that people will be able to demand their rights. This will eventually lead to members of communities themselves having the means to effectively assert their rights to food and nutrition. In the Iringa Nutrition

Programme (INP), human rights were strongly emphasised. This was evident in slogans such as *"the right to survive"* which were used in mobilising people to participate in the implementation of the programme (Jonsson et al, 1993). Leaders and the community at large were challenged to ensure that children were not dying from malnutrition related diseases (Jonsson et al, 1993).

In summary it can be said that nutrition programmes are important for three main reasons. Firstly, nutrition is an investment in human capital resources which is a crucial input in the development process. Secondly, improvement of the nutrition status of children and the general community has a saving effect on other sectors of the economy such as health and social welfare. In addition, resources at individual levels which would have been used if death had occurred have also been saved. Thirdly, nutrition programmes are a means to ensure the human right to basic needs such as food and good nutrition for children who would otherwise die in the absence of deliberate strategies to prevent this. Efforts in this regard include implementation of nutrition related programmes especially at community levels.

2.2 Implementation of Nutrition Programmes

Many nutrition related programmes have been designed and implemented in order to alleviate the problem of malnutrition in different countries. Some of the programmes have been able to achieve their goals while others have not. Experience from all these programmes provides valuable lessons on what can work, how and under what circumstances.

The determinants of malnutrition are complex in nature and in most cases differ from one place to another. The determinants include the socio-economic, cultural and political environment which are also different from one place to another and sometimes from household to household in the same society (Underwood, 1983; Andersen, 1991).

For cost effective and sustainable interventions these differences need to be considered during the design and planning cycle of the programme. There is no standard package which can be used to alleviate malnutrition in different communities. Experience from various programmes indicates that successful programmes are those which focus on the local environment and behavioural patterns (Andersen, 1991). The lessons from these programmes show that there are basic principles which are crucial for any programme irrespective of the society involved in the implementation and causes of malnutrition. The basic principles include adequate conceptualization, community participation, commitment, effective monitoring system, clear structure for programme implementation, needs orientation, targeting and beneficiary selection, staff selection and adequate supervision, training, sustainability, and positive impact of the programme (Underwood, 1983; ACC/SCN, 1991; Andersen, 1991; Jonsson et al, 1993; Balachander, 1993; Andersen et al, 1995; Jonsson, 1995).

2.2.1 Adequate Conceptualization

The most crucial principle in implementing nutrition programmes effectively is conceptualisation of the programme and its objectives (Underwood, 1983). The process of conceptualisation should involve all people who will be involved in the implementation

of the programme. These include beneficiaries and others who are fiscally and physically responsible for the implementation of the programme.

In order to attain adequate conceptualisation, available factual information should be used to determine the problem, its magnitude and possible causes (Underwood, 1983; Berg, 1987; Pelletier, 1994; Pelletier and Jonsson, 1994; Jonsson , 1995). In this regard conceptualisation should start by making people aware of the problem, causes and possible solutions before embarking on the implementation of the programme.

Experience from the nutrition programmes in Iringa, Tanzania and Central Lombok and Java in Indonesia provides good examples of this basic principle. In both programmes conceptualisation was enhanced by using a simple approach which could be used by all people at any level of programme implementation. In Iringa the Triple A approach was used while in Lombok it was *Mawasi diri* approach. In both approaches there were three stages namely assessment, analysis and action. Assessment began with the detection of the problem, analysis involved identifying the solutions and the action stage involved decisions on what should be done to solve the problem (Johnston, 1993; Jonsson et al, 1993). The cycle continued to assess the effect of the actions until the problem was solved.

Political leaders who make decisions and allocate resources at all levels were mobilised especially in Iringa to participate in the process of conceptualisation. The leaders participated through seminars and workshops. As a result of adequate conceptualisation

there was substantial support from political leaders and other decision makers. In Iringa high level political support and action was the hall-mark for the success of the programme (Jonsson et al, 1993). In Lombok and Java the conceptualization process resulted in arousing the interest of leaders and other decision makers because all key people were involved in the implementation of a programme which was thought to improve their living standard (Johnston, 1993). At community level the conceptualisation process enabled the community to build confidence that they could take a leading role in solving their problem (Johnston, 1993; Jonsson et al, 1993). Conceptualisation thus facilitated an understanding by the community that solving the problem around them was their responsibility.

Although malnutrition as a problem can be universal, there are area specific variations in the differential contribution of various causal factors. Conceptualisation enables people to identify those differences such that they can be accommodated in the planning of interventions. Recognition of and accommodation to these local factors can determine the likelihood of interventions being successful (Underwood, 1983).

2.2.2 Community Participation

Community participation (CP) implies three main aspects namely sharing power and scarce resources, deliberate efforts by social groups to control their own destiny in order to improve their living conditions and opening up opportunities from below (Ghai, 1988). CP as a process is viewed as a means of strengthening the power of beneficiaries, especially the underprivileged. This is because by involving the community in decision making it allows beneficiaries to influence the direction and execution of the programme

(ACC/SCN, 1991).

Experience from various programmes indicates that CP is an essential element for sustainable development, especially in the area of food and nutrition (Shrimpton, 1995; Midgley et al, 1986). Therefore, social development is easily facilitated if people are allowed to participate fully in making decisions that affect their welfare and which they are accountable for (Midgley et al, 1986). Accountability is the cornerstone of any community based programme (Rhode, 1988). Whenever there is community accountability, the community will spend time and efforts to analyse their own situation, make decisions and conduct follow-up to see the effects of their decisions (Jonsson, et al, 1993). CP is a reflection of commitment and therefore ensures responsibility and accountability for the actions decided by the community (Midgley et al, 1986; Jonsson et al, 1993; Shrimpton, 1995).

At the conference on Primary Health Care (PHC) held at Alma Ata (USSR) in 1978, CP was accepted as one of the strategies to achieve health for all by the year 2000, and the area of food and nutrition was identified as one of the priority areas for actions (WHO, 1978). Active community involvement in the design, initiation and implementation of nutrition programmes is considered to be a critical determinant of the long term success of any nutrition interventions (Austin and Zeitlin, 1981; Underwood, 1983; Andersen, 1991; Chambers, 1992). The evidence of community participation is clear where successes have been recorded in implementing nutrition programmes as in the TINP or in the INP and *Posyandus* programmes in Indonesia. These programmes were tailored to the local

environment, and CP has been real.

However, CP does not reduce the need for government actions, it merely enhances the actions such that government becomes more supportive in nature (Chambers, 1992; Jonsson, 1995).

As discussed earlier CP is essentially associated with decision making, both at community and individual levels. For communities to participate in decision making, information is required. Information is supplied through training, continuous supportive supervision and through development of participatory research methods (Chambers, 1983; Chambers, 1992; Pelletier, 1994; Shrimpton, 1995). Once the community is knowledgeable, CP as a strategy results in improved coverage of activities and improved efficiency because of willingness to participate effectively due to agreement about priorities, interventions and processes (Jonsson et al, 1993).

An assessment conducted on different programmes to examine CP in the needs assessment, organization, leadership, training, resource mobilization, management, orientation of activities, monitoring and evaluation, found that the INP scored high compared to other programmes like TINP, Family Nutrition Improvement Programme (UPGK) in Indonesia and National Growth-Monitoring Programme (NGMP) in Thailand (Shrimpton, 1995). CP in the INP was enhanced by the use of the Triple A approach by communities through their decision making mechanisms such as committee meetings and Village Health Days (VHDs). Also involvement of local structures in the implementation and

supervision of the programme, support from government, massive training, use of mass media and involvement of youth and women's groups were responsible for facilitating CP (UNICEF, 1989; Jonsson et al, 1993). In order to conclude whether or not there was adequate CP the following indicators were identified during the workshop on "Managing Successful Nutrition Programmes" which was held in Seoul, Korea in 1989.

- **Support from government**

It is necessary for any programme to get support from both local and central governments. Support obtained means that the implementation is in line with existing government policy. In many successful programmes, support from the government was one of the key elements for fostering CP, especially when the local government was involved. Programmes such as TINP in India, INP in Tanzania, Supplementary Food Production Programme (SFPP) in Zimbabwe and UPGK in Indonesia provide evidence to this fact. Support from the respective government was through provision of resources such as funds and personnel and also using government facilities such as dispensaries and schools for facilitating programme activities (Oduber, 1987; ACC/SCN, 1991; Andersen 1991; Jonsson et al, 1993; Balachander, 1993; Pollet and Fincham, 1993).

- **Participation in the decision making process**

Participation of local structures in decision making should occur from the point of planning to evaluation. In reality communities participate in short term planning and long term planning is left to professionals (ACC/SCN, 1991). Probably this is because of the complex nature of the planning process which needs to involve different sectors. However,

many programmes were found to be able to ensure CP in decision making in relation to implementation and monitoring of the programme.

In the INP for example, the community was involved in making decisions through the implementation structures which included representatives of the committees as well as by involving individuals through VHDs (Jonsson et al, 1993). The Community was represented in health committees, village governments and district councils. The case was similar in the SFPP where community committees made decisions affecting the allocation of funds (ACC/SCN, 1991). Other programmes which were successful in terms of enabling community participation in decision making are Nutrition and Primary Health Care (NPHC) in Thailand and UPGK in Indonesia (ACC/SCN, 1991; Shrimpton, 1995).

- **Community groups**

Community groups include local committees such as health committees which take the responsibility of managing the programme at the local level. The use of such a committee to manage the programme was found to promote a sense of local responsibility and ownership of the programme by the community (ACC/SCN, 1991; Jonsson et al, 1993;). In the INP, the village leadership played a remarkable role in the management of the programme, villages with weak leadership lagged behind those villages with strong leadership (Jonsson et al, 1993). Community organisations are therefore important especially in promoting activities in the community (Shrimpton, 1995). It appears that the creation and strengthening of community organisation capacity is important for attaining long term and sustainable objectives such as empowerment. Experience from many

programmes indicates that successful programmes are usually characterised by involvement of community organisations which are part of the existing community structures.

- **Training and using local community members as programme staff**

Training will be covered in section 2.2.9 but at this stage suffice it to say that training of local staff is a strategy for ensuring CP and later sustainability of the programme. In order for a programme to be sustainable local staff must be involved in the implementation of the programme. Therefore the training of local staff will ensure that the staff are capable of implementing the programme especially when external staff are involved.

- **Contribution of resources**

Contribution of resources alone cannot fully indicate CP unless the contribution is fully linked to decision making power (ACC/SCN, 1991). An increasing sense of ownership of nutrition programmes should lead to a greater voice in the process of implementation , with the main objectives being to eliminate external dependency and ensure sustainability of the programme (Underwood, 1983; ACC/SCN, 1991). Many successful programmes indicate great potential for sustainability when there is adequate contribution of resources at local level for the implementation of the programme. For example in the INP in Tanzania more than 80 percent of the villages supported their village health workers through contributing cash or in kind. In UPGK in Indonesia and the Barangay Integrated Development Approach for Nutrition Improvement of Rural Poor (BIDANI) programme in the Philippines the community was responsible for the maintenance of supplementary

feeding activities in the programme (ACC/SCN, 1991). The mobilization of resources is also an indication of quality of leadership and commitment by all those involved in the process of programme implementation. In local settings this is done through labour, time or money.

Mobilization of the community is not an intervention by itself but rather a strategy to ensure the optimisation of people's involvement and contribution (WHO, 1987). In order to attain optimal involvement in programme initiation and implementation, particularly in decision making processes, a strategy should be well formulated during the design phase to ensure that the community will be motivated to participate in conceptualization, needs assessment, identification of priorities, and monitoring the progress of implementation (Jonsson, 1995). The mobilization process as it was undertaken in Iringa shows that this is a crucial process for identifying strategic allies who support the goals of the programme. It is also important ground work for marketing the outcomes of interventions, ensuring CP and soliciting support from various stakeholders (Jonsson et al, 1993;).

- **Linkages between programme activities and existing community organisations**

Linkages between nutrition programmes and other activities particularly those which relate to the objectives of the programme are regarded as a means to strengthen community capabilities in addressing issues related to malnutrition in their area (ACC/SCN, 1991). This was evident in the TINP where a linkage of the programme with women's groups enabled the programme to be communicated effectively among mothers (Balachander,

1993). In the INP the linkage between the programme and youth and women's groups enhanced adequate communication not only to those who were involved in the implementation but to the entire country. As a result the programme became known all over the country (Jonsson et al, 1993).

- **Information communication and sharing among the programme staff and beneficiaries**

Communication of information for the management of programmes, especially feedback of information to the local level is a crucial factor for fostering community participation. Communication and sharing of information by all people involved in the implementation of the programme not only assists the implementation of the programme but also helps to sustain community interest and increase community involvement (ACC/SCN, 1991; Pelletier, 1994; Jonsson, 1995).

It should be noted that although the above mentioned elements are regarded as indicators for community participation in the programme, there must be deliberate efforts and strategies in order to make them happen. One element is not enough to guarantee community participation and therefore adequate implementation of the programme. A combination of these elements will signify community participation. However, it is not possible to have all of them in one programme with the same strength, some will feature more than others in different programmes. This is due to the different circumstances in which the programmes are implemented.

2.2.3 Needs Orientation

One of the key elements of community development is to facilitate the process of needs assessment whereby beneficiaries participate in the identification and prioritisation of needs (Arole, 1988). Identification of priorities is a vital process in optimising limited resources such as human, finances and time. The process involves identifying the most pressing needs among the list of needs identified during the assessment. If the beneficiaries are involved in the identification of priorities then it is likely that they will be motivated to contribute to meeting the intended goals (Rhode, 1988; Cowan, 1988; Ghosh, 1988; Andersen, 1991). It is therefore important during the design phase to work out strategies which will ensure participation of beneficiaries in the whole process.

Community participation in needs assessment is a basic principle in empowering beneficiaries (Ghai, 1988). The empowering of beneficiaries is realised when they can be involved in assessing their needs and then determining their priorities. It should be noted that it does not matter whether or not the process is done by the community on its own or with some help from outside the community. What is important are the mechanisms which ensure constant involvement of beneficiaries (Shrimpton, 1995). Structures of implementation can be viewed as an attempt to ensure continuous community participation during the course of programme implementation. To make programmes needs oriented, different approaches can be used such as social mobilisation and social marketing (Jonsson et al, 1993; Balachander, 1993; Griffiths, 1994).

In summary it can be said that most of the national nutrition objectives can be realised through community based programmes (Underwood, 1983). In this regard involving community members in the process of identifying their needs is crucial. Success is mainly due to the fact that the community itself is given a leading role to determine its own needs based on the cultural setup.

2.2.4 Effective Monitoring System

Monitoring is a continuous process of watching and assessing both the implementation of the programme activities in the context of the implementation plan, and the intended objectives and outcome with the intention of taking appropriate actions (Mason et al, 1984; Casley and Kumar, 1987; Habitch, 1990). The primary role of this system is to generate data/ information which will be used for decision making regarding the implementation of the programme. The objectives of programmes may need to be modified during the course of implementation due to unexpected changes such as policies and funding problems. Under these circumstances monitoring becomes vital and instrumental in the process of programme implementation.

- **Elements of an effective monitoring system**

An effective system will be one which is able to detect as early as possible the need for action regarding the implementation of the programme. Monitoring systems become effective and sustainable if some of the data is used at the point of collection (UNICEF, 1992; Jonsson et al 1993; Pelletier, 1994; Jonsson, 1995). The system should be able to operate in a simplified manner and be flexible enough to accommodate any need which

arises during the course of programme implementation (ACC/SCN, 1991). It is important for a monitoring system to be simple such that all people who are involved are able to understand and use the information which is generated by the system. Simplicity also minimises the chances of making mistakes during data collection and processing and at the same time it facilitates decision makers to make reliable decisions. Lessons from different programmes indicate that effective monitoring systems depend primarily on the adequate understanding by the programme participants of the programme objectives, mode of implementation, their responsibilities and benefits of the programme (Underwood, 1983; ACC/SCN, 1991; Jonsson et al, 1993; Balachander, 1993; Jonsson, 1995). A flexible monitoring system is important due to the complex nature and shifting of interrelationships which influence nutrition status among communities. The ability to respond to changing needs for programme adjustments will depend on the flexibility of the system. The objectives of the programme should determine the type of monitoring system. This implies that the need for information will be defined by the objectives of the programme and the cost of putting the system in place, including training of personnel (Underwood, 1983). The training of personnel is an important element for effective management of the system especially for the collection and processing of data as well as the presentation of the outcome of the system (ACC/SCN, 1991; Pelletier, 1994; Jonsson, 1995).

In addition, an effective monitoring system should be able to motivate personnel involved in the implementation of the programme through feedback. Most of the successful systems have a clear system of feedback. Adequate information and two-way

communication in the INP enabled all actors to participate in assessment, analysis and action (Jonsson et al, 1993).

❑ Characteristics of indicators

Indicators used in monitoring systems should be reliable, relevant to programme objectives and able to be disaggregated and/or show trends over time (Mason, et al, 1984; Pelletier, 1994). Experience from successful programmes indicates that disaggregation of data provided further insight of the local situation. In the INP data were disaggregated by sex, age, socio-economic status and time (Ljungqvist, 1988).

It is important to emphasise that for a system to be effective, programme goals and objectives should be the determining factors for the content of information to be generated by the system and the way the system will work to ensure that all key participants are involved in the monitoring system.

In summary it can be said that in order to have an effective monitoring system a strategy should be worked out before starting the programme. The strategy should empower people to be able to detect problems, identify the causes and solutions as well as to establish effective ways of information communication and sharing for decision making, starting from the point of information generation. Also efforts should be made to ensure that there is a demand for information by all decision making structures. The demand will be the driving force for a viable and sustainable system.

2.2.5 Clear Structures for Programme Implementation

Clear and stable structures for implementing a programme are an important factor for the success and sustainability of a programme. This is mainly important in order to facilitate coordination of various ongoing community activities (Underwood, 1983). As mentioned earlier causes of malnutrition are many, such that all sectors of human development need to be involved. In this regard efforts from different sectors are needed in order to deal with malnutrition effectively. In order to use input from different sectors at national and lower levels, clear structures are needed to coordinate the efforts.

Within a programme the importance of structures is observed when the following questions can be answered by the structures. Who is supposed to make decisions regarding resource allocation at a particular level ? How are decisions made ? How do community members participate in the process of decision making ? How are different levels of programme implementation linked to one another ? How is the programme monitored ?

It should be noted that the establishment of programme implementation structures should take into consideration the possibility of using the existing structures. Experience from many programmes shows that the use of existing structures enhances the incorporation of programme activities into ongoing activities as well as linking implementation of nutrition programmes with that of other development programmes. For example the INP in Tanzania, the TINP in India and the SFPP in Zimbabwe had clear implementation structures which were linked to the existing administrative structures at all levels of

implementation (ACC/SCN, 1991; Jonsson et al, 1993; Balachander, 1993). In those programmes responsibilities of any segment of the structures were clearly defined such that accountability was ensured. Linkage between the implementation structures and local structures facilitated community involvement in the implementation of the programme. However, the strength of community participation differed from one programme to another depending on the leadership involved in the structures.

2.2.6 Commitment

Commitment to the programme by all people involved as well as government is a crucial factor for the success of the programmes (Underwood, 1983; ACC/SCN, 1991; Jonsson at al, 1993; Rhode et al, 1993). Commitment is an indication that the programme has been accepted and that people are ready to assume responsibilities related to the implementation of the programme. Commitment is usually reflected by the actions of those who have agreed to implement the programme. Commitment by government is reflected in the policies which are in place to support programme activities. Such policies include Food and Nutrition Policies of many countries like Tanzania, the Nutrition Act of the Philippines as well as other legislation which facilitates nutrition related programmes. In addition to policies and legislation, commitment of government is also reflected through allocation of resources such as funds and personnel to facilitate implementation of the programme. At the community level commitment is reflected through contribution of resources such as labour, time and cash in order to facilitate the implementation of the programme in their area. Generally at the community level, commitment is reflected through community participation (Underwood, 1983; ACC/SCN, 1991; Jonsson et al,

1993)

It should be realised that political commitment is important for implementing a programme in a successful manner (Monckeberg, 1983). However, to obtain a political commitment is not an easy undertaking. The main priority of politicians is to get and remain in power. Therefore support to nutrition programmes is rendered only if there are clear benefits which will ensure that they are going to stay in power.

It is for this reason that when lobbying for political support one should take into consideration political benefits. Experience in developing nutrition related policies in many countries provides an example of political considerations because in order for the policies to be in operation they must be politically attractive and acceptable (Monckeberg, 1983). Although political issues should be avoided as much as possible, sometimes they should be taken as input in the process of designing nutrition programmes. Experience from the INP indicates that political commitment was important for successful implementation. This was done by enabling the community to understand the need to have a nutrition programme in their area. Politicians then started to work from people's need for their political purposes. This was a benefit for the programme because politicians understood that if they wanted to be popular, they had to work within the needs of the communities. It is important to have dynamic policies which will ensure that the implementation of nutrition programmes is not just a matter of politics but a means of solving nutrition related problems within communities.

In summary it can be said that commitment of all stakeholders is important in order to implement a programme successfully. Commitment can be regarded as acceptance of responsibility towards the implementation of the programme. In order to ensure long-term sustainability of the programme commitment of all stakeholders should be visible before initiating the programme.

2.2.7 Targeting and Beneficiary Selection

Targeting is a process of identifying beneficiaries (households and communities) (Jonsson et al, 1993). Targeting is a fundamental process because targeted beneficiaries should play a major role in problem identification and diagnosis as well as programme initiation (Andersen, 1991). Targeting and selection of beneficiaries is an important process to ensure cost effectiveness and to focus on those who are most in need. Targeting can be done in three main ways. Firstly, it can be done based on geographical location. This involves decisions such as implementing the programme in the entire country or in certain locations. Secondly, targeting can be done based on individuals who are at risk of being malnourished due to certain circumstances. Examples are under fives and pregnant women. This type of targeting intends to ensure that the individuals do not get malnutrition related problems. Thirdly, targeting is done based on the need. Criteria used in identifying the needy are usually based on the socio-economic data or nutrition related information such as anthropometry. In this type of targeting, criteria used in determining eligible beneficiaries are strict (ACC/SCN, 1991).

All categories of targeting can be used in one programme in order to meet specific objectives of different components of the programme. For example nutrition programmes which have a feeding component will use strict criteria to determine eligible targets for feeding while the education component of the same programme will direct the education to the entire community.

Experience from successful programmes such as the TINP and the INP indicates that targeting was one of the important elements which enhanced focussed implementation. In addition it was observed that in order to be clear about the target group, a definition of a target group needs to be made clear during the design and planning process. One of the advantages of having a clear definition of the target group is related to monitoring the achievement of the programme in terms of process and impact. This is because efforts are concentrated on a specific group which is easily identified and accepted within the agreed definition (ACC/SCN, 1991).

Lessons from the TINP and the INP show that the process of targeting is politically vulnerable (Underwood, 1983; ACC/SCN, 1991). This is because conflict may arise between programme and political interests. For example it may be decided that certain services such as a dispensary are to be located in a particular area due to political reasons hence the process of targeting may not be accepted by government. In such a situation targeting may fail. However, in the absence of such conflicts, targeting can be successfully implemented.

In order to realise effective targeting there must be information available which will be used to define the target groups. Experience from the TINP and the INP indicates that information from existing or newly formed Growth Monitoring and Promotion (GMP) data can be used to locate those at risk and also those who are in need. Growth monitoring has been used extensively as a tool for targeting under fives and households at risk of malnutrition (Rhode, 1988; Ghosh, 1988; Cowan, 1988; Andersen, 1991; Owusu and Lartey, 1992; Jonsson, et al, 1993). Information on the socio-economic situation from regional to household level was also found to be useful in targeting. However, on some occasions surveys were necessary in order to obtain some information which was missing from the existing information system. If the targeted population is involved in the conceptualization of health and nutrition related problems it will enable them to assume greater responsibility for improving the situation and also to exercise their right to control their own development (Jonsson et al, 1993; Pelletier, 1994).

It is important therefore to have a thorough understanding of the approach and methodology to be used in targeting nutrition interventions. Experience from successful nutrition programmes indicates that the community can and will actively participate in any activity only if they are involved in the identification of and addressing their own needs in the order of priority which they see fit (Field, 1985; Arole, 1988; Jonsson et al, 1993; Balachander, 1993). Several authors have identified ineffective targeting as a major constraint to achieving the intended objectives (Andersen, 1991; Scrimshaw, 1994; Pelletier, 1994).

2.2.8 Staff Selection and Supervision

- **Selection of staff**

Experience from some of the successful nutrition programmes indicates that there are more advantages to using the existing staff than employing new staff specifically for the programme. For example in the SFPP in Zimbabwe and the INP, existing extension staff were drawn into the programme because it was difficult to employ new staff due to limitations of resources. It was also decided not to establish parallel structures as this would affect the sustainability of the programme. It appears that most of the successful programmes view incorporating local staff from the government as one of the potential factors for sustainability (ACC/SCN 1991). However, caution is needed when local staff are used in order to avoid overburdening them. This can be avoided by good management.

- **Supervision**

Close supervision has been recognised as an important element in many programmes (ACC/SCN 1991; Jonsson et al, 1993; Balachander, 1993). The importance of supervision is realised when it results in motivation of staff. In this regard supervision is not merely checking up of lower staff but rather is an inspiration process which aims at improving the performance of the programme staff. In order for supervision to realise the inspiration objective, supervisors should be able to provide constructive criticism of staff performance and at the same time be able to appreciate any successes achieved by the programme staff. In addition, supervision should be able to give incentives to the staff even if it is only by praise of word. Experience from various programmes indicates that

supervision has resulted in motivating programme staff through training especially through study tours and seminars (Rhode, 1988; Johnston, 1993; Jonsson et al, 1993; Balachander, 1993).

2.2.9 Training

Experience from different programmes indicates that training programmes need to be programme specific (ACC/SCN 1991; Johnston, 1993; Jonsson et al, 1993; Balachander, 1993). The specificity will be determined by the objectives of the programme and the time frame in which the objectives are expected to be met. Types of training at higher levels will depend on individual basic knowledge, how that knowledge needs to be incorporated into the programme and what additional skills are needed in order to implement the programme effectively. For example if the majority of staff come from the health sector it will be fairly easy to know what additional skills will be needed for them to work in the programme. In the case of multi-sectoral staff standardised training will be needed to ensure that all of them will be able to implement the programme. However, this has presented problems and therefore the best way is to train people based on the specific tasks which they will perform in the programme (ACC/SCN, 1991).

At community level the type of training will vary depending on literacy level. Therefore defining training needs seems to be a crucial aspect for every programme. This has been observed in the SFPP, the TINP, the INP and Integrated Child Development Support (ICDS) in India (ACC/SCN, 1991; Jonsson et al, 1993; Balachander, 1993). The training needs should be identified continuously because training once is not enough.

On-the-job training should occur after initial familiarisation and mechanisms should be built into the programme which will ensure that the process of identifying the training needs is a continuous process. In some programmes Training of Trainers (TOT) has been observed as one of the mechanisms to ensure the continuous process of identifying and responding to training needs (Jonsson et al, 1993).

It appears that for any training at all levels of programme implementation, there is a need to standardise the training objectives and procedures for a particular group. In many programmes including TINP, SFPP and INP a training handbook was found to be important for standardising training procedures and important messages related to the programme. The additional advantage of having a training handbook is that the process of training can be easily monitored and assessed.

2.2.10 Sustainability

Sustainability of the programme is viewed as the ability to implement the programme without significant external resources, especially funding (ACC/SCN, 1991). Elements which determine sustainability of the programme can be categorised into two categories namely functional and resource sustainability. Functional sustainability is characterised by the technical ability to implement the programme without external assistance while resource sustainability is characterised by having no external support for resources such as funding and technical staff.

Experience from successful programmes indicates that most of the sustainable programmes can be replicated within the country or areas with a similar social cultural setup (ACC/SCN, 1991; Jonsson et al, 1993). The majority of such programmes start as a pilot with the intention of scaling up. For example the INP started in one region and later it was expanded to more than 10 regions. The Alternative School Nutrition Programme (ASNP) in the Philippines started with 23 schools but later was expanded to 1400 schools.

The ICDS in India started with 33 blocks and later it was expanded to more than 1000 blocks. The sustainability of these programmes is mostly reflected through functions and to a certain extent government support in terms of resources especially funding and staff. Most of the activities are performed by the local staff and beneficiaries themselves (ACC/SCN, 1991; Jonsson et al, 1993; Balachander, 1993; Johnston, 1993). Other programmes are said to be sustainable because they are linked with national institutions and programmes.

❑ Linkages with national institutions

Linkages with national institutions such as universities and research oriented institutions has ensured the strengthening of the technical capabilities of the programme implementors (ACC/SCN, 1991; Jonsson et al, 1993). Examples of such programmes include the INP which was linked to the national nutrition centre Tanzania Food and Nutrition Centre (TFNC) and local community development institutions (Jonsson et al, 1993). The BIDANI in the Philippines was linked to national academic institutions and the ICDS of India was linked to medical colleges and other technical institutions (ACC/SCN, 1991).

❑ Linkages with national programmes

Linkages with national programmes enhanced the use of recognised and familiar structures as well as available experience in involving communities in the implementation of programmes (ACC/SCN, 1991; Jonsson et al, 1993). For example the UPGK of Indonesia and the INP of Tanzania are linked to national Maternal and Child Health (MCH) programmes. The fact that the MCH programme has a large coverage and substantial involvement of local structures enhances community participation in the linked programmes through the use of staff experienced in training and also the involvement of local leaders in the mobilisation of community members. In addition, national programmes have well established structures and therefore the linkage ensures that the structures are also used for enhancing implementation of activities.

❑ Political stability

Stability of the government is an important factor for the sustainability of the programme. Most successful programmes were found to be implemented in countries with a stable political environment. When governments change, usually the priorities of the government also change and in most cases this is reflected in allocation of resources. In countries where political stability is questionable it becomes difficult to maintain and sustain normal administrative procedures such as supervision, monitoring and paying programme employees. Health services in Peru, Columbia and Guatemala in the 1970s were frustrated because of political crises among other things (Muller, 1993).

In this regard it particularly makes sense to emphasise community ownership of the programme. However, due to the low income of many communities it is important to promote activities which will broaden the economic base of the community such as income generating activities in order to be able to support programmes and other initiatives. This approach has been used in the ASNP in Philippines, the Weaning Food Projects (WFP) in Ghana and the NPHC Programme in Thailand.

In summary it can be said that sustainability of a programme is an indication of success in implementation because it ensures that the realised achievements will be sustained. However, in order to ensure sustainability of the programme it is necessary to firstly, formulate strategies which will be used to promote the capacity of local staff and the community in general to manage and implement the programme. Examples of strategies include training and mobilisation for community and government support. Secondly, there must be efforts to solicit community and government commitment to the implementation of the programme. Commitment is reflected through the level of community involvement and government contribution in terms of resources. Thirdly, there must be linkages between the programme and national institutions and programmes especially to support the technical needs of the programme.

2.2.11 Impacts

Lessons from many programmes which have recorded some success in implementation indicate that they were able to solicit more support from government and beneficiaries in general after the programmes showed a positive impact. For example the use of the

Mawasi diri approach in facilitating community participation in health related programmes in Indonesia proved that community participation was possible and that wherever this was visible, the quality of activities and level of community contribution to human development projects was high (Johnston, 1993). As a result the Department of Health in Indonesia supported the approach and incorporated it into other health related programmes. The success recorded by Women's Family Welfare Programme (WFWP) in the same country also resulted in the department supporting the programme. The department standardised the activities and prepared the training model for extending the programme to other parts of the country (Rhode et al, 1993). The impact of the INP and the TINP in improving the health and nutrition status of the children and increasing health related knowledge of community members as well as political leaders and other government staff resulted in remarkable support from the governments and communities involved in the implementation (UNICEF, 1989; Balachander 1993; Jonsson et al, 1993).

Summary

This chapter has indicated that there is justification for government and other financial institutions to invest in nutrition related programmes. The implementation of a programme is part of the process of developing human capital resource and cost saving efforts in other sectors of the economy in the long run. Also the implementation of nutrition programmes is regarded as a means to ensure human rights to life. Development depends on human capital among other factors and thus nutrition and development are linked. In order for nutrition programmes to attain their objectives, there are basic factors which are important to consider during the implementation of the programme. These

factors include adequate conceptualization, community participation, commitment, an effective monitoring system, clear structures for programme implementation, needs orientation, targeting and beneficiary selection, staff selection and adequate supervision, training, sustainability, and positive impact of the programme.

CHAPTER 3

THE STUDY AREA

Preamble

The study was conducted in two regions of Tanzania Mainland namely Mara and Singida. The profile of the country and the two regions will be discussed in this chapter. The discussion will centre on history of the country, geography, social and economic aspects, the health and nutrition situation and policies and programmes related to health and nutrition.

3.1 History of the Country

The United Republic of Tanzania resulted from the union of two independent countries, Tanganyika and Zanzibar on April 24, 1964. This section will concentrate on the former Tanganyika which is now called Tanzania Mainland. Throughout the document Tanzania Mainland will be referred to as Tanzania.

3.2 Geography

3.2.1 Location and Topography

Tanzania mainland lies between latitudes 1 degree South and 12 degrees South and longitudes 22 to 40 degrees East (Ngallaba et al, 1993). Except for the narrow belt of 900 square kilometres along the Indian Ocean coast, most of the country is higher than 1000 metres above sea level. The highest point in Africa - Mount Kilimanjaro is found in the northern part of the country. The peak of the mountain reaches 5895 metres (Ngallaba et al, 1993).

The country is surrounded by the Indian Ocean to the East, and the countries of Kenya to the North-east, Uganda to the North-west, Rwanda, Burundi and Zaire to the West, Zambia to the South-west, and Malawi and Mozambique to the South (Ngallaba et al, 1993).

The topography of the country is associated with some diseases and nutritional disorders such as malaria, anaemia and Iodine Deficiency Disorders (IDD) (Kavishe and Mushi, 1993). Anaemia is prevalent along the coast and low land areas due to the high prevalence of malaria while a high prevalence of IDD is observed at high altitude due to inadequate iodine in the soils and in the vegetation (Kavishe and Mushi, 1993). Malaria and IDD are among the health and nutritional problems of public importance in Tanzania as they affect the majority of people in the country.

3.2.2 Land and Lakes

The country occupies 945,234 square kilometres of which 6.5 percent is water (Ngallaba et al, 1993). There are several large lakes and rivers which provide many areas with the potential for fishing activities. Despite the abundance of water in the country the majority of people still depend on rains for farming both cash and food crops.

Mara region has a total surface area of 30,150 square kilometres, of which 56 percent is land and the rest is water, mainly from Lake Victoria and River Mara (TBS, 1993). Information about the surface area of Singida region is not available but from the map it appears that Singida occupies a larger surface area compared to that of Mara (Figure 1).

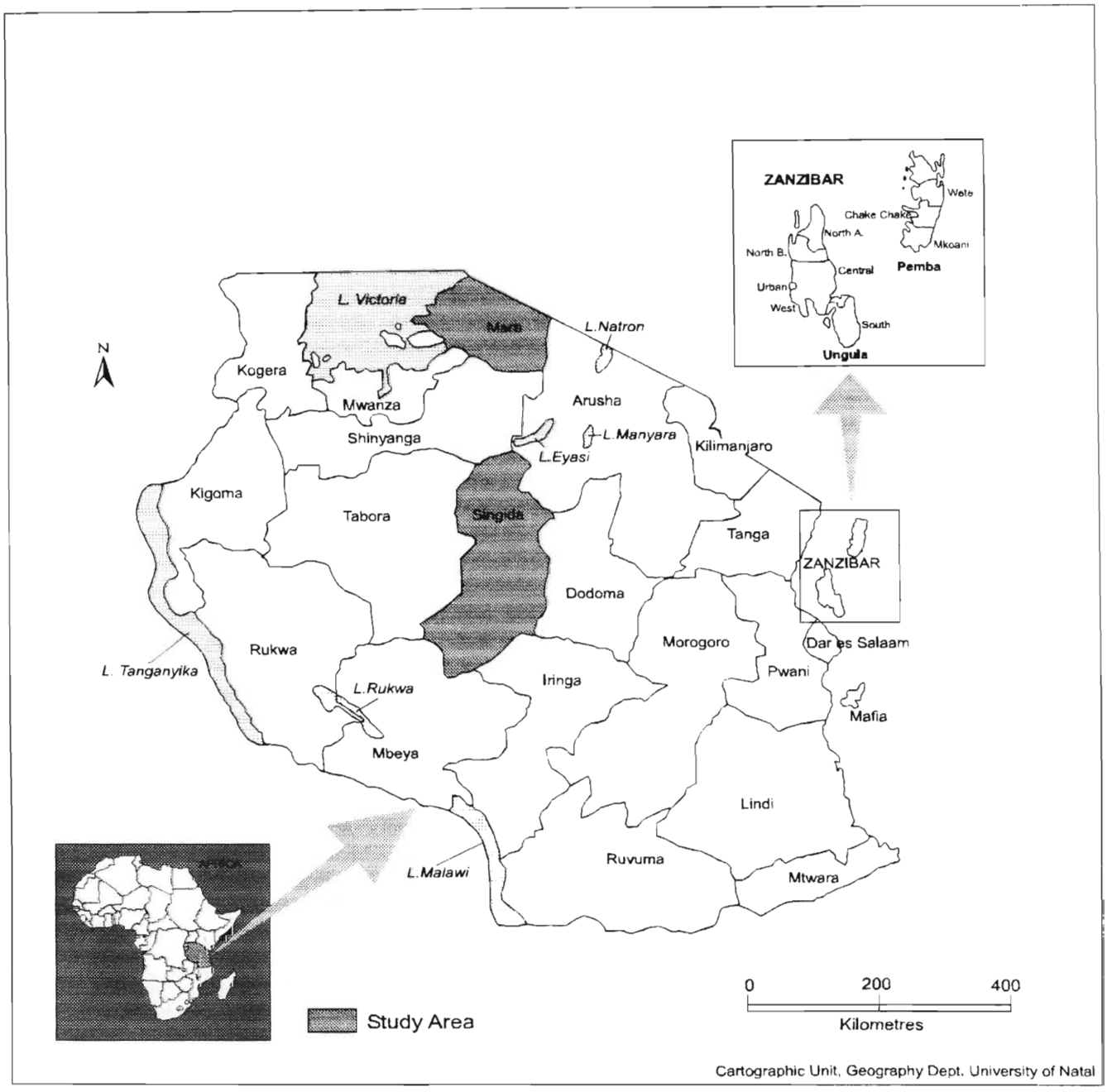


Figure 1: Map of Tanzania showing regions involved in the study

Source: TBS AND MoCDWAC, 1995

3.2.3 Climate

Tanzania has a dry period from May to October, succeeded by a period of rainfall during November/December which reaches its peak during March. In the dry season most of the areas in the country face shortages of green vegetables resulting in a high prevalence of Vitamin A Deficiency (VAD). This is mainly manifested in the central regions of the country where the rainfall period is short compared to other parts of the country. Singida being one of the central regions of the country is more prone to VAD than is Mara.

3.2.4 Population

The population of Tanzania according to the 1988 population census, was 23.1 million with an equal proportion of males and females. The average household size was 5.5 persons and population density 26 people per square kilometre (TBS, 1988). The annual population growth rate was 2.8. To date it is estimated that the population of Tanzania is more than 28 million people (Planning Commission, 1995). The demographic indicators for 1967, 1978 and 1988 are shown in Table 1.

Table 1: Tanzania: demographic indicators for 1967, 1978 and 1988.

Indicators	Census 1967	1978	1988
Population (millions)12.3	17.5	23.1	
Density (pop/sq. km.)	14	20	26
Percent Urban	6.39	13.7	18.33
Crude birth rate	24.4	19.0	15.0
Crude death rate	6.6	6.9	6.5
Infant mortality rate (per 1000 live births)	155	137	115
Life expectancy at birth	41	44	48

Source: Bureau of Statistics, 1967; 1978; 1988.

Table 1 shows that the population of Tanzania from 1967 to 1988 has almost doubled. Although the population is still predominantly rural, the proportion of urban residents has been increasing steadily, from 6 percent in 1967 to 18 percent in 1988 (Ngallaba et al, 1993). There was improvement in life expectancy as it rose from 41 years in 1967 to 48 years in 1988. The inter-censal growth rate dropped from 3.2 between 1967 and 1978 to 2.8 between 1978 and 1988. Crude birth rate decreased from 24.4 in 1967 to 15 in 1988, while crude death rate remained more or less constant. Table 1 also indicates that infant mortality rate per 1000 live births decreased from 155 in 1967 to 115 in 1988.

According to the 1988 population census the population of Mara region was higher than Singida region. Mara had 952,616 people while Singida had 792, 387. The population growth rate was 2.75 for Mara and 2.57 for Singida.

3.2.5 Administrative Divisions

The country is divided into 20 administrative regions, each of which are further divided into three or more districts. The districts are divided into divisions which are again divided into wards. Wards are divided into villages which are the smallest administrative unit. Village administration is enhanced by the Village Government (VG). This system of administration provides a unique and effective environment for mobilizing people to participate in different development projects including those related to health and nutrition (Kavishe and Mushi, 1993; Jonsson et al, 1993).

Administratively Mara region has 5 districts namely, Tarime, Serengeti, Bunda, Musoma Rural and Musoma Urban, with a total of 80 wards and 385 villages (TBS, 1993). Singida region has 4 districts namely, Iramba, Manyoni, Singida Rural and Singida Urban with a total of 74 wards and 346 villages (TBS, 1988).

3.3 Social and Economic Aspects

3.3.1 Social Aspects

Generally Tanzanian society is authoritarian in nature. In each village there are legal structures which are responsible for the welfare of the people and development in the village. People from the village elect their representatives to form decision making structures. Apart from the structures there is general meeting at least once in year to which every village resident is supposed to attend. Any decision made either by the structures and

general meeting or only the general meeting is regarded as a majority decision and every one has to respect it. Those who disrespect such decisions are punished. It is important to take note of this aspect of authoritarian because of its effect on the implementation of the programme especially in facilitating community participation.

Tanzania has more than 120 tribes, loosely defined and differing from each other in culture, social organization and language (Camerapix, 1992; Materu, 1994). There is no single tribe which dominates the others and this has resulted in a balance of power throughout the country and much lower levels of ethnic conflict than elsewhere in Africa (Camerapix, 1992). Swahili is the national language and is spoken by more than 95 percent of Tanzanians (Camerapix, 1992; Materu, 1994). The stability and the presence of one national language has created a conducive environment for the implementation of development programmes.

The major religions are Islam and Christianity. The latter includes the majority of the population (Ngallaba et al, 1993). There is also a small percentage of Tanzanians who still adhere to traditional beliefs (Camerapix, 1992). In Mara and Singida the two religions are dominant. Religious leaders have been used on many occasions in mobilising their followers to participate in the implementation of development programmes including the Child Survival, Protection and Development (CSPD) programme.

3.3.2 Economic Aspects

Tanzania has a mixed economy in which the agricultural sector plays a key role (Planning Commission, 1995). Agriculture which includes crop production, animal husbandry, forestry, fishery and hunting contributes the largest share of any sector to the Gross Domestic Product (GDP) and national income (Ngallaba et al, 1993). According to the Tanzania Bureau of Statistics (TBS) and the Ministry of Community Development, Women Affairs and Children (MoCDWAC) (1995), agriculture employs about 80 percent of the economically active population.

Major economic activities of Mara and Singida regions include mainly traditional farming and animal husbandry (TBS, 1993). Mara region is economically stronger than Singida due to the fact that Mara region has economically viable natural resources such as the Serengeti National Park, fishing industry from Lake Victoria and minerals, mainly gold. The regional economy is an indication of the resource base available which can be mobilised to support development programmes.

3.4 Health and Nutrition Situation

3.4.1 Health Situation

The government emphasised equity in the distribution of health services and views access to services as a human right (Ngallaba et al, 1993). In response to worldwide efforts to attain the social goal of "Health for all" by the year 2000, the Tanzanian health strategy focuses on the delivery of primary health care (PHC) services (Ngallaba et al, 1993; TBS

and MoCDWAC, 1995). In 1991 a new PHC strategy was developed by the Ministry of Health (MoH), with the objective of strengthening district management capacity, multi-sectoral collaboration, and community involvement in health related activities. Government commitment as well as guidance to enhance provision of health services to all people in the country is well articulated in the National Health Policy which was adopted in 1990.

❑ Mortalities

☞ Maternal mortality

Maternal mortality constitutes one of the major health problems in Tanzania. The mortality rate is estimated to be between 200 - 400 per 100,000 births (TBS and MoCDWAC, 1993). Maternal mortality rates are 60 times higher in Tanzania than in any country of Northern Europe (TBS and MoCDWAC, 1995). The high risk during individual births combined with the higher numbers of children born to women in Tanzania means that women are more than 200 times likely to die as a result of child bearing in their life time than women in Europe (TBS and MoCDWAC, 1995). Maternal Mortality Rate (MMR) for the country and the two regions for three consecutive years are summarised in Table 2.

Table 2: Maternal Mortality Rate (MMR) in Tanzania and the two regions of Mara and Singida for three consecutive years (1992, 1993 and 1994)

	Years		
Level	1992	1993	1994
Mara Region	67	59	106
Singida Region	242	171	238
National	199	211	197

Source: MoH, 1996.

Table 2 indicates that Mara had a lower MMR than Singida in all three years. However, both regions indicated some improvement in 1993 which did not last long because in 1994 there was a rise in MMR in all of the regions. The reasons for improvements and deterioration is not clearly known. It is likely that the improvement of the Health Information System (HIS) in the districts has resulted in more data and therefore is able to show a more accurate picture regarding mortality data (MoH, 1996).

☞ Childhood mortality

Childhood mortality is also a problem in Tanzania. The figures of the mortality rates for the two regions and nationally are summarised in Table 3.

Table 3: Infant and under five mortality rates in Mara and Singida regions in comparison with national rates of 1975 and 1985.

Region	Infant Mortality Rate		Under five Mortality Rate	
	1975	1985	1975	1985
Mara	140	125	236	211
Singida	137	96	231	157
National	137	115	231	191

Source: Bureau of Statistics 1978 and 1988 census.

Table 3 indicates that Infant Mortality Rates (IMR) and Under Five Mortality Rates (UFMR) declined during the period 1975 to 1985. However, the rate remained high for Mara compared to national figures while for Singida the rate was equal to or lower than the national figure.

❑ **Morbidity**

Malaria is a leading cause of deaths and hospital admission. Data from the MoH (1996) shows that 55.3 percent of children under five years of age admitted to health centres in 1995 were suffering from all forms of malaria. Other diseases included in the list of top ten are Upper Respiratory Tract Infection (URTI), diarrhoeal diseases, pneumonia, worms and eye diseases.

Acquired Immune Deficiency Syndrome (AIDS) is also becoming a threat to the Tanzanian population (MoH, 1996). By the end of 1994 the country had about 200,000 orphans and it was expected that the number would double by the end of this millennium (MoH, 1996). In response to this calamity the national AIDS task force was established in order to advise the government on AIDS control strategies. So far mass education through radio, posters, newspapers, leaflets, drama and political meetings has been successfully used, and as a result more than 90 percent of the population are aware of AIDS (TFNC, 1996).

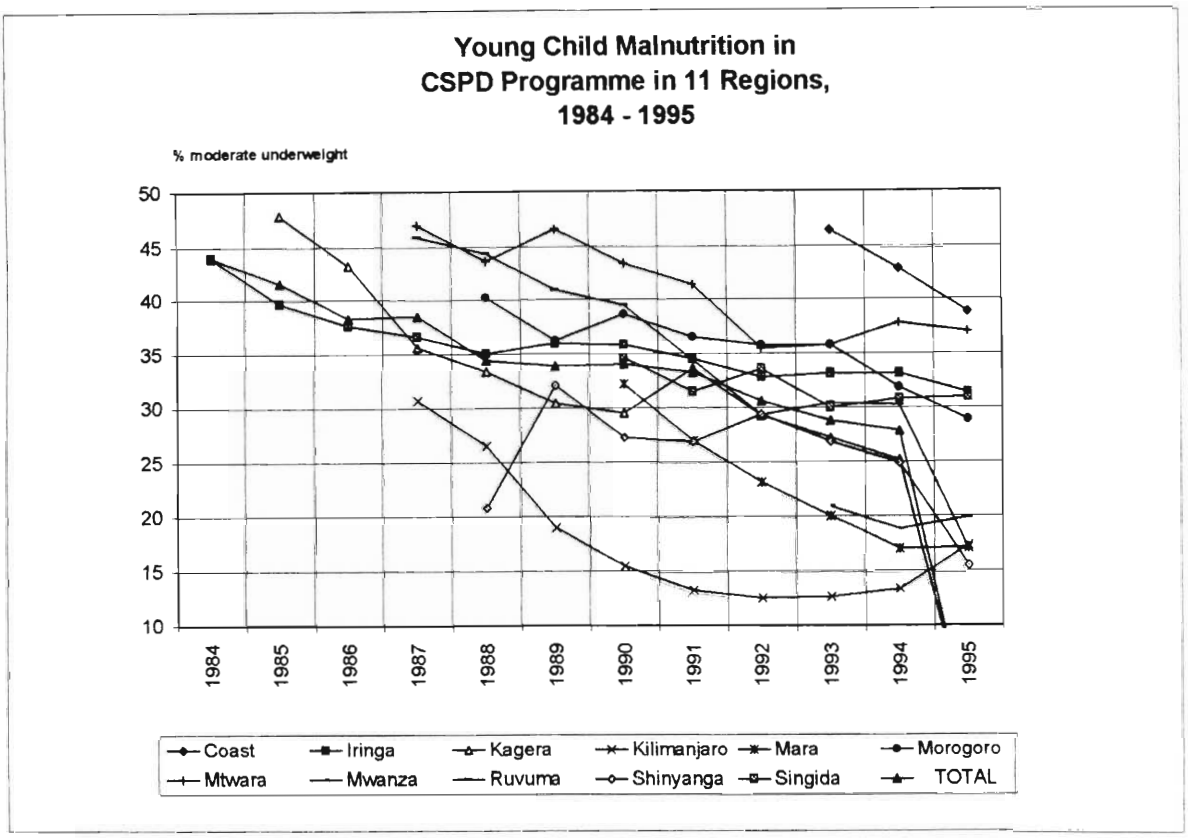
3.4.2 Nutrition Situation

Tanzania like many other developing countries is affected by four major nutritional disorders namely, Protein Energy Malnutrition (PEM), anaemia, IDD, and VAD (Kavishe and Mushi, 1993). Poor nutrition status in a society is manifested by high rates of child and maternal mortality as well as high rates of low birth weight (LBW) babies (Kavishe and Mushi, 1993).

❑ Protein Energy Malnutrition

The national nutritional data collected in 1995 through the national Mid Decade Goal Survey (MDGS) showed that the total underweight for age prevalence for under fives was 29.5 percent, stunting was 41.6 and wasting was 5.5 percent (TBS/UNICEF, 1996). This shows that stunting is the main problem in the country followed by underweight. In areas where there are specific programmes aimed at improving nutrition status, a remarkable decline of underweight for age has been observed (see Figure 2).

Figure 2: Malnutrition trends of young children in CSPD programme in 11 regions of Tanzania (1984 - 1995)



Source: UNICEF, 1995

These include areas where CSPD programme is being implemented. The situation of underweight in all the regions implementing the programme as shown in Figure 2 seems to be improving although at different rates.

❑ Micronutrient Deficiencies

☞ Anaemia

National estimates published by TFNC in 1986/87 showed that 32 percent of the total population were anaemic (TFNC, 1996). The same estimation showed that 40 percent of the anaemic population were pregnant or lactating women, 45 percent were under fives and 15 percent were school children and other adults. Geographically, the coastal zone and other low lying areas have very high prevalence rates of anaemia, and the prevalence decreases towards moderate and higher altitudes (Kavishe and Lorri, 1990).

☞ Iodine Deficiency Disorders (IDD)

It is estimated that 10 million people in Tanzania are living in areas deficient in iodine and are therefore at risk of developing iodine disorders (TFNC,1996). Data available indicate that more than 30 percent of the Tanzanian population are affected by IDD. The severity of IDD is highest in the highlands and mountains of the Western and Eastern arm of the great Rift Valley (Kavishe et al, 1988). The distribution of goitre in Tanzania is shown in Figure 3.

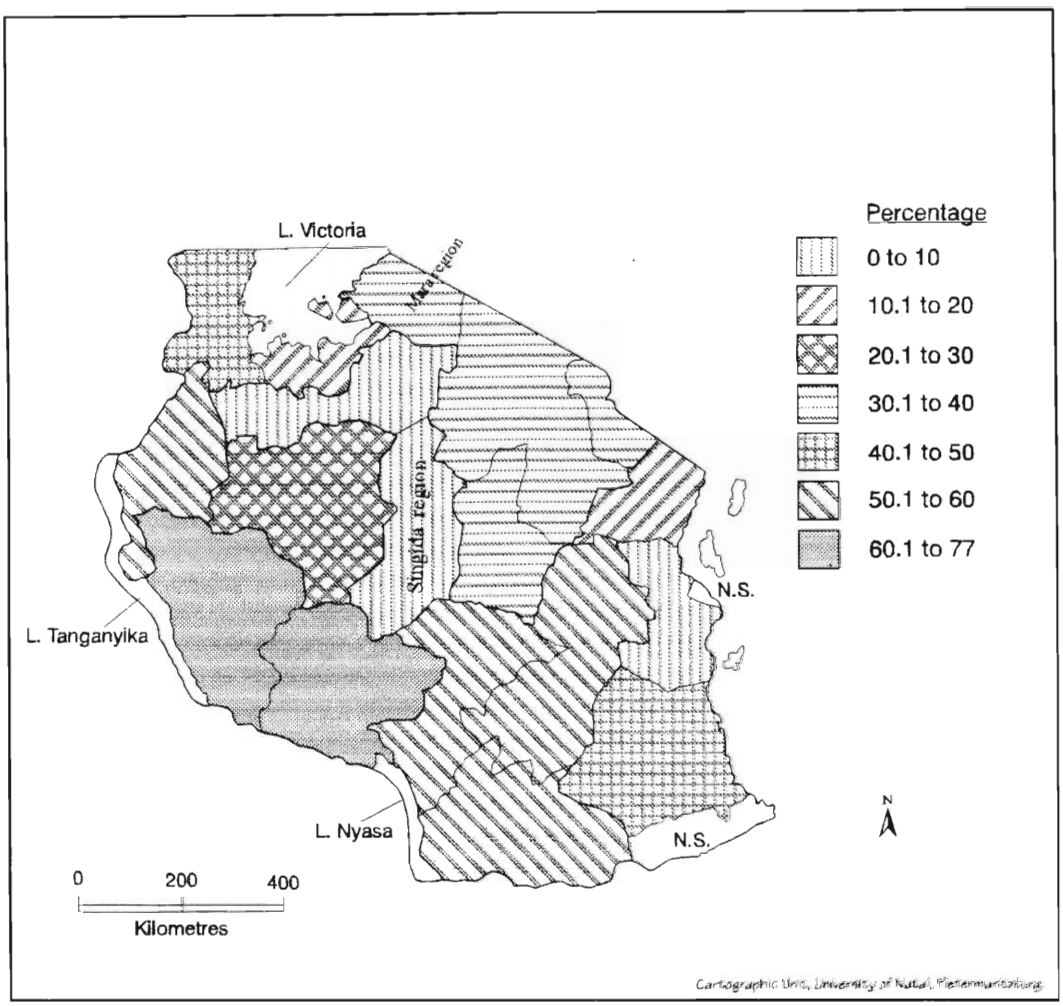


Figure 3: The prevalence of goitre in Tanzania by region

Source: TFNC, 1996

Figure 3 indicates that the situation of IDD in Mara and Singida is more or less the same. However, there are some pockets in Mara particularly in the highlands of Tarime district and neighbouring districts where IDD is more prevalent than any other area in the two regions.

☞ Vitamin A Deficiency (VAD)

National and regional data on VAD are not available. However, spot surveys conducted between 1981 and 1991 indicate the existence of VAD in the country. The problem is severe in children of less than 6 years of age, in pregnant and lactating women while school children and other adults are least affected (TFNC, 1996). The problem is generally localized in semi arid and drought prone areas, mainly the central parts of the country. It is estimated that VAD affects 1.4 million people or 6 percent of the population (TFNC, 1996). Singida is among the regions situated in the central part of the country and therefore is much more affected by VAD than Mara.

❑ Low Birth Weight (LBW)

LBW is an important indicator of maternal nutritional status during pregnancy and is also a determinant of the survival chances of the new born (Ngallaba et al, 1993; Kavishe and Mushi, 1993). Infants weighing less than 2.5 kg at birth are classified as LBW babies. In any community where the percentage of LBW is greater or equal to 10 percent, it is an indication that there are nutrition problems among women of reproductive age (TFNC, 1996). The incidence of LBW for the period of 1995 was 10.6 percent in Mara and 9.6 percent in Singida (Mara CSPD, 1995, Singida CSPD, 1995).

3.5 Policies and Programmes Addressing Health and Nutrition Issues

Following independence and for about 30 years subsequently, provision of many health and nutrition related services were without any guidance from a defined policy (Jonsson, 1986). Most of the policies related to health and nutrition were adopted in the 1990s (Ministry of Health 1990; Planning Commission, 1992). The policies include the National Health Policy (NHP), the Food and the Nutrition Policy (FNP), the National Population Policy (NPP) and the National Agriculture Policy (NAP).

Immediately after independence the government declared that poverty, disease and ignorance were the major obstacles to the development of Tanzanians (TANU, 1967; Johnsson, 1986; Kavishe and Mushi, 1993). All efforts and national decisions thereafter were focussed on the elimination of these three main obstacles (TANU, 1974; Jonsson, 1986). However, the declaration was not adequate as it was very general and there was a need for more specific policies and programmes.

From the previous sections it was shown that the country is facing nutrition problems and hence there is a need to address these problems. There are various programmes which do this either at national or community level. The programmes which attempt to address the existing problems include Maternal and Child Health (MCH), disease control programmes such as for AIDS and malaria, control for micro-nutrient deficiency disorders such IDD, VAD and anaemia.

Other programmes include family planning, household food security and CSPD. These programmes are usually linked to communities through community structures. This study will concentrate on the CSPD programme only.

Summary

The discussion in this chapter has revealed a number of issues which are worthwhile to emphasise. Firstly, socially and politically the country is stable and these conditions facilitated the implementation of many programmes including the CSPD in Mara and Singida. In addition, the presence of one national language in the country enhanced communication among the stakeholders of different programmes during training and decision making.

Secondly, economically the country is poor. The majority of people are poor and therefore their involvement in decision making in order to determine their destiny is of paramount importance. Community based programmes such as CSPD seem to be the best way to facilitate the involvement of people in solving their own problems and the nutrition status of children should be regarded as an indicator of success of any development programme.

Thirdly, the situation of health and nutrition has shown some improvements where deliberate actions have been taken such as in Mara and Singida. However, more needs to be done to ensure that the successes are sustainable at reasonable cost. In addition, the presence of linkages between nutrition related programmes and community structures poses strong potential to support community initiatives which aim at improving their conditions.

Fourthly, there are policies in place which indicates commitment of the government to facilitate community development. There are policies which address government concern in the areas of health, nutrition, food, and population to mention a few. Government commitment to improving the living standard of people is thus evident.

CHAPTER 4

METHODOLOGY

Preamble

The methodology for this research was designed to examine the implementation of the CSPD programme focussing on the basic processes involved during its implementation. In order to obtain relevant information and to understand the processes, community based knowledge and experiences are essential. This knowledge and experience can be obtained by learning from and with community members (Basch, 1987; Knodel, 1989; Chambers, 1992). To capture effectively the knowledge and experiences from the people involved in the implementation, qualitative procedures of information collection were necessary. However, quantitative procedures were also used to collect data which would be needed to complement the understanding of the qualitative findings.

An official request was made to the respective regional authorities through the Tanzania Food and Nutrition Centre (TFNC) with regards to undertaking the study. Regional authorities granted permission and support in terms of staff who accompanied the researcher and also assisted in selecting the enumerators who participated in the study.

One of the research supervisors (Professor R. Fincham) participated briefly in one of the regions in order to understand the environment around the research area, as well as to understand the way in which CSPD programmes are implemented in Tanzania. This participation was important because he was able to see the relevance of the methodology after conducting discussions with various people at different levels in the region.

The subsequent sections in this chapter discuss the strengths and limitations of the methods of data collection as used in the study and selection of the regions, districts, villages and households. Sections three and four discuss how the collection and processing of data were done.

4.1 Strengths and limitations of the methods

Methods involved in conducting research can be classified into two categories namely quantitative and qualitative procedures (Miles and Huberman, 1994). Each procedure entails a number of methods of data collection. There are several methods which could be employed in a research of this nature. In this discussion, only methods selected for this study will be discussed in detail. Each method of data collection is designed to collect certain types of data and usually is more appropriate to one research question than the other and hence each has strengths and limitations (Williamson et al, 1977, Miles and Huberman, 1994).

4.1.1 Qualitative procedures

Qualitative procedures include methods such as focus group and key informant discussions as well as observations. A number of researchers in social science have described focus group discussion as a valuable tool for collecting qualitative information (Basch, 1987; McCarthy, 1988; Stewart and Shamdasani, 1990). Interviews with key informants and observations made by a researcher are commonly used in clarifying the findings which emerge from group discussions (Maccoby and Maccoby, 1959; Scrimshaw and Gleanson,

1992). The techniques are now widely applied in the field of health and nutrition to obtain information on feelings and opinions of people about a given problem; people's experience and utility of services or other phenomenon (Basch, 1987; Miles and Huberman1994).

In the context of this study, focus group and key informant discussions as well as observations were used to collect information. The methods were ideal for this study for the following reasons. Firstly, they provide information which exposes perceptions, opinions, underlying attitudes and behaviours of the community involved in the implementation of the programme. Secondly, they are flexible and hence provide more room for discussions and this increases the chances of collecting extra and useful information which might otherwise not be considered by the researcher (Miles and Huberman, 1994). Thirdly, the methods allow the community to be involved in the study as they become first hand beneficiaries of the study as opposed to passive laboratory objects (Basch, 1987; Knodel, 1989; Chambers, 1992). In such a situation the discussion itself becomes meaningful and the information generated can be immediately used by all parties involved in the discussion (Scrimshaw and Gleason, 1992).

In summary, the strengths of the methods used in the study are based on their ability to focus on naturally occurring events and processes in real life circumstances (Miles and Huberman, 1994).Often the methods have been advocated as the best strategy for discovery and exploring processes in a society (Basch, 1987; Knodel, 1989; Chambers, 1992; Miles and Huberman, 1994). On the basis of these strengths, focus group and

informant discussions and observation methods were selected as the best methods for data collection from the two areas.

Despite the strengths of the methods discussed above there are some limitations which should be noted (Basch, 1987; Miles and Huberman, 1994). The methods are labour intensive in data handling and processing. Raw field data needs to be corrected, translated, edited and typed, audio-tape recordings need to be transcribed and corrected. The methods have less standardised instrumentation compared to methods used in quantitative procedures and the researcher is normally the main standardisation device. A guideline was prepared to guide the discussion which was flexible to enable probing where necessary. In this study, the meaning of the information collected at the group discussion was checked by audio-tape. From the tape, Swahili was translated into English and transcripts were prepared to verify the meaning during the analysis stage.

Another limitation especially at the village level is that only individuals who are willing to participate and capable of speaking in public will be involved. Some people could be excluded due to hearing or speech problems or feelings that they would be intimidated when articulating their views in public. To control this limitation, adequate explanation was given to the people through local extension staff a day before the exercise in order to cultivate willingness to participate and to create a relaxed atmosphere for the exercise. The prior explanation and self introduction before starting the discussions helped in checking intimidation which could be attributed to the existing differences among the participants such

as individual position in the society, age, gender, and party policies. In addition, the researcher as a moderator encouraged participants to speak by using their names and any response was accepted and praised. The venue used for discussions was the village office which was familiar to all participants. To make the atmosphere more appealing for discussions refreshment was provided to all participants during the discussions. The groups involved in focus group discussions were homogeneous in terms of their position in the society, for example all villagers who had a leadership role formed their own group while ordinary villagers formed theirs.

When data collected from group discussions is translated into another language there is a possibility of losing some meaning during the translation process. Although Swahili was used in the focus group discussions and English in the preparation of the transcript and later analysis, the meaning was constantly maintained throughout because the researcher who was also the moderator during the discussions was fluent in both English and Swahili. The fact that the national language was used throughout the focus group discussions made participants feel comfortable to talk.

The reliability of the information collected from the group discussions was checked by holding discussions with key informants and observing the reaction of the participants towards various responses. At the district level the majority of people who were involved in the discussions were well known to the researcher and this made it difficult for them to lie. In addition, the experience and prior knowledge of the researcher about the area of the

study made it easy to determine whether or not the information given was reliable.

4.1.2 Quantitative method

The quantitative method used involved a structured questionnaire for collecting primary data on the village profile and households. Programme reports were the main source of secondary quantitative data. Anthropometric measurements for every under five were recorded in a questionnaire after the interview. Quantitative data in this study is used to describe the sample characteristics and to clarify qualitative findings.

One of the limitations of this method is that the data collected is not immediately available to the people involved in the study. It was agreed that the findings of the study would be communicated to them at a later stage. Other limitations included the need for extra people to administer the questionnaire, at the same time maintaining quality data collection throughout the field work. With help from the TFNC and regional authorities in both regions people experienced in administering questionnaires and taking anthropometric measurements were available to provide the assistance. However, training was necessary in order for them to be familiar with the questionnaire. The method of data collection using a structured questionnaire is time consuming and expensive. In this study enumerators were required to walk from one household to another in order to collect the required data and later take anthropometric measurements. The exercise of taking measurements added more requirements for the study, such as a length board and a weighing scale. Each enumerator was paid a salary and transport allowance. In order to ensure effective use of time and

money available, thorough planning was done to avert unnecessary costs and waste of time such as spending extra days in the field. In addition, it is difficult to avoid cheating when using a structured questionnaire especially when open ended questions are involved. On the other hand, when the questionnaire involves predetermined answers the exercise becomes rigid and provides no room for more discussions.

Training of people to administer a questionnaire is important. The training was conducted by the researcher. The enumerators used in the survey work were employed by the Tanzania Bureau of Statistics (TBS) as field enumerators and each had more than three years of field experience. This was an advantage for this research because additional training was only needed for familiarisation of the questionnaire. The researcher had been working with enumerators as their trainer and supervisor during the Household Budget Survey (HBS) in 1990, and the Mid-Decade Goal Survey in 1995 and hence their experience was valuable for this study, especially in obtaining high quality information.

4.2 Selection of the Regions, Districts, Villages and Households

The selection of the regions, districts, villages and households was done to optimise access to information regarding the processes involved in the implementation of the programme in different areas and across social groups.

4.2.1 Regions

Information from the regions implementing CSPD programmes in Tanzania has shown varying rates of decline in malnutrition (see Figure 2 on page 58). Based on these differences, the regions were grouped into two categories. One category included regions which showed a relatively rapid decline in the rate of malnutrition and the second group encompassed regions which showed a relatively slow decline in the rate of malnutrition during the period of programme implementation. The two regions of Mara and Singida (one from each category of regions) were selected because the programme in the two regions started in the same year.

4.2.2 Districts

Districts were selected based on the following factors; i) number of ethnic groups in the district - the districts which have many ethnic groups were eligible for consideration because social and cultural aspects have a significant influence on household and individual behaviour (Andersen, 1991; Pelletier, 1994), ii) main economic activities being undertaken in the district - districts which had many economic activities representing a wide range of activities being undertaken in the region were potential for selection. The reason for these criteria was to be able to understand the processes involved in the implementation across as many different ethnic groups as possible. iii) Time frame - time which was available for the research was limited and therefore careful selection of districts was necessary in order to minimize time spent on logistics, iv) financial resources - funds available were enough to cover a limited number of days.

After considering all these factors, three districts in Mara region (Tarime, Bunda and Musoma Rural) and two districts in Singida region (Manyoni and Singida Urban) were eligible for selection. One district was then selected from each region using a random sampling procedure, which led to the selection of Musoma Rural and Manyoni districts from the Mara and Singida regions respectively.

4.2.3 Villages

There were 78 and 92 villages implementing the programme in Manyoni and Musoma Rural districts respectively. The time and funds available made it possible to carry out interviews in 11 villages, which is 14 and 12 percent of the total number of eligible villages in Manyoni and Musoma Rural respectively. After calculating the total number of villages which could be covered in a particular district, random sampling procedures were used to select sample villages for the interview.

4.2.4 Households

It was possible to interview 35 households in a day and this made it possible to cover 385 households in Musoma Rural and 387 in Manyoni district. Selection of households was also affected by time and financial constraints. After calculating the number of households to be covered in each village, a systematic random sampling procedure was used to select households for interview based on the list of households available at the village office. Each enumerator started from the centre of the village and moved in a different direction, the first house in a particular direction was interviewed. Three houses were then skipped before

interviewing the occupants of the next house. In cases where the occupants of the house were not available enumerators moved to the next house until they found occupants of a household.

4.3 Collection of Data

4.3.1 Qualitative Data

Qualitative data was collected through observations, key informants and group discussions.

- **Observations**

Observations were made at each level by the researcher on behaviour, attitudes and other reactions towards certain questions or arguments, quality of leadership, involvement and status of women. The observation was done during the discussions with the focus group, key informants, individuals, as well as on the interaction of people throughout the study. The observations were recorded in a notebook. Any interesting observations were either included in the next discussions or were clarified by key informants, leaders or any person depending on the nature of the issue.

- **Key Informants**

Special discussions were held with individuals who had specific knowledge and experience about the environment in which the programme was being implemented. Three informants were identified in each village by ward extension staff and verified by community members.

The following questions were used in the identification of the informants:

- who has been in the area since the inception of the programme ?
- who has been involved in the implementation of the programme for a long time ?
- who has been a key person in the success of the programme in the area ?

These questions were asked at each level in order to identify three key informants. Where more than three people were identified, only three were chosen. It could be argued that by excluding some individuals valuable information would not be revealed. This was checked by inviting them to participate in the group discussions.

Discussions with key informants were held individually and very informally. The discussions were mainly centred on how the programme was initiated, perceptions of people regarding the implementation of the programme, problems of implementation and if the programme was of any importance to people or not. Each informant was told that s/he was one of the knowledgeable people in the community and asked if s/he could share that knowledge. This was done to insure that normal and friendly conversation was maintained throughout the discussions. The intention of using key informants was to clarify findings which emerged as a result of using focus group discussions and observations.

❑ Group Discussions

In this study, group discussions were conducted at village, ward, district and regional level. At the regional and district level all members of the Regional Task Force (RTF)and District Task Force (DTF) who were available were involved in the group discussions.

At the village level there were two categories of people. The first category included people who did not have any leadership role in the village while the second category included village leaders. The reason for dividing the members into two groups was to obtain homogeneous groups. Selection of people in the first category was on a voluntary basis while in the second all members of the village government were asked to participate. Efforts were made to ensure that groups made up of ordinary villagers were homogeneous, for example all members of the focus group were those who had children under five. Participation of women in the group discussions was not a problem because most of the women contributed adequately. This can be explained by the fact that women were more involved in the programme than men and therefore they were more familiar with the programme and confident with the subject.

To guide the focus group discussions a guideline was prepared based on the experience of the researcher, literature and various reports prepared by the programme (see Appendix 2). Before starting group discussions people were asked to introduce themselves and then permission was obtained from the participants to audio-tape the discussions. Notes were also taken and any events or observation related to the discussion were noted.

During the discussions people were called by their names in order to involve all the participants and also to develop trust and confidence among group members during the process of discussion. In this way discussions were organised such that all sides, the researcher, the community, leaders and members of the district and regional task force were able to benefit from the discussions. Also nobody was allowed to dominate the discussions. In order to be able to manage the group during the discussions, a maximum of ten people were included in a group. In each village a maximum of three focus groups were conducted, two groups of ordinary villagers and one group of leaders.

At the end of the discussion, a brief presentation was made by the researcher to the participants emphasizing the strengths and weaknesses related to CSPD implementation, as revealed during the group discussions and also based on the experience of working with the people in these areas. Suggestions were made regarding possible improvements in the implementation of the CSPD at that level.

4.3.2 Quantitative data

Two structured questionnaires (see Appendix 3 and 4) were used to collect data at the village and household level respectively. Both parents were interviewed, but in cases where one of them was not available, then the one who was available was interviewed. Where both parents were not available, the person who usually took care of the child in the absence of both parents was eligible for interviewing. The village questionnaire was filled in by the researcher while the household questionnaire was filled in by experienced enumerators who had undergone additional training for two days.

Anthropometric measurements were taken at the central point in a village because there was only one length board and weighing scale. The advantage of having a central place for taking measurements was that error of measurements was minimised because only the researcher and one enumerator took the measurements. All under fives whose parents were interviewed were involved in the anthropometric measurements. An electronic scale (Secca) was used to measure the weights in kilograms and the readings were recorded up to one decimal point. The length board used by TBS/UNICEF in the mid-decade goal assessment survey in Tanzania (1995) was used in taking lengths and heights of children in this study. The recumbent length children who were less than two years was taken, while the height of those who were more than two years was measured (in centimetres to the nearest 0.1cm) while standing against the board. Plates 1 and 2 show enumerators conducting interviews while plate 3 illustrates the researcher reading the weight of an under five from an electronic scale.

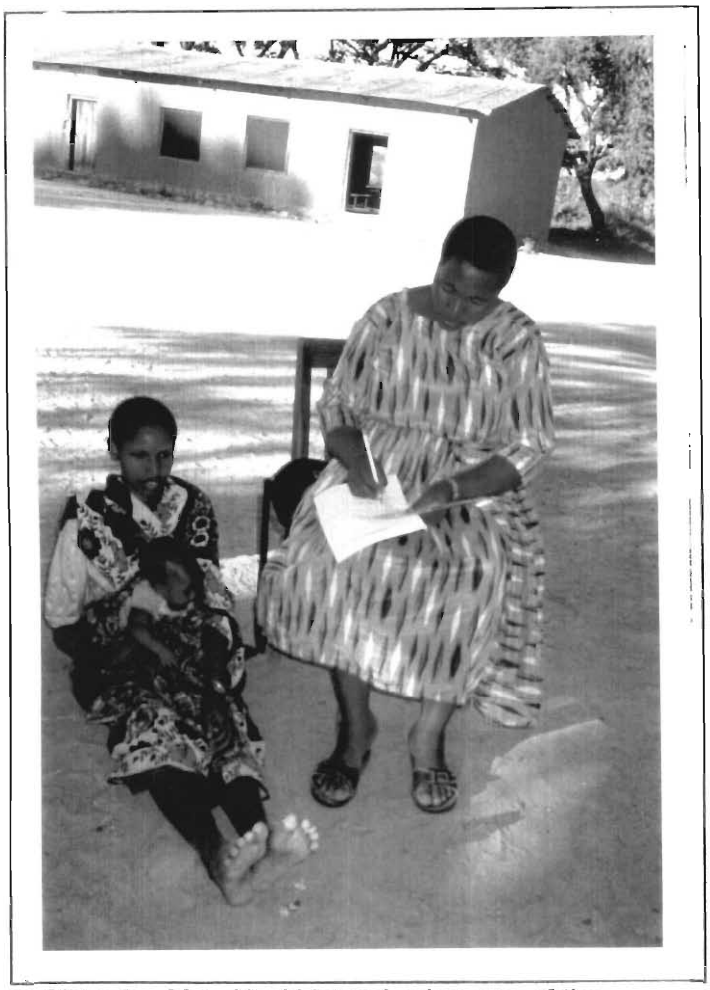


Plate 1: Mrs. Nyaki interviewing one of the mothers in Manyoni district

Plate 3: Mr. Nyang'ali reading Weight of a child in Musoma Rural district

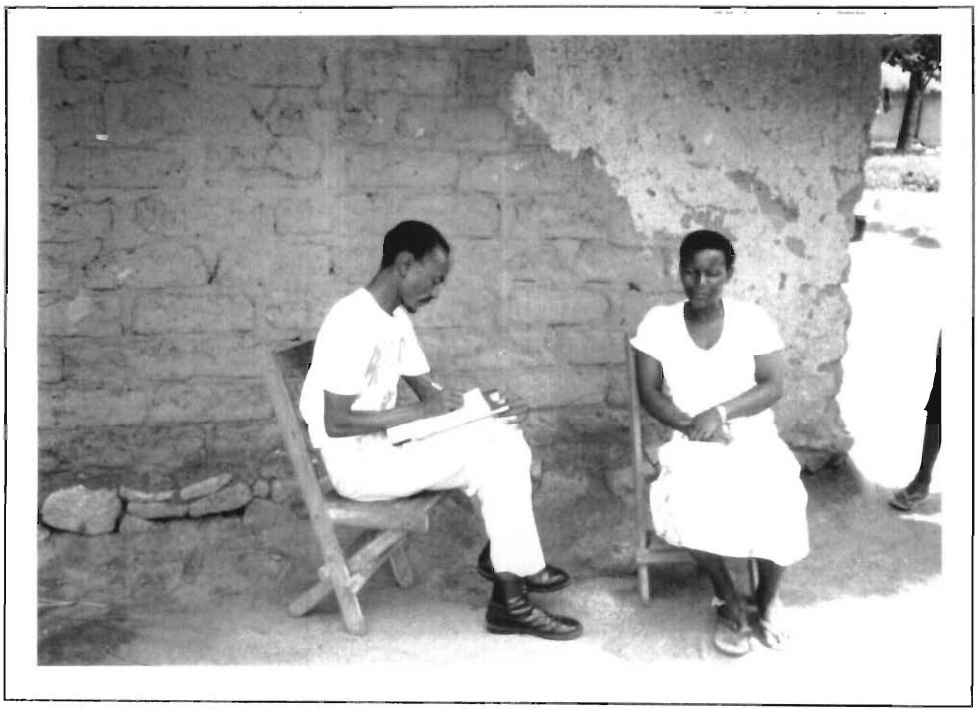


Plate 2: Mr. Kilingo interviewing one of the mothers in Musoma Rural district

4.4 Processing of Data

4.4.1 Qualitative Data

Audio-tapes were transcribed and then a comparison made between notes taken during group discussions and the transcriptions from the tapes. This comparison was important to ensure that no information was left out. Information from group discussions was grouped according to the guideline used during group discussions. The information was further categorised in terms of the themes and levels at which they were collected.

4.4.2 Quantitative Data

Processing of quantitative data started immediately after the interviews by manually checking all the responses recorded on the questionnaire in order to maintain field data collection quality. Thereafter, data was punched into the computer using "EPIINFO" software version 6.04. Data entered onto the computer was checked for accuracy using the questionnaire. Anthropometric indices were calculated by using ANTHRO software version 1b while frequencies and cross tabulation analysis were done using EPIINFO version 6.04 and MINTAB version 11.

CHAPTER 5

RESULTS AND DISCUSSION

Preamble

In this section the results and discussion are presented together. The first subsection of this section describes the nature of the sample involved in the study. The description mainly covers the main source of food and income for households and the nutrition status of the children in the area of the study. The subsequent subsections discuss elements which enhanced implementation of the CSPD programme. These elements include awareness, commitment of stake holders to implement the programme, training, presence of appropriate structures, the presence of adequate linkages between the CSPD programme and other programmes and the establishment of an effective monitoring system within the programme. Other elements include leadership and positive outcome of the programme.

As pointed out in chapter four emphasis is put on the qualitative information due to its ability to provide more insight regarding the processes involved in the implementation of the programme. Quantitative data is used to describe the characteristics of the study area illustrating the similarities and differences between the two areas involved in the study and also to substantiate qualitative findings such as existence of malnutrition, involvement of people in the implementation of the programme and usefulness of Road to Health Cards (RtHC). Appendix 1 (Table 1) summarises quantitative data which could provide more insight to the reader regarding characteristics of the two districts such as male against women headed households, household size, distribution of under fives in the households and maternal education.

5.1 Description of the Sample

In this study, Mara and Singida regions are each represented by a single district namely, Musoma Rural and Manyoni district respectively. Throughout the discussions Musoma Rural will be referred to as Musoma.

5.1.1 Main Source of Income and Food

It was found that most of the households in both of the districts depend on agriculture for income and food (Musoma 77.1 % and Manyoni 82.9 %). Significantly more households ($p = 0.000$) in Manyoni depended on agriculture than in Musoma. The fact that the majority depend on agriculture for income and food means that failure in agricultural performance will affect not only the economy of the households but also their nutrition status.

A shortage of food in the two districts was being experienced when the survey was conducted and the government was assessing the magnitude of the shortage in order to initiate food relief. The situation at the time of the survey was such that few households could afford to have even two meals a day. Normally households prepare three meals a day.

5.1.2 Nutrition Status

Although reports on CSPD progress in both districts indicate that there is improvement in nutrition status in terms of underweight, the study showed that stunting is still a problem. Stunting is a manifestation of long-term or chronic under nutrition. The stunting situation for the two districts is shown in Table 4.

Table 4: The stunting levels of children under five in Musoma and Manyoni districts

Nutrition Status	District			
	Musoma		Manyoni	
	No.	%	No.	%
Stunted	80	37.6	123	35.7
Non-stunted	133	62.4	222	64.3
Sub-Total 2*	213	100.0	345	100.0

* Not significant; (*p = 0.054)*

Table 4 indicates that there is no significant difference (p = 0.054) in terms of stunting between the two districts. Both districts show a higher percentage of total stunting compared to the national figure, reported by TBS in 1996 as 32.1 percent. It is not possible to comment on the effect of the programme on nutrition because there is no information about the levels of stunting before the programme started in both districts. Nevertheless, it can be assumed that because there is remarkable improvement in the levels of underweight in the programme areas then it is likely that the levels of stunting could be improved in the long run especially as development issues are addressed by the programme.

In summary this study was conducted in an area where most people depend on agriculture for living and more than one third of under fives are stunted. The sample reflects purely rural populations which are similar to the situation of the country. As discussed in chapter three, the majority of people in Tanzania live in rural areas and depend on agriculture for their lives.

5.2 Elements Which Enhanced Implementation of the CSPD Programme

This section attempts to point out factors which enhanced implementation of the programme in the two districts with a focus on the processes involved during the implementation. In order to understand the section, Figure 4 summarises the elements in relation to their importance in terms of adequate implementation of the programme.

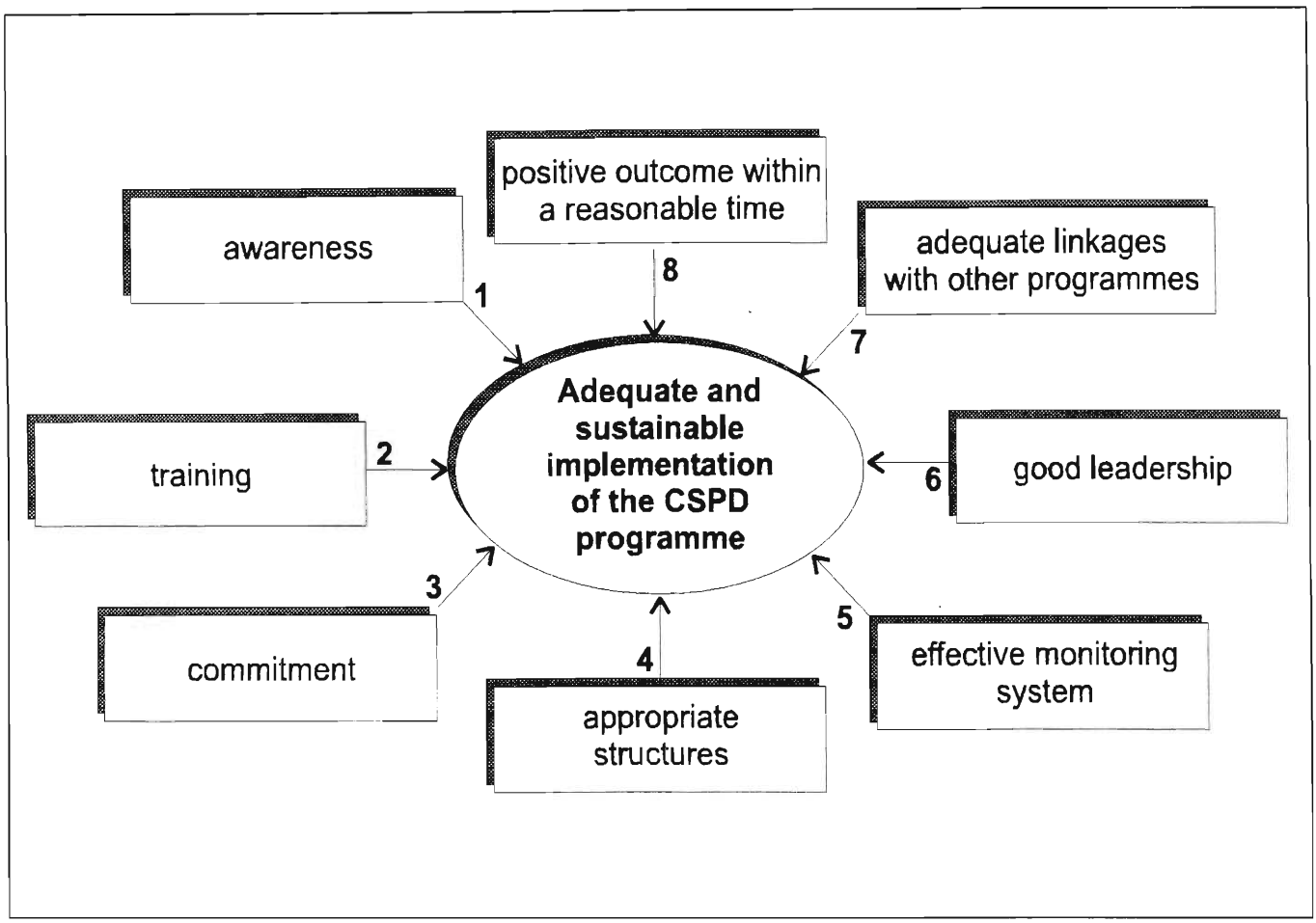


Figure 4: Elements which enhanced adequate implementation of the CSPD programme in Mara and Singida regions

The number of each line of Figure 4 indicates the importance of the elements to the implementation of the programme, one being the most important and eight least important.

5.2.1 Awareness

Under this section awareness will be examined as an essential input in the conceptualisation process. Complete awareness is attained when an individual is knowledgeable about the problem, causes and possible solutions to malnutrition. As discussed in chapter two complete awareness is needed in order for individuals to be able to conceptualise the objectives and expected outcomes of the programme. Discussions with village leaders and other members of the community revealed that awareness of the problem of child death and its consequences was a strong motive for people to participate in the implementation of the programme. Results from household interviews in relation to the existence of malnutrition in the villages are shown in Table 5.

Table 5: Respondent opinion on the existence of malnutrition in their village by district

Is there malnutrition in your village?	Musoma		Manyoni	
	no.	%	no.	%
Yes	356	92.5	295	76.2
I am not sure	12	3.1	35	9.1
No	17	4.4	57	14.7
Total*	385	100.0	387	100.0

* Significant; (p=0.000)

Table 5 indicates that although Musoma had significantly more people (p=0.000) who were aware of the malnutrition problem there was also a substantial percentage of people in Manyoni who were aware of the problem. During group discussions with both leaders and members of community it was expressed that the rate of child deaths related to malnutrition

in the villages used to be high before the programme. This is illustrated by the following quotes:

"... we used to bury children every month ... " *Leaders - Kisamwene and Mhalala village*

"... death of children was a problem because apart from the family losing a child, also the family was supposed to spend resources for mourning and funeral. In addition, other people were also required to participate in mourning and later funeral. This means that people had to stop working for at least two days. The situation was felt more during farming season where time is very precious." *Leaders and members of community - Kiabakari, Mazama and Kitopeni village*

It seems that people were aware of the problem and its consequences, but they did not know the causes.

"... majority of people believed that malnutrition was a disease ..." *Leaders - Kiabakari and Kitopeni village*

Malnutrition was regarded as a disease and therefore the only solution was for each family affected by malnutrition to visit the health facility for treatment. Despite treatment at health facilities people still continued to face the problem of malnutrition.

" ... after discharging the child from hospital there was no more follow-up ..." *Leaders - Butiama village*

"... every family was left to deal with malnutrition on its own as it is for any disease ..." *Community members - Kisamwene and Mhalala village.*

One of the reasons for the persistence of the problem of malnutrition even after rehabilitation in hospital was lack of a follow-up scheme for the children who were discharged from the health facilities. In addition, there was no support system in place whereby affected families could be counselled and supported in the process of rehabilitation beyond health facilities. This experience resulted in a situation where appropriate solutions were needed. It should be noted that it is easier to see and treat severe malnutrition than stunting. It is therefore likely that malnutrition cases which were referred to the health facilities were severe cases.

The fact that people were aware of the problem ie. death of children in the area made the introduction of the programme easier. This was revealed by a group discussion with village leaders. They said that:

"... after discussion with district officials it was found that one of the objectives of the programme was to reduce children mortality, ... " *Leader - Kisamwene village*

"... people were interested in the programme because one of the objectives was to solve the problem which was known by the entire community ..." *Leader - Mazama village*

This indicates that awareness of the problem enhanced discussions and later agreement on starting the programme. The acceptance of the programme by the community suggests that there was an expectation among members of the community that the programme was going to solve the problem which they were experiencing. As mentioned earlier the limited knowledge people had made them think and probably believe that malnutrition was a health

related problem and therefore the solution could only be found from health facilities.

After a village accepted the programme, seminars were organised by the district for all people who would be involved in the implementation of the programme. The objective of the seminars was to raise the level of awareness particularly on the causes and solutions to the problems. After the seminars people became more aware that malnutrition was not a disease and in order to eliminate it, collective efforts were required from different people and all sectors of human development. In addition, people understood that the primary role of eliminating malnutrition lay with individual families and the community in general. The basic role of the community is to create an environment in which the process of eliminating and preventing malnutrition can be effectively achieved by individual families. This aspect was revealed during separate group discussions with leaders and community members. It was said that:

"... we have realised that we can play a significant role in the process of eradicating and preventing malnutrition ..." *Leaders - Butiama, Mazama and Mhalala* village

The programme has given us knowledge and confidence ... " *Community member - Sanjaranda village*

It appears that awareness of the problem alone was not enough to start interventions because people were not confident that they could play a significant role in eliminating and preventing malnutrition in their community. Efforts invested to increase awareness on the

causes and possible solutions of the problem of everybody who was seen as a key role player in the implementation of the programme raised their confidence to start interventions. Families, community members and leaders realised that they had a role to play in eradicating malnutrition in their area. Complete awareness regarding malnutrition is an important element in enhancing the conceptualisation and implementation of the programme. This suggests that in order to be able to start interventions people must be completely aware of the problem, causes and possible solutions. Complete awareness also facilitates the understanding of people's role in the implementation of the programme. In addition, complete awareness also played a significant role in motivating people to participate in the implementation of the programme. During the discussions on whether or not to accept the programme, people became interested after realising that the programme was intended to solve the problem which they were aware of and that the solutions were within their control.

"... we were motivated to hear that the programme intended to reduce child death" *Leader-Kitopeni village*

People were motivated to participate in the programme because they discovered that the programme intended to provide a solution to a problem which they had been facing for a long time. Therefore, the community developed expectations which motivated them to participate in the programme activities such as health education and Growth Monitoring and Promotion (GMP) and Village Health Days (VHDs). Involvement of people in the VHDs and level of expectations for each districts are indicated in Appendix 1 (Table 2 and 3). Plate 4 shows

mothers attending an education session on how to make weaning foods while plate 5 illustrates a Village Health Worker (VHW) distributing energy-dense porridge after a demonstration on how to make the porridge using available food stuff.

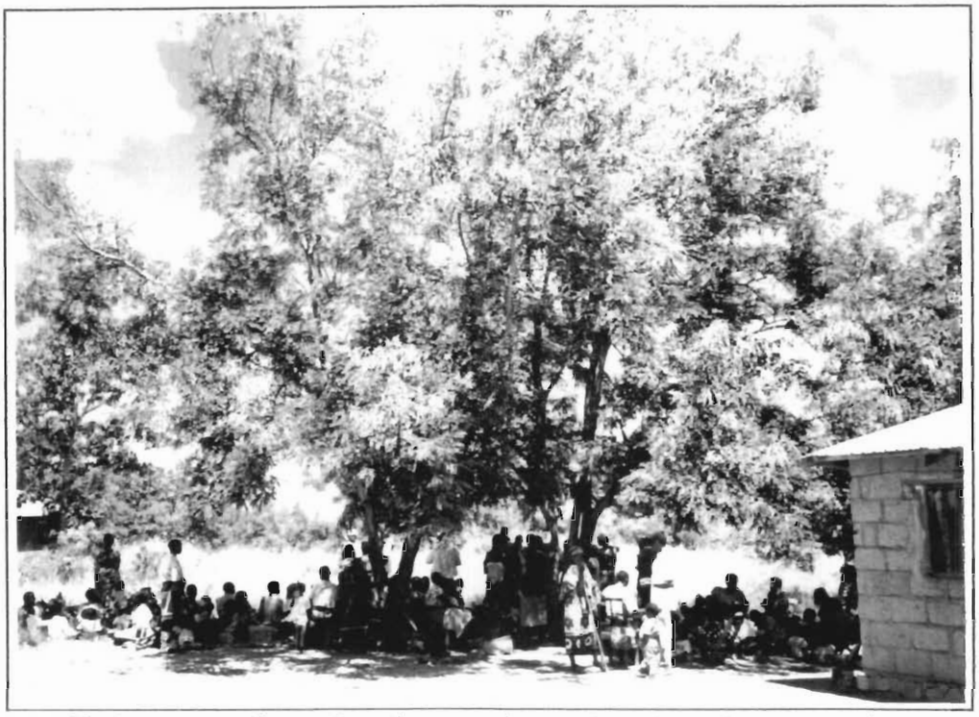


Plate 4: Mothers attending education session on how to make energy dense porridge from semi germinated cereals in Kisamwene village.

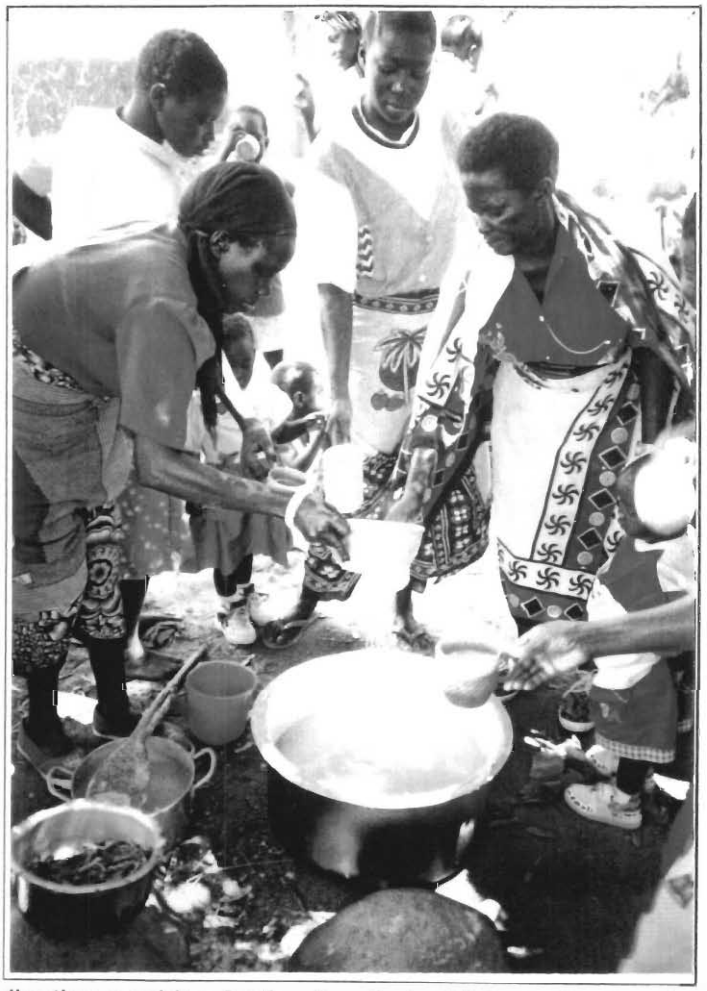


Plate 5: Mothers collecting porridge for feeding their children after the demonstration

Motivation of people to participate is a result of expectations which people build upon based on their knowledge about the problem and what might come out the programme. If expectations are positive it is likely that people will be motivated but when they are negative people will not participate. It appears that the expectations of people towards the programme were positive.

It also appears that the initial level of awareness of the existence of the problem was a key element in facilitating the building of consensus on the causes of the problem, possible solutions and roles which needed to be carried out by different key role players. Implementation of the programme involved different people from different sectors. For them to work harmoniously they needed to agree on what to do.

"... to agree on the causes of and solutions to the problem of malnutrition was enhanced by people's awareness of the problem ...". *Community development officer - Musoma*

In summary it can be said that the programme used the knowledge of the people regarding what they thought about the problem in order to firstly, build confidence among the stake holders, secondly motivate people to participate in actions to solve the problem and thirdly to establish an appropriate entry point which would ensure that the actual needs and expectations of the people were taken into consideration. Fourthly, complete awareness enhanced building consensus on what should be done and by whom.

5.2.2 Training

As discussed in chapter two training was found to be an important element for empowering those involved in the implementation of various successful programmes. In this programme, training conducted before, during and after the programme implementation covered all people who were responsible for the implementation of the programme at all levels namely village, district and region.

- **Village level**

After accepting the programme at the village level, training was organised for village leaders and later for the community at large.

> "... two seminars were organised at the village levels..., the first seminar was for village leaders while the second was for the whole community..." *Leaders - Sanjaranda, Mhalala, Kisamwene and Mazama village*

The training seminars enabled the community and the leadership to understand that malnutrition was not a disease, as mentioned previously. The fact that people were aware of the problem made it easier for training to concentrate on the causes, possible solutions and roles which needed to be undertaken by different stakeholders in order to solve the problem.

The effect of training was felt by all members of the community including their leaders. This was revealed during group discussions at village level. It was said that:

"... we realised there is no miracle in eradicating malnutrition ...".*Leaders - Butiama and Sanjaranda village*

Training in this regard therefore built the confidence of people that they could solve the problem. It was also noted that training inculcated a sense of responsibility in community members and their leaders. In regard to this issue it was said that:

"... eradication of malnutrition in the community is not solely the responsibility of individual families but rather the whole community ...". *Leaders and members of community - all villages*

This shows that the community felt that it was their responsibility to ensure that malnutrition did not affect their community and this was attained after initial sensitisation training. In this regard the training was able to break the traditional belief that malnutrition was a problem related to health and that only the health sector was responsible for solving the problem. In addition people realised that there was a need to participate in the process of eliminating malnutrition in their community.

Apart from general training there was specific training for people who were selected to perform specific duties in the programme. These people included VHWs and members of the Village Health Committee (VHC). Special curricula were designed for VHWs and VHCs in

order to give them more skills in issues which would empower them to undertake their responsibilities.

"... we spent two months in training..., one month for theory and the other month for practical ..." *VHW*

The training was designed so that VHWs would be able not only to undertake their responsibilities but also to manage vital statistics related to the programme. This boosted the skills and confidence of VHWs. Although training was aimed at empowering VHWs to undertake programme activities, it was learned that there were occasions when they left the programme and worked elsewhere. This resulted in a debate on whether or not to continue to train more VHWs. It was felt that if the VHWs were not leaving the village then it is not a waste of resources because the village could still use their skills in other ways. These individuals should thus be regarded as an additional resource base in the village.

Training at community level was observed as an important element which empowered the community to implement the programme with confidence and at the same time made members of community feel the need to participate in the programme. Specific training for VHWs and VHCs was important to ensure that skills were imparted which would allow them to work effectively, especially because they were key people at the village level for programme implementation.

Training was similar in all villages but some differences were observed in terms of record keeping, quality of reports prepared by the VHWs and also contribution of VHWs during group discussion. One of the reasons which was given for this was that some of the VHWs had been retrained. This suggests that training once might not be enough.

❑ District and regional level.

Training at these levels was organised for all leaders, heads of departments and other people who were selected to undertake specific tasks during implementation of the programme.

☞ Training of leaders

It was revealed during group discussions at district level that:

> "... before starting the programme at the district level awareness seminars were organised to all district leaders". *District official- Manyoni district*

> "The objectives of the seminars were to introduce the concept of the programme and sensitize the leaders in order to support the concept." *District health officer - Musoma district*

It was learned that the leaders who were involved in the awareness seminars included government, party and religious leaders. Discussions with these leaders indicated that the training enhanced their capability to mobilise and convince people to be responsible for solving their own problems, including that of malnutrition.

"It was important for leaders to be equipped with the programme philosophy because they will be in a position to explain the idea of the programme and link it with other activities which were taking place in the communities ...". *District Planning officer - Musoma district*

The training also enabled the leaders to speak the same language regarding the programme and encourage their followers to actively participate in the implementation of the programme. Apart from mobilising their supporters to participate in the implementation of the programme, leaders from the programme areas were said to be more effective in participating in discussions compared to leaders from areas which did not have the programme. The reasons behind the observed differences were said to be the training which they received from the programme. The training enhanced their skills in preparing reports and linking nutrition issues with other activities in their areas.

☞ **Training of experts**

This training included all experts in the district such as heads of departments and other people who attended planning meetings at the district level. The training of experts at district level was aimed at soliciting support from the technical staff to facilitate the implementation of the programme at the district level. Discussions with district officials revealed that:

"... involvement of heads of departments in training was necessary because of assisting the selection of capable individuals who would be members of the task force and implementation committees ...". *District community development officer - Manyoni district*

The task force is responsible for the day to day running of the programme and members are selected from different sectors. It was important to involve heads of departments in the process because they knew the right candidate from their departments who would be involved in the task force. In addition, involving them from the beginning enabled them to make responsible decisions regarding the selection of members of various technical structures. The ultimate selection of members of the technical committee indicates that training facilitated the understanding of the roles to be undertaken by the selected individuals during the implementation of the programme. This was evident through the composition of the task force. Members of the task force were selected from the sectors which had many activities in the programme. Also there was a provision of co-opting any sector in case the need arose.

☞ **Training of Trainers of Trainers**

This is the training of people who will be used to train trainers for the programme at different levels of programme implementation. The training enabled the programme to have adequate trainers at each level. The trainers were also used as motivators.

" ... people who were selected to become trainers were also expected to motivate people to participate in the programme activities..." *Community development officer - Musoma district*

People who were selected to join programme implementation structures had to attend specific training. It was noted that in this specific training, issues related to management of

information systems, administration, communication skills and the importance of components of the programmes were covered. The result of this training was the selection of trainers of trainers (TOTs). These TOTs were responsible for training trainers at lower levels. This kind of training enabled communities to have their own trainers. The advantage of these trainers is that people were able to consult them any time they encountered a problem regarding implementation of the programme. Also it can be regarded as a way of creating a resource centre within the community for the implementation of the programme.

☞ **Study tours**

Apart from the training discussed above, study tours were also organised for different people from various levels. The aim of these study tours was to expose people to areas which were already implementing a similar programme. This enabled them to see and learn from others who were involved in the implementation of similar programmes. One of the interesting comments made by some of the district leaders in Musoma was:

"... it was amazing to see a village leader presenting a well structured report about the progress of programme and other related activities in Kagera region ..., This inspired us to support our people to do the same...". *Planning officer- Musoma district*

It should be noted that the study tours were organised as part of sensitisation efforts. It appears that leaders who participated in study tours developed an interest in the programme and were ready to support their people to do the same.

This shows how study tours can be a strong force in changing people's minds once they find positive elements which they can imitate.

☞ Retraining

The need for retraining was observed in many villages due to changes which had taken place in the country and in different fields, such as the introduction of new programmes, existence of certain policies and changes in local government. All these developments have resulted in modifications of some aspects related to the implementation of the programme. Retraining is an effective way to incorporate experience into skills and also it is an opportunity for sharing experiences among individuals involved in the implementation of the programme.

"... we understand that there is a need of re-training VHWs and members of VHCs ... the problem is funding ..." *CSPD coordinator - Musoma*

Discussion with members of the task force in both districts indicated that retraining had made a great deal of difference in programme implementation.

"... the performance of VHWs who happened to be retrained has been improved..., the improvement has been attributed to additional skills... and motivation as a result of being called again ...". *District health officer (VHW trainer) - Musoma district.*

It appears retraining not only added skills to VHWs but it was also regarded as an incentive for motivating the VHWs to work with the programme.

"... seminars and workshop usually are organised to discuss specific issues related to the implementation of the programme..., sometimes is regarded as retraining because the people involved acquire knowledge ...". *Community development officer - Manyoni district*

This suggests that retraining can be done through workshops and seminars. However, in order to make them effective, adequate preparation is required especially in identifying issues which need to be discussed, who should attend and what should be the outcome.

At this point one could say that training covered all people who were to be involved in the implementation of the programme. The fact that different training programmes were prepared to suit different categories of people indicates that it was likely that most of the training needs were met. Also people were given the chance to visit and learn from others who were physically implementing similar programmes. All these efforts ensured that the training was appropriate and as a result training was important in enhancing implementation of the programme.

Although data regarding the amount of money involved in the training was not available, the impression was that training took a large proportion of the programme budget especially at the beginning of the programme. This indicates the importance that was placed on training.

5.2.3 Commitment

Discussions with leaders at different levels and members of the communities revealed that implementation of the programme was enhanced by the commitment of the people involved. Minutes regarding the discussions on whether or not to accept the programme were examined. In the minutes, the roles to be played by different parties were indicated. Although what was agreed in the meetings can be regarded as a commitment, it is not enough to ensure implementation unless a mechanism is in place to enforce commitment.

Discussion in chapter two indicated that commitment is usually reflected by actions by those who are said to be committed. In this programme commitment was most evident through actions which were taken to facilitate implementation of the programme. Some of these actions include:

- discussions related to the acceptance of the programme
- establishment and use of by-laws
- rates and levels of involvement during implementation
- contribution of resources
- follow-up scheme for malnourished children
- government support

❑ Discussions related to the acceptance of the programme

All forms of discussions at village level disclosed that people were given time to discuss the programme before it was accepted. It was said that:

> "...meetings were organised to discuss the idea of initiating the programme in the village..., attendance was impressive ..." *Leaders - Butiama and Mhalala village*

> "... after the discussions about the programme we agreed to start the programme..., and minutes of the meeting are available ..." *Leaders - all villages*

The fact that people were willing to hold a specific meeting to discuss the issue of starting the programme in their villages indicates some commitment to solving the problem.

The willingness shown by people did not end by holding the meetings but it went further by documenting the outcome of the meeting in the minutes. The implication of minutes is that they can be used as evidence of what was agreed in the meetings.

> "...this programme has been initiated after agreement which was reached through discussions between village leadership and all members of the village. The agreement we made was our commitment to the programme and therefore we need to honour our commitment ..., *Leader-Sanjaranda village*

Putting the agreement to start the programme in the minutes indicates that there was a commitment to start the programme in their villages in order to solve the experienced problem.

❑ Use of by-laws

It was expressed during group discussion with village leaders that:

> "...force is necessary to ensure smooth implementation of the programme...," *Leader-Butiama village*

It is important to make a clarification here that although the word force has been used it does not mean that people were forced to commit themselves but rather it is used as a mechanism to check that the agreement which was made was not abused. The point here is not to force people but to ensure that people respect their commitments. Generally people who failed to adhere to decisions made by the government, village leadership or general village meeting were fined. A number of villages have established dispute councils which are responsible for dealing with people who fail to adhere to accepted decisions. Plate 6 shows members of a dispute council after meeting parents who failed to bring their children for weighing.

Plate 6: Butiama dispute council and parents who failed to bring their children for weighing

In Musoma this fine is called *nzagu* and it is paid in cash or animals. How the money is used is determined by the village leadership. In most cases the money was used in activities related to development programmes including the CSPD programme. The establishment and use of by-laws in this programme at village level is an indication of commitment.

The fact that the process of establishing by-laws involves different people at different levels in the government shows that commitment is also reflected within the government. The importance of government support in the implementation of the programme will be discussed later.

- **Rates and levels of involvement**

Involvement of people in the implementation of the programme can be regarded as commitment of people to the programme. Involvement of people during initiation and implementation includes participation in the decision making process regarding the programme, contributions of cash or materials, labour and ideas for the implementation of the programme. Resource contribution is covered in the next section.

It was learned that participation of people in the meetings related to the programme was high.

"... efforts were made to ensure that all people attended the meeting..." *Leaders in Butiama and Mhalala village*

It was important to ensure that the majority of people participated in the meetings because a voting system was used to make decisions. Therefore, in order for the decision to be valid, the majority of village members must vote.

The information collected from households regarding the people's involvement in the programme is shown in Table 6.

Table 6: Response of households in relation to involvement of people in the programme at village level

	Musoma		Manyoni			
	No.	%	No.	%	X^2	P
1. Were you involved in the initiation process ?						
I was involved	318	82.6	315	81.3		
Not involved	67	17.4	72	18.7		
Total	385	100.0	387	100.0	2.031	0.362*
2. Are you involved in implementation of the programme ?						
Involved	334	86.8	332	85.8		
Not involved	51	13.2	55	14.2		
Total	385	100.0	387	100.0	0.660	0.660*

* Not significant; $p \leq 0.05$

Table 6 indicates that the rates of participation in both districts were equally high with more than 80 percent of households interviewed participating in the programme during initiation and an equal percentage are participating in the implementation of the programme. It appears that the majority of people participated in meetings which were specifically for making decisions on either initiating or implementing the programme activities.

Therefore the decisions which were made during the meetings were the decisions of the majority. The majority of people in the villages were thus involved in decision making.

❑ Contribution of resources

Contribution of resources to support some of the programme activities by different stake holders indicates commitment to ensure that the objectives of the programme are met. The percentage of people who said that they contributed to the implementation of the programme is shown in Appendix 1 (Table 4). It was noted that at village level there were contributions of cash, animals, food and labour to support certain activities related to the programme. Items such as animals were auctioned and the money was deposited in a special account.

"... we have a special account in the bank..." *Leaders - Sanjaranda, Butiama, and Kisamwene village*

It was learned that there were different ways in which people could contribute resources for supporting the implementation of the programme.

"... each family is required to contribute Tsh. 500/= per year as '*Lishe* fund'..." *Leaders - Mazama and Kiabakari village.*

"... each family has to work in the village farm... the harvest is used for school lunch ..." *Leader- Sanjaranda village.*

"... village government is an agent of the district council for collecting development levy in the village. Twenty percent of the collection is paid to the village ..., some of this money is used for programme activities. Therefore people are encouraged to pay the levy because some of the money remains in the village." *Leaders in Sanjaranda and Kisamwene village.*

The efforts which were made by the leadership at village level to ensure that people contribute some resources to support the implementation of the programme is an indication of great commitment to the programme.

The available mechanisms which ensure contribution of resources by beneficiaries indicates that there is a possibility of sustaining the programme at village level. However, it should be noted that the amount which was contributed was very little due to limited sources of income for the majority of village members. Therefore improvement of the economic base of the villages seems to be important if long term sustainability of the programme is to be realised.

Some of the activities which were supported include payment of VHWs and primary school lunches. It was interesting to note that not all villages had bank accounts for the programme. This made a big difference in terms of the morale of VHWs. In villages where an account was available there were few or no complaints regarding payments of VHWs. As a consequence the working spirit in those villages was high and there were few drop-outs of VHWs.

At district and regional levels, people were involved physically in supporting the implementation of the programme through attending meetings, VHDs and training. For example it was said that:

"... last VHD we had a team from the district..." *Leader - Sanjaranda village*

Apart from human resources, funds were also allocated by higher levels to support some of the programme activities which required money that the villages were not able to provide. These activities included training, paying allowances of experts from districts or other places and the purchase of equipment such as weighing scales.

Contribution of resources at the level of programme implementation is an important indicator of sustainability, ownership and responsibility. Support from higher levels is equally important especially in areas where the economic base is low.

- **Follow-up schemes**

It was found that in all villages there were follow-up schemes for severely malnourished children identified during weighing sessions. The schemes were managed by VHWs in collaboration with the VHC. Also parents, village leaders and sometimes higher level leaders were involved depending on the nature of the problems. The scheme ensures that all children identified with severe malnutrition obtain due attention to prevent death.

In order to understand the level of commitment, the way a follow-up scheme works was investigated. It was said that:

"After identifying a child with severe malnutrition, VHWs and VHC arrange days on which the parents are visited at home. During the visit the VHW discusses in detail possible causes of malnutrition and ways in which it could be tackled using the household resources. In case the problem needs more resources than those available in the household, the village leadership is informed through the VHC. The leadership then decide what to do. The child remains under the follow up scheme until the VHW is satisfied with improvement. This is done by observing the development of the child using the road to health card". *Village Health Workers-Kisamwene and Sanjaranda village*

It appears that the scheme involves the entire community depending on the nature of the problem as each segment of the community has a role to play. Also provision seems to be available where extra resources can be mobilised if household resources are inadequate for solving the problem.

During the survey in Kisamwene village located in Musoma district, two children were observed with severe malnutrition by the survey team. The names of the children and parents were recorded and presented to the village leadership. The parents of the two children were known to the village as alcoholics who were not providing adequate care for their children. The issue had already been discussed by the village leadership before the survey and the decision was that the parents would feed the children twice a week at the village office premises. Food to feed the children was provided by the village. The author witnessed one of the feeding sessions. The children were fed not only to provide nourishment but also as a sort of punishment to the parents for not providing adequate care for the children. During the feeding session all the parents were present for at least two hours and this ensured that the children had time to see their parents and enjoy their presence. This is a high level of village commitment because it shows how the leadership cares for the welfare of children in

the village. It should be noted that this kind of punishment was temporary but it seemed to be working because the parents said that they learned from the punishment and they were now prepared to provide care for their children at home. This shows that if community leadership is really committed to a programme it can devise means which will ensure that the programme is successfully implemented.

❑ Government Support

It was learned from village leaders that during VHDs, government leaders from district and regional levels were invited to attend functions related to the programme as guests of honour, facilitators or motivators. There have been occasions where leaders from the national level have participated in programme activities such as VHDs. Participation of leaders in the programme activities reflects government support to the programme. Most of the participants in the group discussion said that:

> " ... participation of leaders in the programme especially during VHDs boosted the morale of people ..." *Leaders- Butiama and Sanjaranda village*

Government support as reflected by the participation of leaders in the programme activities was an indication of commitment by government.

It was noted that although people outside the community participated in the programme their role was mainly facilitative in nature. People outside the community include government

officials and leaders and donor agencies.

"... the role of district task force and district in general is to facilitate the implementation of the programme at the community level". *District official - Manyoni*

At district and regional levels there are structures which oversee the implementation of the programme and most of the leaders at these levels are part of those structures. In all meetings related to the development of districts or regions the CSPD programme is permanently on the agenda.

"... the CSPD programme is a permanent part of the agenda in all development meetings in the district ..., it is the responsibility of the district to monitor the progress of the programme..." *District Executive Director -Manyoni*

This again shows that the leadership at these levels is committed and responsible for the implementation of the programme. This can be illustrated by the following example. In one of the meetings where the programme was reviewed the regional commissioner was the chairperson of the meeting. The coordinator of the programme in Singida region presented a progress report but the report did not indicate any element of funding. The chairperson adjourned the meeting and sent the coordinator back to prepare a comprehensive report. Most of the participants, the majority of whom were leaders accepted the decision. This shows that the leaders were responsible for the implementation of the programme and also indicates that there is an element of commitment towards implementation of the programme and therefore leaders felt that the programme was important.

5.2.4 Appropriate Structures

There are two issues involving structures which seem to have contributed to enhancing implementation of the programme. The issues are firstly, the presence of well defined structures from village to regional level and secondly the ability of existing structures to accommodate the programme without parallel structures being formed. The two aspects were also found to be the case in many successful programme as discussed in chapter two. In order to understand this, each level of programme implementation will be examined.

- **Village level**

At village level the Village Government (VG) is the main structure which is responsible and accountable for the welfare of the village and any development activities taking place in the village. Any activities introduced in the village must be endorsed by the VG and this was the case for the CSPD programme.

"... district officials approached the Village Government in order to introduce the idea of initiating the CSPD programme...". *Leaders - all Villages*

The VG is made up of three committees one of which is Social Services Committee (SSC). When the programme was accepted by the community this committee was responsible for the implementation of the programme. Because other activities were also taking place within the community, such as water projects for which the SSC is responsible, a subcommittee was to be established to assist the SSC, this subcommittee is the Village Health Committee

(VHC).

The VHC as part of the SSC is responsible for the implementation of the CSPD programme. Technically the VHC committee is assisted by VHWs. When the programme was initiated at the village level, the basic structures were in place. The only change which was made was to strengthen the existing structures so that they had more focus regarding implementation of the programme. This was done by establishing a subcommittee from the existing committees and by training people who were selected to join the subcommittee. In this way there was no conflict regarding the implementation of the programme or other activities because what needed to be done by which committee was clear. In addition, all committees are supposed to report to the VG. In this way, the coordination of all activities taking place in the village is ensured. In terms of gender, villages are strongly advised to involve women in decision making structures. All villages which were involved in the study had women in their VG and other committees. For example, in some villages women were selected as either chairperson of, or secretary to, the VG. This suggests that women were involved in the decision making structures. Plate 7 and 8 shows members of VG in Kisamwene and Butiama villages.

Plate 7: Some of the members of the Kisamwene village government

Plate 8; Prof. Fincham (supervisor), Mr. Nyang'ali (author) and Mr. Ngonyani (member of the Mara RTF) group picture with some members of the Butiama Village Government

❑ District level

At the district level there are legally accepted administrative structures which control district development plans and activities. These structures can be classified as technical and political structures. The technical structures include all heads of departments while political structures include the district council. The district council is made up of all councillors, members of parliament and other appointed leaders such as the district commissioner. The district council is responsible for all decisions related to the development plans in the districts. The role of the technical structure is to advise the district council on matters which need technical inputs. When the programme was introduced at the district level the same structures were used to establish substructures for the programme implementation. This was evident through the following quote:

> "... the CSPD implementation structures at district level were established by using members from the existing structures." *District planning officer - Musoma district*

The implementation structures of the CSPD programme are mainly classified into two categories namely technical and decision making structures. Detailed information of the structures involved in the implementation of the CSPD is shown in Appendix 6.

As discussed earlier, training was done in order to ensure that the additional roles were understood by all stake holders and at the same time to fit them into the functions of the existing structures. The substructures which were established were mainly to facilitate

accountability. At this level as at village level all substructures were accountable to the legally recognised structures. In this way coordination and accountability regarding implementation of the programme were well ensured.

❑ Regional levels

At the regional level , like the district level, there are structures which are legally recognised. The categories of the structures for implementation of the CSPD are also similar- technical and decision making structures. When the programme was introduced in the region, the existing structures were used to accommodate the programme as for other development programmes. This was evident through the following quotes:

"... any programme introduced in the regions has to be discussed ... the way it is going to fit into the normal structures..." *Regional planning officer Mara region.*

" ... If there is a need ... substructure will be formulated from the existing structure in order to facilitate coordination and accountability ..." *Regional planning officer Mara region.*

It appears that structures were established in order to have more focussed implementation and also to minimise bureaucracy. The linkage between programme implementation structures and administrative structures is shown in Appendix 6.

In general, all decisions made by programme substructures were supposed to be known to legally recognised structures which were responsible for general decisions for development

at a particular level. It is important to note that the overall responsibility regarding implementation of the programme was laid on the structures which were also responsible for developmental activities at a particular level. In this regard one could say that the existing structures were used to implement the programme. The advantage of using the existing structures as noted through the implementation of the programme was that no extra payment was needed for the people to work in the programme and also complementarity of activities was more easily achieved if the people were dealing with several activities with the same aim.

5.2.5 Effective Monitoring System

As discussed in chapter two effective monitoring in a programme exists when the programme is able to generate and use information for decision making regarding the implementation of the programme at all levels. The monitoring system of the CSPD programme at all levels of implementation will be examined.

- **Household level**

The household is the smallest unit of programme implementation and is the first level where the process of monitoring was found to take place. It was learned from community members that at household level, monitoring was associated with the health of children and specifically with the nutrition status of under fives in the household.

Households which had under fives possessed a clinic card for every child in a household (see Appendix 5). The card was the starting point for the monitoring process because the weight of the child is recorded on the card after every weighing. The weight from each weighing is marked as a dot showing weight against age of the child on the card and later the dots are joined to make a graph.

"... after plotting the weight of the child on the card we observe if there is any improvement ..." *Mother*

It was therefore possible to determine if the nutrition status of the child was improving or deteriorating by reading the graph. This is the beginning of the process, but more importantly, what decisions were made by parents as a result of the information generated from the card after weighing ?

As mentioned previously, parents monitored the weights of their children through the card and used it to assess the growth of their children. Thereafter they initiated discussions around the observed situation depicted by the card. This process becomes more obvious when the child is not growing well, as it was said:

"... in case the weight of the child dropped..., we discuss it with VHW to identify the cause..., then we get advice..., depending on the advice... we discuss it with our husbands and decide what to do..." *Mother*

The information generated from the card facilitated decision making at household level, either between the parents or parents and VHWs or health facility staff. In this process problems are detected early and timely decisions can be taken to prevent further deterioration of the child's growth. Growth monitoring is one of the types of information systems. At this level it appears that the system was effective because the information generated was used in making decisions starting from the point of collection. At the household level, it was found that parents were able to use information from the card and make decisions on what to do in order to improve the observed situation. The card is easily understood by community members due to its simplicity. The card uses colours to express the condition of the child after weighing and plotting. This makes it possible for those who are not able to read and write to understand the information generated by the card. The card is viewed as one of the instruments which is used to monitor the growth of the child and thus start an interaction regarding the growth and development of the child. Information collected from household interviews regarding awareness and usefulness of the card is summarised in Table 7.

Table 7: Awareness and usefulness of road to health card by district

	Musoma		Manyoni	
	no.	%	no.	%
Awareness of the card				
Yes	352	91.4	372	96.1
No	33	8.6	15	3.9
Total	385	100.0	387	100.0 *(p=0.007)**
Usefulness of the Card				
Very Useful	360	93.5	366	94.6
Useful	19	4.9	18	4.6
I do not know	6	1.6	3	0.8
Total	385	100.0	387	100.0 *(p=0.477)***

* Significant; $p \leq 0.05$, ** not significant; $p \leq 0.05$.

Table 7 indicates that the card was well known to most of the households in both districts (91.4 and 96.1 percent for Musoma and Manyoni respectively). However, Manyoni had significantly higher (p=0.007) percentage than in Musoma. Although it was difficult to obtain reasons to explain the observed differences, it is assumed that training and interaction with health facility staff have been more effective in Manyoni than in Musoma. In terms of usefulness of the card all districts showed an equally (p=0.477) high percentage of people who appreciated the usefulness of the card. This means that the card was an important tool for monitoring the nutrition status of the children in households.

Monitoring at this level is effective not only because the information generated is firstly used by parents to facilitate decisions but also the information is needed by the next level of programme implementation.

"... the village is required to send a report to the district every quarter showing the nutrition status of children in the village." *Chairperson - Mazama village*

This demand for information by immediate and other levels is an important factor to ensure that the system at the lower level works.

It was found that health facilities played a significant role in ensuring that the process takes place effectively at household level. This is because of the sound interaction between the parents and health facilities which was said to be evident during clinic days when mothers are provided with health related education, children are weighed, immunized and dialogue between health staff and individual mothers also takes place.

"... the presence of a dispensary in this village and the good relationship between health facility staff and members of village has enhanced implementation of the programme ..., it is easy for parents to get advice and other services" *Leader - Sanjaranda village*

Health facilities were found to be responsible for retraining and supervising VHWs on technical issues.

"... technically VHWs are supervised by the nearest health facility ..." *Chairperson - Kisamwene village*

It appears that mechanisms and efforts were in place to facilitate the monitoring of the child at household level by providing support which would facilitate the parents in monitoring and improving the condition of their children. For example the health facility has to ensure that all

parents have cards for their children, and that VHWs perform their work in a technically sound manner. The person in-charge of the facility is the secretary to the VHC.

> "... the role of health facility in relation to the programme is to provide support such as to provide health education to parents, distribute road to health cards to mothers and assist VHC..." *In charge of dispensary - Kiabakari village*

In this regard the health facility is regarded as a support centre for the programme and is a source of health related information and knowledge.

❑ Village level

Monitoring at this level is both outcome and process oriented. This was evident through the indicators used for detecting problems regarding the implementation of the programme. The indicators mentioned during group discussions at village level are summarised in Table 8.

Table 8: Outcome and process indicators used in monitoring implementation of the programme at village level as outlined in the group discussions in all districts.

Indicator	For Monitoring	
	Outcome	Process
Complaints		√
Meeting intended goals		√
Weighing coverage		√
Immunization coverage		√
Attendance during VHDs		√
Attendance in various meeting		√
Increase in disease incidence	√	
Increase in malnutrition rate	√	

Table 8 indicates that most of the indicators used are for monitoring the process of implementation. Monitoring of the process ensures that the intended outcome will be attained with reasonable quality. This is because any obstacle which might inhibit the attainment of the intended outcome during the implementation can be detected early and corrected. It was learned that some villages did modify the VHDs after realising that attendance was not good.

" the attendance to VHDs was not impressive... it was discovered that people had to walk long distances to attend the day... activities which were undertaken during the day were also tiresome to people ..., then modification on how to organise the day was done..." *Chairperson - Kiabakari Village*

This implies that the villages were able to detect the problems related to the implementation process early and take appropriate decisions and actions to rectify them. In some villages it was decided that the weighing should be done one week and then hold one VHD for the whole village after the weighing was completed. In other cases, the village was divided into zones based on accessibility and separate VHDs were conducted in each zone.

The results of weighing and VHDs are discussed by the VG and thereafter a copy of the results is sent to the district level including the minutes of VG meetings. The format of the report sent to the district level is summarised in Table 9.

Table 9: Format of village quarterly report

- *Name of the village*
- *Total number of people in the village*
  - *Male*
  - *Female*
  - *Under fives*
- *Weighing coverage*
- *Nutrition status (by numbers and percentage)*
  - *Green*
  - *Grey*
  - *Red*
- *Immunization coverage*
- *Incidence of diseases*
- *Number of children deaths and suspected reasons for the deaths*
- *Status of other development activities*
- *Status of programme equipment and facilities*
- *Remarks (Problems, success and deliberations)*

Table 9 shows that not all indicators are reported to the district level such as attendance of meetings and VHDs. This means that some of the indicators are only used for management purposes at the village level. As discussed in chapter two the system of collecting data becomes sustainable and effective if at least some of the data is used at the point at which it is collected. This finding shows that apart from using the data, a clear distinction was made at the point of data collection between what is required at that and other levels. The monitoring process at village level is summarized in Figure 5.

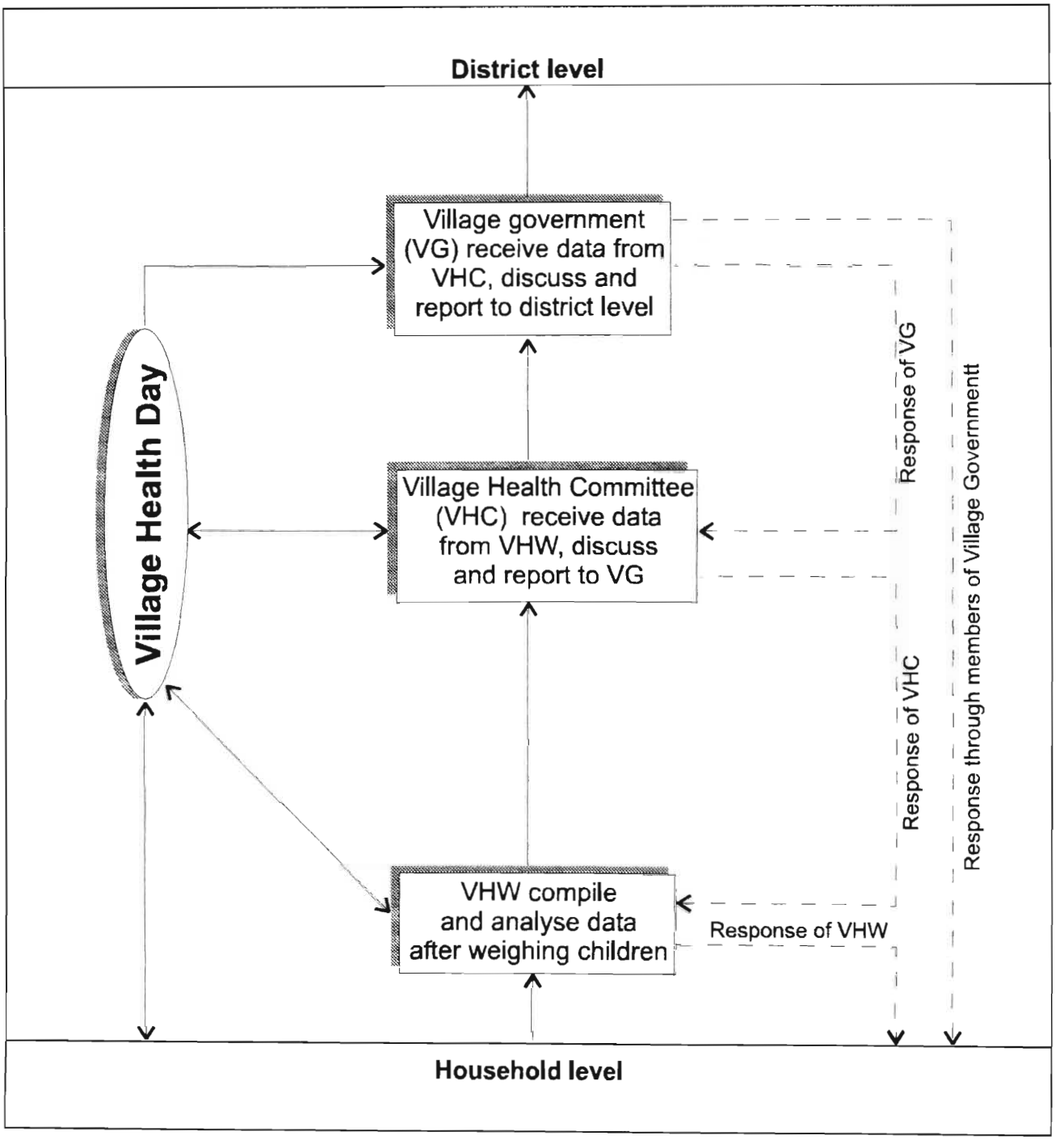


Figure 5: Monitoring process of the CSPD programme at village level

Figure 5 indicates that at village level the monitoring process is systematically done by involving community structures. The process starts by VHWs compiling and analysing the results of weighing sessions before presentation to the VHC. VHWs immediately respond to the results through actions which are under their control. The VHC will receive a report from the VHWs and will make some decisions about issues which are under its control. Later the report will be presented to the VG where it will be discussed as well as what has been decided by the VHWs and VHC. The minutes and the reports from the VG will be presented to the community on the VHD and thereafter will be presented to district level.

After discussing some elements of the process, actions which have resulted from the process will now be presented. In Manyoni there is a village called Sanjaranda. In this village the VHWs reported to the VG a child who was severely malnourished as a result of conflict between the parents. The father rejected the child saying he was not his and he was not responsible for any aspect related to the child's survival. The government decided to summon the parents and asked them to save the life of the child by resolving their dispute. The father insisted that the child was not his and that he did not want to be responsible for anything related the child. The VG decided to report the matter to the social welfare department for assistance. While waiting for the response, the VG provided some money to buy food for the child.

This example illustrates the effectiveness of the process of monitoring and actions resulting from the process. The strength of the process lies with the community structures as discussed in chapter two. The structures allow people to be involved in the process and thereby they acquire a sense of ownership by accepting responsibility for ensuring successful implementation of the programme in their village.

- **District level**

At district level there are two important bodies which are directly responsible for the implementation of the programme. These are the technical and decision making structures. Monitoring at the district level is performed by the technical structure. This is a group of people chosen to work on the programme on a daily basis. Their main functions are to monitor and facilitate the implementation of the programme at district level. In addition they are responsible for advising the decision making structure on matters related to the programme.

In order for the programme decision making structures at district level to make appropriate decisions, they need to be informed through the information generated by the programme. The generation of information depends on the indicators used to monitor the implementation programme at the district level. The indicators are shown in Table 10.

Table 10: Outcome and process indicators used in monitoring implementation of the programme at district level as outlined in the group discussions in all districts.

Indicator	For monitoring	
	Outcome	Process
Number of meetings		✓
Meeting attendance		✓
Complaints (implementors/beneficiaries)		✓
Achieving intended goals	✓	
Malnutrition rate	✓	
Immunization rate	✓	
Absence of nutrition status data		✓
Updating of village register		✓
Lack of collaboration among sectors		✓

Table 10 indicates a similar situation to that observed at village level, that many of the indicators are process oriented. However, the district quarterly reports revealed that there was also a financial element which was not reflected in the village reports (see Table 9). This is an indication that at the community level financial resources were not conspicuous because most of the support which they receive is in the form of material or equipment. In addition, it elucidates the fact that most of the financial resources are basically used at higher levels, probably for administration. In each quarter a report is prepared by the technical team and discussed by decision making forums during a review meeting. The review meeting is the main forum for monitoring the implementation of the programme at district level. All stakeholders at the district level are supposed to attend the meeting and participate in decision making regarding implementation of the programme. The format of the report is summarised in Table 11.

Table 11: Format of district quarterly report

- *Introduction*
  - *objectives*
  - *components*
  - *coverage*
- *Implementation by components*
  - *planned activities*
  - *achievements and constraints*
  - *remarks showing lessons learned*
- *Priorities for next quarter*
- *Financial statement*
  - *source of finance*
  - *expenditure*
- *Procurements*
- *General remarks*

The above format of the quarterly report is similar in all districts. At these quarterly meetings, plans are reviewed and the implementation progress of the programme for the whole district is assessed. Priorities are also set for the next quarter at these meetings. The process at district level is summarized in Figure 6.

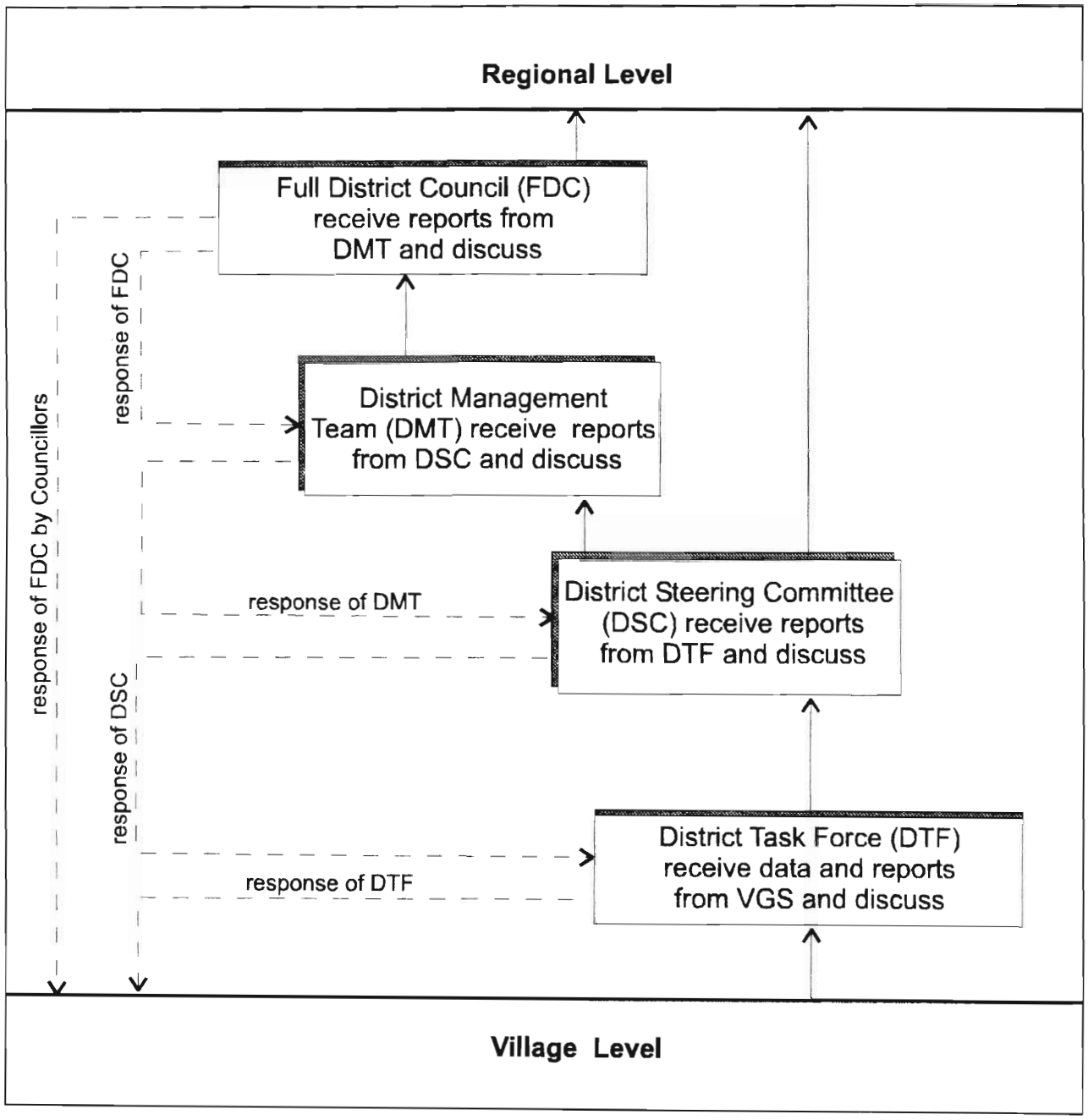


Figure 6: Monitoring process of the CSPD programme at district level

Figure 6 illustrates that information from village level is compiled and used by the technical team District Task Force (DTF) before presentation to the programme decision making body, the District Steering Committee (DSC) which is the final organ of decision making in the programme. The result of use of the information by the technical team is reflected when it responds immediately to certain issues. These issues are those which require immediate attention such as an outbreak of diarrhoeal disease or other illnesses. After data compilation at lower levels, the report will be presented to the next level. The report includes the actions which were taken to respond to issues which needed urgent or immediate attention such as an outbreak of a particular disease. The final decision making body at the district level as far as development programmes are concerned is the Full District Council (FDC). The body is advised by a technical team - the District Management Team (DMT). Reports from all programmes including the CSPD will be presented to the DMT before being discussed by the FDC.

It is important to make a distinction between technical and civil structures related to this programme at district level. There are no community representatives in the technical structures but communities are well represented in civil structures which are responsible for decision making at district level. This distinction is vital when looking at the feedback mechanisms. For the technical structures, the feedback (response) is done by letters or physical visits while in civil structures feedback is done through the representatives. However, practically, representatives also have been used to report back responses from all technical structures.

There are three aspects which emerge from the diagram. Firstly, the linkages which exist among the structures. The linkages ensure that decisions made at one level can be checked by other levels and therefore minimise the chance of having contradictory decisions. Secondly, a feedback mechanism is ensured through representatives and thirdly, the fact that there is a need to present to the higher levels the actions that have been taken by lower structures ensures checking the appropriateness of decisions made at lower levels. As indicated in chapter two, the monitoring process must be associated with a response mechanism which will feed into the implementation process. This is what was observed in the programme in both districts.

- **Regional Level**

At regional level as at district level there are two important bodies which are directly responsible for the implementation of the programme. These are the technical and decision making structures. Monitoring at the regional level is performed by the technical structure. The technical structure is supposed to present an implementation report to the decision making structure on a quarterly basis during review meetings. Representatives from all the districts which implement the programme attend these meetings.

It was found that review meetings serve four main functions, firstly, reviewing the plans and objectives of specific activities in the programme to see if they are still valid and realistic. Secondly, it is a decision making forum. Thirdly, it is a forum for exchanging experiences among different districts and fourthly, it is a way of detecting the competence of leaders in

different districts in the region. In relation to leadership one of the district officials in Musoma said that:

" ...it is quite embarrassing to find that every quarter your district is not doing well. This will show that there is a problem of leadership in the district" *Nyambelwa, G.- education officer*

This statement indicates that leaders are conscious of their role in the implementation of the programme. It appears that the output of monitoring can be used to improve leaders' involvement in the programme by auditing their decisions in relation to the information generated by the monitoring system.

It was noted that regional review meetings were powerful instruments for monitoring the programme. Districts are able to compare their progress and learn from other districts. Moreover, people at the meetings are responsible for making vital decisions regarding the programme. Any information not presented to the meeting is requested from the relevant quarter. An example is the Singida regional review meeting which the author attended in 1992.

During that meeting the regional coordinator presented the quarterly report which did not have a statement regarding funds and equipment of the programme. The chairperson adjourned the meeting and requested the coordinator to bring the report with the required information. *Personal observation*

What emerges here is the effectiveness of the meeting and understanding by the chairperson of what information is important for monitoring the progress of the programme. The process of monitoring at regional level is summarized in Figure 7.

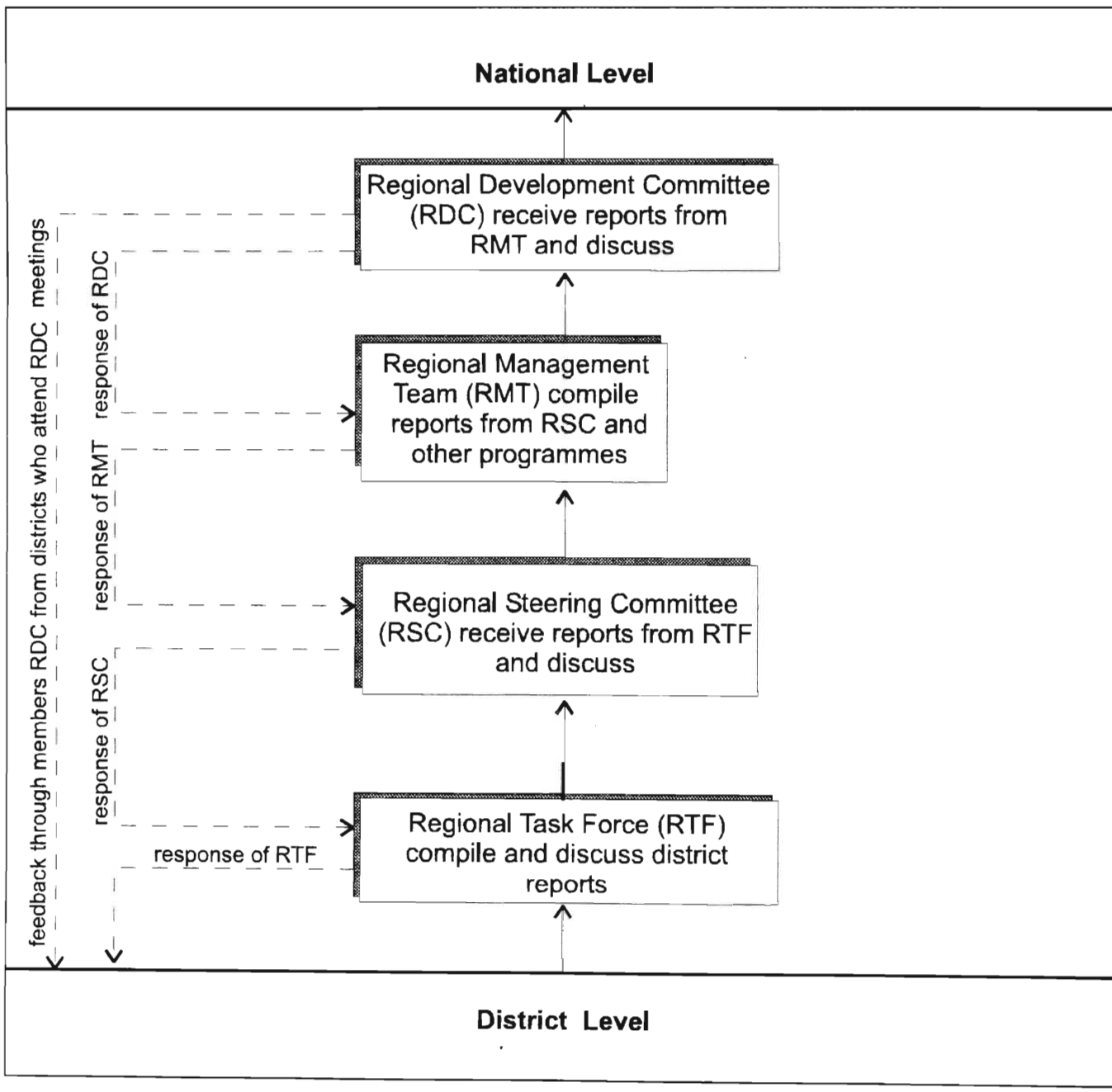


Figure 7: Monitoring process of the CSPD programme at regional level

Figure 7 is similar to Figure 6 which summarises the monitoring process at district level. However, there is no civil structure at regional level although there are members of parliament representing their constituencies in the decision making structures. Nevertheless, the assurance of a response mechanism and checking of decisions is evident as illustrated in Figure 7.

5.2.6 Leadership

It was interesting to note that there were some differences among the villages in terms of programme performance. The differences were observed in areas such as organisation of VHDs, the utilisation of existing by-laws, management of follow-up schemes and contribution of resources for the implementation of the programme. One of the reasons which was spelt out clearly during group discussion was quality of leadership.

Investigations around leadership showed that the majority of leaders who were democratically elected were sensitive to issues which they thought would affect their next election. These type of leaders were found to be more hesitant in taking actions which would make them unpopular. This suggests that the leaders did not have enough confidence to lead people. On the other hand leaders who were appointed by the district to work in the villages such as Village Executive Officers (VEO) were not hesitant to take action when it was necessary. In villages where there was adequate collaboration between these two types of leaders, levels of people's involvement were high, organisation and management of VHDs and follow-up schemes were impressive. This point suggests that when implementing any

programme one has to be cautious of depending on leadership which is made up of elected politicians. There should be a mixture of elected and appointed leaders. Examples will be now examined which indicate the importance of leadership in the implementation of the programme.

In Manyoni there are two villages called Mhalala and Sanjaranda. The difference between the two villages is the performance of the programme. In Mhalala, the village used to have a milling machine, fish pond and shop as income generating projects for the village. Village leaders were responsible and accountable for the management of the projects. The CSPD programme benefited from the projects because the village was able to pay VHWs and feed children in the pre-school. Sometimes the village was able to buy medicine for their dispensaries. After changing leadership the projects lasted for only one year.

The village is no longer able to pay VHWs and as a result the programme has suffered not only because the village is not able to pay VHWs and feed children but also the morale of community members to participate in the programme has dropped significantly and they do not have confidence in the leadership. As a consequence of this, leaders are not able to mobilise people to participate in the programme activities. It was found that the progress of the programme in this village was not impressive. The follow-up scheme was not working well in this village because VHWs were working without adequate support from the VHC and village leadership.

During group discussions with village leaders the matter was sensitive because when the question was posed as to why all the projects were no longer operating no one was prepared to answer. Participants started to show some worries. Then it was decided not to proceed with the question. But when a similar question was posed to other members of the community they said:

"... we made a mistake by changing the leadership...." *Member of community - Mhalala village*

It shows that the leadership was an important factor not for the programme alone but also for other development programmes.

In Sanjaranda the performance of the programme was very impressive. There is no child with severe malnutrition and those with moderate malnutrition are all known by the village administration. The village by then had TSH. 500,000/= (R 4,510/= or USD 830/=) in the bank. The village has a farm in which every member of the village has to work and the harvested crop is used for pre-primary and primary school lunches. During the off season, every household has to contribute 20 kg of maize for school lunches. The village maintains their own source of water, pays VHWs and sometimes buys medicines and other materials for their dispensary. It was observed that most of the members of the VG were retired officers. These people have experience in management and have been exposed to various activities regarding development. When members of village were asked about the success they said:

"... we have strong leadership here. Most of them are educated and have been working in government so what do you expect ...". *Member of community - Sanjaranda village*

Again it shows that leadership was an important factor for enhancing implementation of the programme. This aspect of leadership was observed in all villages. Whenever there is success or failure in the village the issue of leadership was mentioned as one of the reasons for the success or failure.

Generally in all villages which had good leadership the performance of the programme was impressive. In villages where some of the leaders had more exposure such as retired officers the quality of leadership was found to be high and resulted in good performance of the programme.

5.2.7 Adequate Linkage between CSPD and Other Ongoing Activities

When the CSPD programme was introduced, there were other activities taking place at all levels of structures. Other activities came into being when the programme had already been introduced. The fact being that all activities were aimed at the same people, it was important to avoid competition in order to utilise limited resources effectively.

"... the CSPD programme is not implemented in isolation ... " *District executive officer - Manyoni*

"... in general all development activities are aiming at community ... CSPD is one of them..." *District planning officer - Musoma*

It is therefore vital to understand the relationship between the CSPD programme and other ongoing activities in terms of using limited available resources. If the relationship is competitive in nature instead of complementary, then weak programmes will suffer, particularly those with no beneficiary support or an adequate strategy to tap the available resources.

It was found that at each level of the CSPD programme implementation there was more than one programme. This implies that coordination was needed to ensure that all the programmes were well implemented without duplication, competition and confusion which often frustrates the beneficiaries. The nature of coordination was found to differ from one level to another.

At village level, coordination was enhanced by the VG through its respective committees. At this level coordination and linkage was observed to be adequate.

"... the main responsibility of the Village Government is to coordinate all development activities taking place in the village." *Village chairperson - Mazama village*

Examination of coordination at district and regional level revealed that coordination and linkages between the CSPD and other programmes depended on whether there were common target groups or if the programmes were coordinated by the same department. On certain occasions coordination depended on individuals who were involved in the implementation of the programmes. Programmes which dealt with women and children had stronger linkages than other programmes which had different target groups. In addition, if two

or more programmes were implemented by the same department, coordination was strong compared to programmes implemented by different departments irrespective of their target groups. For example in Musoma there was a sound linkage between the Health Sanitation and Water (HESAWA) programme and the CSPD because they were coordinated by the same department. In Manyoni there was a sound linkage between the CSPD and water related programmes because the coordinator of the water programme was a member of CSPD District Task Force (DTF). In both districts AIDS and MCH programmes had strong linkages with the CSPD because all programmes were targeted at the same people and also some of the people who were dealing with AIDS and MCH programmes were also members of the DTF.

For coordination to be effective, there must be efforts to ensure that all key role players such as facilitators and donors are also coordinated. However, it was learned that the coordination of donors in both districts was a difficult issue due to differences in policies among the donors regarding financing of programmes. For example UNICEF funds are donations while World Bank funds are loans. The financing policy would be completely different leading to difficulties in coordinating the activities funded by the two institutions.

The examination of structures in section 5.2.4 suggests that there should not be problems in coordination as the structures are capable of promoting adequate coordination. During group discussion at district level it was strongly emphasised that the structures are adequate to guarantee coordination among the programmes implemented in the districts. It was said

that :

"During district planning meetings development plans and progress reports are discussed, also specific programmes' activities are reviewed in order to pinpoint the weaknesses and strengths of each programme as well as examine if there is anything that the programme can benefit from other programmes such as personnel, training opportunities and other administration issues". *District planning officer - Musoma*

The planning meetings seem to be crucial for identifying the areas which need linkage and coordination. However, there were occasions when other programmes at district and regional levels seemed to be independent and there was no linkage with CSPD at all. A personal observation regarding this was the existence of silent competition between officials dealing with different programmes at district and regional levels, lack of transparency and unnecessary bureaucracy. In addition individual expectations and interest of leaders also affected coordination.

It was also learned that programmes which had large resources were more appealing to the leaders and were powerful in terms of influencing their decisions. If the policy of such programmes was in favour of coordination and linkage with other programmes then these processes would take place otherwise it was difficult to establish linkages with other programmes. This implies that sometimes structures alone cannot facilitate coordination unless donor policy and personal interests support linkages.

Although the structures for enhancing linkages in both districts were similar, there was a difference in terms of strength of the linkages depending on the position of individuals who were involved in the structures. In Musoma, it was found that the coordinator of the programme was the District Planning Officer (DPLO) while in Manyoni, the Community Development Officer (CDO) had been seconded to the planning department to coordinate the programme. This had an influence in the process of mobilizing resources, human and financial at the district levels. The DPLO is the official who is responsible for coordinating all district development plans and is also responsible for advising district authorities on priorities of the district for resource allocation.

The responsibilities of the DPLO means that Musoma is in a better position than Manyoni in terms of soliciting and maintaining linkages with other departments due to the position of the coordinator in the district. In addition, it is easier to facilitate coordination because planning as a sector is neutral and is compatible with any sector. It was observed that Musoma had more programme facilities and more involvement of district leaders and other departments compared to Manyoni. This could be explained by the position of coordinators in their respective districts.

There are issues which have emerged from this section which are worthwhile stressing. Firstly, the presence of structures is a necessary but not sufficient condition for enhancing coordination and linkages among different programmes. It seems efforts have to be employed in order to overcome other obstacles such as donor policies. In both districts it

was observed that there were some difficulties in terms of coordinating donors.

Secondly, it appears that selection of people to participate in the implementation of programmes needs to be done strategically in order to facilitate not only implementation but also to exert some influence on other ongoing activities in such a way that linkage is established and competition is avoided among the activities especially those aimed at the same people. This is because programmes which aim at the same group of people are more likely to exercise linkage and coordination. Thirdly, the strength of the linkage depended firstly on the departments which were involved in coordinating the projects, and secondly on the position of individuals who were involved in the implementation structures. If there was a person from the CSPD implementation structure who was also involved in the implementation structure of another programme then there was a linkage between the two programmes. The strongest linkage was found to be when the programmes were coordinated by the same department.

In summary it can be said that the adequate linkages which existed between the CSPD programme and other ongoing activities in all levels of programme implementation was an important element. This is because there was a high level of complementarity between the CSPD programme and other activities which was facilitated by existing structures of programme implementation.

5.2.8 Positive Outcome of the Programme

The outcomes of the programme were realised in reduced child mortality, improved nutrition status of children and associated benefits of the programme.

- **Reduced child mortality**

During discussions with members of the community and their leaders in almost all of the villages, the majority of them appreciated that the programme has managed to reduce deaths of children in their village especially those associated with malnutrition. The reduction has occurred within a reasonable period of time. In those discussions it was said that:

> "... programme has managed to reduce significantly the problem of child death..... at the moment children are not dying any more from malnutrition..., ... we like and support the programme ..." *Community member Sanjaranda village*

As mentioned in section 5.2.1 one of the expectations which developed among members of the community was that the programme would be able to provide solutions regarding the death of children in their village. The fact that the programme managed to meet this expectation within a reasonable time, made people feel that it was worthwhile participating in the programme.

Reduction of mortality is something which can be felt in the community, everybody in the community could see that the rate of attending funerals had declined. As a result people could spend more time in other productive work. It appears that if a programme is to be accepted

and participation is wanted, it should start by addressing issues which need immediate attention as perceived by the beneficiaries. Also the programme should be designed in such a way that the expected outcome is realised within a reasonable span of time. However, not all problems can be solved in the short term, some will need more time to be solved than others. Therefore a clear distinction should be made between short and long term solutions and all stake holders should be aware of the time span which is expected in order to solve a particular problem.

❑ Improved nutrition status and knowledge

It appears that as a result of implementing the CSPD programme the nutrition status of children has improved and knowledge of people regarding nutrition has increased.

☞ Improved nutrition status

The comparison of first weighing and last weighing in 1995 showed a substantial decline of underweight cases in all villages participating in the study. Severe cases of malnutrition had dropped from between 5 and 8 percent to 0.9 and 3 percent. It was noted that at village level the severe cases of underweight were identified by names and this made affected parents ashamed, as a result they put efforts into improving the condition of their children. These efforts included participating fully in the programme by attending weighing sessions and following all advice given after weighing.

"...we appreciate that we have seen the outcome of the programme ..., the programme has managed to eliminate the possibility of a child dying from malnutrition ..." *Member of community - Sanjaranda village*

"... children are not dying from malnutrition in this village ..., if a child dies then the cause is something else and not malnutrition related diseases ...". *Member of community - Kisamwene village*

As discussed earlier one of the objectives of the programme was to eliminate child mortality which was mostly caused by malnutrition. The discussion with community members seems to suggest the programme has managed to meet the objectives.

☞ **Increased knowledge on nutrition**

Discussions with leaders at village and district levels revealed that knowledge regarding nutrition status of children has increased. Some of the leaders said that:

"The implementation of the programme has resulted in understanding of the importance of good nutrition for children". *Leaders in Kisamwene, Sanjaranda and Butiama village*

This indicates that people know that the nutrition status of children is important and therefore they need to participate in the implementation of the programme in order to maintain good nutrition status of their children.

"All activities aimed at improving the living standard of people can be assessed in terms of their impact on the nutrition status of children in a particular society...". *District official-Musoma*

At district level, it appears that nutrition status is used to assess the impact of other programmes. This also ensures that the programme is implemented in order to generate data which can be used for the assessment.

"... if some one wants to know the quality of life for a particular household tell him to look at the condition of the children in that household..." *Community member Mhalala and Butiama village*

Although nutrition status of children was not specifically mentioned, it is likely that nutrition status is among the factors which can be used to describe the situation of children. The increased knowledge and urge to maintain the good health of children has contributed to the success of the programme at community level. At district level, the fact that it is believed that nutrition status can be used to assess the impact of other programmes enhanced the implementation of the programme in order to monitor other programmes implemented in the district.

☞ **Associated benefits of the programme**

There were other benefits which were found to be associated with the programme. These benefits included additional resources allocated to enhance the implementation of the programme. The fact being that the additional resources were also used for other activities related to the programme, the increase in performance and participation of people from different sectors in the programme was observed.

"... the implementation of this programme has enabled the district to acquire facilities that are used not for the programme alone but also for other activities ...". *District administrative officer - Manyoni*

"..therefore not only children have benefited but all people in the district ..., ... transportation for leaders for example has improved such that they visit many areas within and outside the programme areas ..." *CSPD coordinator - Manyoni*

"... the programme has to be maintained ..., ... all departments in the district are using programme facilities such as photocopy and computer..." *District planning officer- Musoma*

"... the district can buy any equipment through the programme which could have not been able to be purchased by using local currency..., this provision is not available in a district which does not implement the programme." *District planning officer - Musoma*

It appears that the additional resources and other provisions motivated people to ensure that the programme is maintained not only to improve nutrition but also for the benefit of other related activities in the area. Other benefits associated with the programme include opportunities for training and travelling.

CHAPTER 6

CONCLUSION

AND

RECOMMENDATION

Preamble

This section will conclude the findings of the study and provide recommendations regarding the implementation of nutrition related programmes.

6.1 Conclusion

The success of the CSPD programme can be explained in terms of achievements realised by beneficiaries. The problem of child death, especially that related to malnutrition has been reduced and people's understanding regarding nutrition issues has been improved. The implementation of the programme in both districts has been enhanced by a combination of eight main factors namely awareness, adequate training, high level of commitment, appropriate structures, an effective monitoring system, good leadership, adequate linkages between the programme and ongoing activities and positive outcome of the programme. All these factors were responsible for facilitating community participation in all aspects of programme implementation. However, no single factor was enough on its own to facilitate adequate implementation of the programme.

As mentioned in chapter four the author did not aim at making a comparison between two districts implementing the programme but rather to understand vital processes involved in the implementation of the programme under different ethnic and economic activities. Irrespective of the diversity in the ethnic groups and economic activities the eight elements mentioned above seem to be vital for the implementation of the CSPD programme.

Awareness of the problem is a necessary but not sufficient condition for starting the programme. In order to start the programme people have to be completely aware of problems, causes and possible solutions. Complete awareness appears to be effective in facilitating the building of consensus on what should be done and by whom in order to solve the problem. Training was important not only for attaining complete awareness but also for imparting knowledge and skills to all people who were to be involved in the implementation of the programme. The training was effective because people's experience regarding the problem was taken into account.

Initial training was not however enough, there was a need for retraining in order to accommodate changes which occurred during the course of programme implementation. Apart from imparting knowledge to people, training and retraining was regarded as an incentive to those who were involved in the implementation especially if training was to take place away from their working place.

Commitment of all stakeholders was seen as an important element for programme implementation. Community commitment to solving problems was observed through the active involvement of community members in the programme implementation. This involvement was evident through participation in decision making, contribution of resources to support the implementation of the programme, use of by-laws to enforce decisions and establishment of schemes for supporting families affected by malnutrition. At higher levels, commitment was observed through physical participation of district and regional staff in

programme activities at the village level and the provision of funds and materials to facilitate implementation of the programme.

Clear and visible implementation structures were found to play a great role in the implementation of the programme by facilitating a monitoring process, decision making, accountability, community participation and information communication and sharing. The structures used for implementing the programme were part of the existing administrative structures. This resulted in the programme being regarded as one of the developmental activities taking place in the area.

The monitoring system was found to be effective because it made problems of programme implementation visible at their earliest stage at all levels of implementation in such a manner that timely correction was possible. In addition, the effectiveness of the system was also manifested by its ability to generate information which was used starting from the point of collection. Furthermore, the presence of mechanisms to ensure actions and feedback as well as reinforcement of good practices enhanced the efficiency of the monitoring system.

Good leadership was found to enhance programme implementation. The performance of the programme especially at village level was associated with quality of leadership. This was because the leadership was responsible for following up on the decisions made in various decision making forums, mobilising people to participate in the programme activities, mobilising resources to support the programme and making links between one level and

another. The leadership was also found to be responsible for the performance of other activities beside those related to the programme.

Linkages between the programme and other ongoing activities were found to be important for maximising the use of limited resources, especially human resources. The importance of making linkages was realised through complementary effects which occurred among the programmes activities such as using the same personnel and expertise for different activities. However, the strength of the linkages was sometimes affected by the position or status of individuals involved in coordinating the activities, whether or not the target group for different activities was the same and also if the coordination of different activities was done by the same department or not.

Initially the expectation that needs would be met was a motive for people to participate in the implementation of the programme. Continued participation in the programme was determined by the outcome of the programme. Positive outcomes which met their needs and expectations appeared to be responsible for motivating people to continue participating in the programme. It was also found that the programme took a reasonable time to solve the pressing problems of the community and as a result they felt that there was a need to participate in the programme.

6.2 Recommendations

6.2.1 Awareness

Awareness of the problems alone is not enough to initiate interventions. Therefore in order to initiate interventions creating complete awareness of problems, causes and possible solutions should be the first step. For any programme to have the effective involvement of all stakeholders there should be efforts to ensure that complete awareness is attained by all those who will to be involved. Complete awareness is important in facilitating the building of consensus on what to do and by whom. Therefore initiation and implementation of a programme should be done along with raising awareness of those involved in the discussions. One way of raising awareness is through training. For training to be effective in raising awareness, initial understanding of the people's knowledge regarding the problem is important. This can be done by incorporating local leaders and other local key informants such as extension staff into the preparation of training especially when the aim is to raise awareness of the people. Local leaders usually know what their people believe which is an indication of their knowledge regarding the problem.

6.2.2 Training

In order for training to be successful thorough planning should be done to include the experience of participants and also to incorporate the local situation into the training programme. Participants should be categorised according to the task which they are to undertake, for example, to facilitate the participation of the community in general and for

leaders and experts to be able to support implementation of the programme. With regard to sustainability, training should aim at training local people who will then train others. The ultimate results of training should be to empower local people to be able to train in the long run. Training programmes should not be static and therefore there should be a plan for retraining in order to use experiences resulting from the implementation to improve the skills of people involved in the implementation. Apart from imparting skills to people, training should be regarded as an incentive to people and therefore when planning is done one has to consider elements which will result in training being able to motivate people.

6.2.3 Commitment

All stakeholders in the programme implementation should be committed to the programme if adequate implementation and long term sustainability is to be realised. Commitment is not words but rather actions. Commitment by all stakeholders can be seen in actions such as: resource mobilisation, community participation, establishment of support mechanisms, establishment of an effective way of generating and communicating information and a means to enforce the implementation of decisions. Efforts must be invested to solicit commitment of all stakeholders before initiation of the programme. This can be attained through training and ensuring that people fully understand and appreciate the benefits.

6.2.4 Appropriate Structures

Structures for programme implementation must be visible at all levels of implementation. Visibility means a clear understanding of the roles which structures are supposed to undertake as this shows areas of responsibility and accountability. Programme structures need to be integrated into existing administrative structures because this will firstly enable the use of existing personnel to facilitate the implementation of the programme through supervision and community mobilisation. Secondly, it is easier to accommodate the programme activities into other development programmes. Thirdly, it eliminates the possibility of having parallel structures which cause problems of coordination and which usually frustrate implementors and beneficiaries. In order to have visible structures efforts must be invested in strengthening the existing structures through training, which enables people within the structures to assume additional roles and responsibilities as well as to make them more accountable not only for the programme activities but also for activities related to the programme. For community based programmes strengthening of existing local structures should be a priority if long term sustainability of the programme is to be realised.

6.2.5 Monitoring System

A monitoring system is an indispensable component of any programme. The system enables implementors to detect early any problem related to implementation and make appropriate corrections. Therefore in order to have an effective monitoring system in the programme efforts must be made firstly to ensure there is a demand for information at all levels of implementation. Secondly, the system must be able to generate information. Thirdly, the

information should be used at every point of generation and fourthly, a mechanism to facilitate feedback should be established. Training should be one of the efforts to ensure that all people involved in the implementation are able to participate in the monitoring system as well as be able to communicate adequately and share the information. Actions resulting from a monitoring system should be known to all stakeholders irrespective of the level of implementation as it will facilitate the motivation of people to participate in the system.

6.2.6 Leadership

Good leadership is important for any development programme. Therefore, during programme planning the element of leadership should be taken into consideration. Wherever possible efforts must be invested in improving leadership and this can be done through training.

6.2.7 Adequate Linkage with Ongoing Activities

Programmes are not implemented in isolation and in order for them to be effective they need to be linked with other activities within the community. Therefore efforts should be invested to ensure that programme activities are integrated within the ongoing activities. This will result in the community coming to regard the programme as part of their day to day activities.

6.2.8 People's Expectations

People's expectations are crucial in deciding whether or not to participate, especially during the initiation of the programme. Therefore, when initiating any nutrition interventions people's expectation should be taken into consideration seriously, if actual involvement is to be realised during the initiation of the programme.

6.2.9 Positive Outcome

The decision of people as to whether or not to continue participating in the programme will depend on the outcome of the programme. For fostering community participation in the implementation and sustainability of the programme, careful selection of interventions is important. It is recommended that implementation should start with interventions which can be well managed and show early success. When selecting interventions, the time in which the outcome of the programme will be visible should be taken into consideration and stakeholders need to understand this. Hence, there must be a distinction between short and long term interventions.

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APPENDIX 1

FURTHER CHARACTERISTICS OF THE STUDY AREA

Appendix 1: Further characteristics of the study area

Table 1: Further characteristics of Musoma and Manyoni district

	Musoma		Manyoni		
	No.	%	No.	%	p value
Head of household					
Female	166	43.1	65	16.8	
Male	219	56.9	322	83.2	
Total	385	100.0	387	100.0	0.000**
Household size by district					
≤ 5 members	196	50.9	256	66.1	
≥ 6 members	189	49.1	131	33.9	
Total	385	100.0	387	100.0	0.000**
under fives in a household					
None	128	33.2	20	5.2	
One child	128	33.2	245	63.3	
Two children	86	22.3	104	26.9	
More than two	43	11.2	18	4.7	
Total	385	100.0	387	100.0	0.000**

* not significant ** significant

Table 1 indicates that there is a significant difference (p= 0.000) between the two districts in terms of household leadership ie. male against female headed households (p= 0.000), size of households (p= 0.000), distribution of under fives in the households (p= 0.000) and maternal education (p= 0.003). The differences suggest that the information that has been collected from the two districts originates from a heterogeneous society. The diversity of the society was important in order to optimise the collection of the information needed to determine if there were basic processes involved in the implementation of the programme in the two districts.

Table 2: Percentage of people participating in Village Health Days (VHDs) by district

	Musoma		Manyoni		
	No.	%	No.	%	p value
Involvement in VHDs					
Yes	343	89.1	330	85.3	
No	42	10.9	57	14.7	0.113*
Total	385	100.0	387	100.0	

* not significant ** significant

Table 2 indicates that the majority of respondents participated in the VHDs. There is no significant difference (0.113) in terms of people's participation in the VHDs in both districts. Participation in the VHDs means that people were involved in the monitoring process of their health and also were able to participate in the process of decision making regarding their health and implementation of the programme.

Table 3: Percentage of people who felt that the programme has met their expectations by district

	Musoma		Manyoni		
	No.	%	No.	%	p value
Programme met expectations					
Yes	338	87.8	322	83.2	
No	47	12.2	65	16.8	0.07*
Total	385	100.0	387	100.0	

* not significant ** significant

Table 3 indicates that the majority of respondents felt that the programme has met their expectations. Positive expectations usually tend to motivate people to participate in any actions which will lead to the realisation of their expectations. There is no significant difference (0.07) between the two districts regarding the ability of the programme to meet the expectations of the people. This suggest that motivation in terms of meeting their expectations was more or less the same in both districts.

Table 4: Percentage of people who reported having contributed something towards the implementation of programme by district

	Musoma		Manyoni		
	No.	%	No.	%	p value
Contribute anything for the programme					
Yes	351	91.2	344	88.9	
No	34	8.8	43	11.1	0.291*
Total	385	100.0	387	100.0	

* not significant ** significant

Table 4 indicates that in both districts there was a substantial percentage of people who contributed at least something towards the implementation of the programme. There is no significant difference (0.291) between the two districts in terms of contribution. This suggests that there is a potentiality for sustaining the programme in both districts.

APPENDIX 2

GUIDELINES FOR GROUP DISCUSSION

APPENDIX 2

GUIDELINES FOR FOCUS GROUP DISCUSSIONS

Regional and District

1. What is the regional/district/ward profile
    - Population by age groups
    - Socio- economic status
    - Cultural set up
2. What developmental programmes are being implemented in the region/district/ward. Is there any link with CSPD ? If yes, how ?
3. How was CSPD initiated in the region/district/ward ?
4. What was the role of the region/district/ward in the initiation process ?
5. What activities are being implemented on this level ?
6. Who proposed the activities ?
7. Was there any discussion to agree on the activities before being implemented ?
8. Who was supposed to implement the activities ?
9. What is the role of the region/district/ward in the implementation process ?
10. How was the community made to understand that they have nutrition problems and that they have to act against them ?
11. What was the role of the region/district/ward in the conceptualization process ?
12. What made people motivated to participate in the CSPD programme ?
13. What was the role of the region/district/ward in motivating people to participate in the programme?
14. What mechanisms are used to facilitate the decision making process within the programme?
15. What mechanisms are used to facilitate the communication process within and outside the programme ?
16. How do you know that there is a problem in implementing the programme ?
17. Which tools did you find useful in
    - *Conceptualization*
    - *Initiation*
    - *Implementation*
    - *Communication*
    - *Motivation*
    - *Decision making*
    - *Monitoring*
18. Why are they useful ?

19. Based on your understanding, do you think there is a reduction of malnutrition in this area? If yes, what factors contributed to the reduction of malnutrition ?
20. How does the region/district/ward mobilise resources for the programme ?
21. What efforts have been taken to ensure the programme is sustainable ?

Village level

A: For members of Village Councils and any village Committee

1. What is the village profile ?
    - Population by age groups
    - Socio-economic status
    - Cultural set up
2. Inventory of developmental programmes in the village
3. How was CSPD initiated in the village ?
4. What was the role of the village council and village health committee in initiating the CSPD programme ?
5. What activities are being implemented on this level ?
6. Who proposed the activities ?
7. Was there any discussion to agree on the activities before being implemented ?
8. Who was supposed to implement the activities ?
9. What is the role of the village council in the implementation process ?
10. How did the village come to understand that there is a problem of malnutrition in the village ?
11. How was the village motivated to participate in the process of eradicating malnutrition in the village ?
12. What mechanisms are used to facilitate the decision making process within the programme ?
13. What mechanisms are used to facilitate the communication process within and outside the programme ?
14. What problems are you facing in implementing the programme ?
15. How do you know that there is a problem in implementing the programme ?
16. What happens if you find a child is not growing well ?
17. What mechanisms are you using to identify children who are not growing well ?
18. Who monitors the progress of those children and how ?
19. Can you cite an example for question 16, 17 and 18 ?
20. How do you communicate among yourselves on matters related to the programme ?

21. As leaders of this village do you think more could be done through the programme ? If yes, what and how ?
22. Do you see any difference if you compare the situation when there was no CSPD programme and now when the programme is in place ? If yes, what is the difference ?
23. Does the community contribute any resources to run the programme ?
24. Do you think there is any activity related to the programme which does not require any financial assistance ? If Yes, mention !
25. What should be done to ensure programme sustainability in this village ?
26. What efforts have been taken by the community to ensure the sustainability of the programme?
27. Which tools are used for *information generation, communication, planning, decision making, motivating people's participation and understanding, programme monitoring and evaluation.*
28. How useful is *Road to health card (RtHC), village register (VR), child follow-up form (CFF), health committee (HC), village health worker VHW), traditional birth attendant (TBA), and village health day(VHD), meetings, and minutes from a meeting.*

B: For Individual villagers who are not members of the village councils or any village committee.

1. What is CSPD ?
2. How was CSPD initiated in this village ?
3. How were you involved in the process of conceptualization, initiation and implementation?
4. What was the role of the village council in the initiation process ?
5. What is the role of the village council in the implementation process ?
6. How did you come to understand that there is a problem of malnutrition in the village?
7. How did you come to be motivated to participate in the process of eradicating malnutrition in the village ?
8. Do you know the mechanisms which are used to facilitate the decision making process within the programme ? Is that different from what is used for other development activities?
9. Do you know the mechanisms which are used to facilitate the communication process within and outside the programme ? Is that different from what is used for other development activities ?
10. How do you know that there is a problem in implementing the programme ?
11. What happens if you find your children are not growing well ?

12. How do you identify a child who is not growing well ?
13. Who monitors the progress of that child and how ?
14. Can you cite an example for question 10, 11 and 13 ?
15. How do you communicate among yourselves on matters related to the programme ?
16. Are you aware of the RtHC, Village register, and child follow-up form ?
17. How useful is *Road to health card (RtHC), village register (VR), child follow up form (CFF) health committee (HC), village health worker VHW), traditional birth attendant (TBA), and village health day(VHD), meetings and minutes from a meeting ?*
18. As members of this village do you think more could be done through the programme? If yes, what and how ?
19. Do you see any difference if you compare the time when there was no CSPD and now when the programme is in place ? If yes, what is the difference ?
20. Do you think there is any improvement of nutrition status in your village ? What contributed to it?
21. As far as programme implementation is concerned, who is the major actor ?
22. If you were given an opportunity to comment on the programme, what would you say?

APPENDIX 3

VILLAGE QUESTIONNAIRE

APPENDIX 3

Village Questionnaire

1. District---------- 2. Ward---------- 3. Village----------
4. How many households are in this village ? [ ]
5. What is the population of this village ?
   males [ ]
   female [ ]
   Children [ ] *(less than five years of age)*
   disabled [ ]
6. What is the type of the main access road to the village ?
   1. All weather road
   2. Seasonal road
   3. Path

7. What are the three major economic activities in this village ?***(List three main economic activities in terms of priority by numbering them starting with the most important one which you think is undertaken by the majority)***

   Fishing
   Trading/Marketing
   Manufacturing
   Handcraft
   Mining
   Livestock
   Hunting

8. What is the main source of drinking water in this village ?
   1. Pipe water
   2. Constructed well
   3. Protected well
   4. Unprotected well
   5. Protected spring
   6. Lake, river, spring
   7. Rain water tank

9. On average how far is it to the main source of drinking water ?
   1. Less than 30 minutes
   2. More than 30 minutes but less than 60 minutes
   3. More than 60 minutes

10. What is the main source of energy for cooking ?
    1. Electricity
    2. Charcoal
    3. Firewood
    4. Kerosine
    5. Gas
    6. Cow dung
11. What is the main type of waste disposal in this village ?
    1. Pit inside compound
    2. Pit outside compound
    3. Rubbish bin
    4. Thrown outside compound
    5. Thrown inside compound
12. What proportion of households possesses latrines ? [ ]

13. Availability of basic services in the village

Service	Available 1=yes, 2=no	Distance 1= less than 30 minutes 2= between 30 - 60 minutes 3= more than 60 minutes
Health facility		
health post	[ ]	[ ]
dispensary	[ ]	[ ]
health centre	[ ]	[ ]
hospital	[ ]	[ ]
Education		
adult education	[ ]	
pre-primary school	[ ]	
primary school	[ ]	
secondary school	[ ]	
Others		
marketing	[ ]	
shopping centres	[ ]	
extension services	[ ]	
----------	[ ]	
----------	[ ]	
----------	[ ]	

14. Do you have a Village Health Committee (VHC) in your village ?
    1. Yes 2. No [ ]
15. How many VHC meetings were conducted last year (1996) ? [ ]
16. How many VHC meetings are there supposed to be in a year ?[ ]
17. How many VHDs were conducted last year (1996) ?[ ]
18. How many VHDs are there supposed to be in a year ?[ ]
19. How many community meeting were conducted last year (1996)? [ ]
20. How many community meetings are there supposed to be in a year ?[ ]
21. After sending your meeting deliberations to the ward level, do you get feed back from higher levels ? 1. Yes 2. No [ ]

APPENDIX 4

HOUSEHOLD QUESTIONNAIRE

APPENDIX 4

HOUSEHOLD QUESTIONNAIRE

A: IDENTIFICATION

1. Region---------- 2. District---------- 3. Ward ----------
4. Village---------- 5. Ten cell leader---------- 6. Household head----------
7. Sex of household head ------- 8. Respondent (1= household head 2= other member of household)

B: INFORMATION FROM THE VILLAGE REGISTER AND CHILD FOLLOW-UP FORM

B1. How many members of the family are in the household ? [ ]
B2. How many children of less than five years old ? [ ]
B3. What is the age of the mother ? [ ]
B4. What is the age of the father ? [ ]
B5. What is the education level of the mother ? [ ]

1.No education
2.Read/Write
3. P/School
4. S/School
5. Above S/School

B6. What is the education level of the father ? [ ]

1.No education
2.Read/Write
3. P/School
4. S/School
5. Above S/School

B7. What is the date of birth of the children who are under five years of age in this household ?***(Born after April 1991)***

First child -----/-----/19-----
Second child -----/------/19----
Third child -----/------/19----
Fourth Child -----/------/19----

B8. What is the nutrition status of the under fives (using child follow-forms) ?

1.Normal (green) 2.Moderate (grey) 3.Severe (red)

First child [ ]
Second child [ ]
Third child [ ]
Fourth Child [ ]

B9. What is the immunization status of the under fives ?

1.Completed for the Age 2. Not Completed for the Age

First child [ ]

Second child [ ]

Third child [ ]

Fourth Child [ ]

C: INFORMATION FROM HOUSEHOLD HEAD

(The aim of this information is to check the reliability of village register)

C1. How many members of the family are in the household ? [ ]

C2. How many children of less than five years old ? [ ]

C3. What is the age of the mother ? [ ]

C4. What is the age of the father ? [ ]

C5. What is the education level of the mother ? [ ]

1.No education

2.Read/Write

3. P/School

4. S/School

5. Above S/School

C6. What is the education level of the father ? [ ]

1.No education

2.Read/Write

3. P/School

4. S/School

5. Above S/School

C7. What is the date of birth of the children (in months) who are Under five years of age in this household ?***(Born after April 1991)***

First child -----/-----/19-----

Second child -----/------/19----

Third child -----/------/19----

Fourth Child -----/------/19----

C8. What is the nutrition status of the under fives (using clinic card) ?

1.Normal (green) 2.Moderate (grey) 3.Severe (red)

First child [ ]

Second child [ ]

Third child [ ]

Fourth Child [ ]

C9. What is the immunization status of the under fives ?

1.Completed for the Age 2. Not Completed for the Age

First child [ ]

Second child [ ]

Third child [ ]

Fourth Child [ ]

C10. Does the information from the register conform to information obtained from the household ? 1.Yes 2. No [ ]

C11. What is the weight of the youngest child in the house ? [ ] kg

C12. What is the height of the youngest child in the house ? [ ] cm

D: SOCIO-ECONOMIC INFORMATION FROM HOUSEHOLD

D1.Which tribe do you belong to ? [ ]

1.Luo 2. Kurya 3. Zanaki 4. Kurya 5. Shashi

6.Nyaturu 7. Rangi 8. Gogo 9. Sandawe

10.Other *(specify).....*

D2.What is the main occupation of the household head ? [ ]

1. Farmer 2.Pastoralist 3.Labourer 4.Business

5.Council employee

6. Other *(specify).....*

D3. Does the household own a radio ? [ ]

1.Yes 2.No

(If "No" go to question D6)

D4.Do you (mother/father) have time to listen to programme (s) related to health and nutrition ? [ ]

1.Yes 2.Sometimes 3.Never

D5.Do other members (besides mother and father) have time to listen to programme (s) related to health and nutrition ? [ ]

1.Yes 2.Sometimes 3.Never

D6.Do you attend community meetings ? [ ]

1.All of them 2. Sometimes 3.Never

D7. Do you attend other community functions (eg wedding, funeral, rituals) ? [ ]

1. Yes 2. Sometimes 3. Never

(If "Never" go to question E1)

D8. Do you talk about other issues related to your life in those functions ? [ ]

1.Yes 2.Sometimes 3.Never

E: INITIATION OF CHILD SURVIVAL, PROTECTION AND DEVELOPMENT (CSPD) PROGRAMME (these questions should be asked to head or mother of the household)

E1. Are you a member of the village council or any committee in the village ?[ ]

1. Yes
2. No

E2. Are you aware of the CSPD programme in this village ? [ ]

1. Yes
2. No

E3. What is the CSPD programme all about ? [ ]

1. Village council activities
2. UNICEF activities
3. Our children
4. District council activities
5. I don't know

E4. Do you know how the CSPD programme was initiated ? [ ]

1. I know
2. Some what
3. I do not know

If 'Yes', or 'some how' ask question E5 and E6 if 'No' go to question E7.

E5. Do you know the intention of initiating the CSPD programme ? [ ]

1. I know
2. Some how
3. I do not know

E6. Were you involved in the initiating process for the CSPD programme ?[ ]

1. I was involved
2. Partially involved
3. Not involved

if 'Yes' or 'some how' ask question E7 and if 'Not involved' go to question E9.

E7. How were you involved ? [ ]

1. Through discussion
2. By performing specific task(s)
3. By doing follow-up
4. Others (*specify*) ----------

E8. Did you contribute anything during the initiation of the CSPD programme ?

1. Yes 2. No [ ]

If the answer is "Yes" go to question E9 if is "No" go to question E10

E9. What was your contribution or support during the initiation phase of the CSPD programme?

1. Ideas [ ]
2. Labour
3. Time
4. Cash/material(s)
5. I did not contribute
6. Others *(specify* ----------

E10. Do you know other people who were involved in the initiating process of the CSPD programme?

1.Yes [ ]
2. No

If "Yes" ask question E11 and if "No" ask question E12

E11. How were other people involved in the initiating process ? [ ]

1. Through discussion
2. By performing specific task(s)
3. By doing follow-up
4. I don't know
5. Others (*specify*)----------

E12. What proportion of villagers were involved in the process of initiating the CSPD programme ?

1. Less than 50 percent [ ]
3. More than 50 percent

F: IMPLEMENTATION OF THE CHILD SURVIVAL, PROTECTION AND DEVELOPMENT (CSPD) PROGRAMME

F1. What activities do you associate with the CSPD programme ? [ ]

1. Activities dealing with mothers and children
2. Activities related to UNICEF
3. Activities related to government
4. I do not know
5. Other *(specify)*.....

If the answer is "I do not know" go to question F5.

F2. Who proposed (introduced) these activities in your village ? [ ]

1. Community leadership
2. Government personnel
3. UNICEF

4. I do not know
5. Other (*specify)* ----------

F3. Was there any discussion on what should be done in your village in relation to the CSPD programme?

1. Yes [ ]
2. Not sure
3. No

If "Yes" proceed to question F4 and "Not sure " or " No" go to question F5

F4. How was this decision reached ? [ ]

1. Through community meetings
2. Through village Government meetings
3. Through village health committee meetings
4. Through household visits
5. I do not know
6. Other (*specify)*----------

F5. Are you involved in the implementation of the CSPD activities in your village ? [ ]

1.Totally involved
2. Partially involved
3. Not involved

If the answer is "Not involved" or "I do not know" go to question F7.

F6. What is/was your contribution or support for the implementation of the CSPD programme ? [ ]

1. Ideas
2. Labour
3. Time
4. Cash/material(s)
5. I did not contribute
6. Other *(specify)*.....

F7. What are your expectations for the CSPD programme ?

1. Improve health of mothers and children[ ]
2. Improve our income [ ]
3. Improve facilities for basic services [ ]
4. Increased employment opportunities [ ]
5. I do not have any expectation [ ]
6. Other (specify)---------- [ ]

F8. Is the implementation of the CSPD programme meeting your expectations ? [ ]

1. Yes
2. Partially
3. No

F9. Who do you think is supposed to implement the programme activities in this village ? [ ]

1. Community
2. Government
3. UNICEF
4. I do not know
5. Others *(specify)* ----------

G: CONCEPTUALIZATION OF NUTRITION PROBLEMS IN THE VILLAGE

G1. Do you think there is a problem of malnutrition in your village ? [ ]

1. Yes
2. To some extent
3. I am not sure
4. No

If "Yes" or " to some extent" continue with question number G2 if "No" or "I am not sure" go to question number G5.

G2. What makes you think there is a problem of malnutrition in your village ? [ ]

1. I saw a malnourished child of my neighbour
2. Through village health days
3. Through hospital/Clinics
4. Through health staff
5. Through village health workers
6. Other *(specify)*----------

G3. Do you know the causes of malnutrition in your village ? [ ]

1. I know
2. I am not sure
3. No

If "Yes" go toquestion G4 and if "I am not sure" or "No" go to question G5.

G4. If "Yes" can you mention some of them ? [ ]

1. Diseases and low food intake (re. CFW)
2. Inborn phenomenon
3. I do not know

4. Other *(specify)*----------

G5. Do you think the majority of people in this village know the causes of malnutrition?

1. Yes [ ]
2. Some what
3. I am not sure
4. No

G6. Has there been any efforts to explain the causes of malnutrition in your village ?

1. Yes [ ]
2. Some what
3. I am not sure
4. No

If "Yes" or "Somewhat" go to question G7 and If "I am not sure" go to question G9.

G7. Who explained the causes of malnutrition in your village ? [ ]

1. Village health committee
2. Village health worker
3. Health workers at the clinic
4. Neighbours
5. I do not know
6. Other *(specify)*----------

G8. How was the explanation of the causes of malnutrition in your village done ? [ ]

1. Through village meetings with council officials
2. Household visiting
3. Mothers specifically were told in the clinics
4. Through a seminar
5. I do not remember
6. Other *(specify)* ----------

G9. Who is supposed to eradicate malnutrition in this village ?[ ]

1. Government
2. Community members
3. UNICEF
4. I do not know
5. Other *(specify)* ----------

H: MOTIVATION FOR PEOPLE IN THIS VILLAGE TO PARTICIPATE IN THE CSPD PROGRAMME

H1.Did you have any expectation from the CSPD programme ? [ ]

1. Yes
2. No

H2. Does the programme meet your expectation ? [ ]

1. Yes
2. No

H3. Do you think people in this village had any expectations from the CSPD programme ? [ ]

1. Yes
2. No

H4 Does the programme meet their expectation ? [ ]

1. Yes
2. No

H5. Do you think people in this village are motivated to participate in the programme implementation ? 1. Yes 2. No [ ]

If the answer for question H5 is "No" go to question H7.

H6. What do you think has motivated people to participate in the CSPD activities ?[ ]

1. The activities deal with children's lives
2. The outcome is easily seen
3. There is appreciation of people's contribution
4. There is a provision for people to participate in planning and decision making
5. I do not know
6. Others *(specify)*----------

H7.Do people participate in the programme ? [ ]

1. Yes 2. No

H8. What assessment would you make on the people's participation/involvement in the CSPD activities ?

1. Excellent [ ]
2. Very good
3. Good
4. Fair
5. Poor
6. I am not sure

H9. Can you explain your answer in H6 ? [ ]

1. Many people attend meetings regarding the programme
2. Not many people attend meetings regarding the programme
3. People's contribution towards the programme is good
4. People's contribution towards the programme is bad

5. Many people attend village health days
6. Not many people attend village health days
7. I do not know
8. Other *(specify)*----------

H10. Is (are) there any other programme(s) besides CSPD going on in this village?

1.Yes [ ]
2.I am not sure
3. No

H11. Can you mentioned it (them) ?

1. Water [ ]
2. Health [ ]
3. Education [ ]
4. Forestry [ ]
5. Agriculture [ ]
6. Nutrition [ ]
7. Income generating activities [ ]
8. I do not know [ ]
9. Other (*specify)* ---------- [ ]

H12. What is the difference between the CSPD and such programme(s) ?[ ]

1. CSPD meets our expectation while others do not
2. Others meet our expectation while CSPD do not
3. They are the same as CSPD
4. I do not know
5. Other *(specify)*----------

H13. Do you like them ? [ ]

1. Yes
2. Some what
3. Not at all

H14. Is there any difference in terms of health and the nutrition situation in this village when you compare the time when there was no programme and now when you have the CSPD programme ?

1. Yes 2. No [ ]

H15. If "Yes" , what is the difference ?

1. The situation is better
2. The situation is not better

H16. If "No" , why ?

1. The situation is worse
2. The situation is the same

I: TOOLS FOR CSPD PROGRAMME

I1. Are you aware of the Road to health card (clinic card) [ ]

1. Yes 2. No

If "Yes" ask question I2 If "No" ask question I3

I2. How useful is the road to health card ? [ ]

1.Very useful
2. Useful
3. Sometimes useful
4. Not useful

I3. Are you aware of the Conceptual frame work [ ]

1. Yes 2. No

If "Yes" ask question I4 If "No" ask question I5

I4. How useful is the conceptual frame work ? [ ]

1.Very useful
2. Useful
3. Sometimes useful
4. Not useful

I5. Are you aware of the Triple A cycle ? [ ]

1. Yes 2. No

If "Yes" ask question I6 If "No" ask question I7

I6. How useful is the Triple A cycle ? [ ]

1.Very useful
2. Useful
3. Sometimes useful
4. Not useful

I7. Are you aware of the Village health days ? [ ]

1. Yes 2. No

If "Yes" ask question I8 If "No" ask question I9

I8. How useful are village health days ? [ ]

1.Very useful
2. Useful
3. Sometimes useful
4. Not useful

I9. Are you aware of the village register [ ]

1. Yes 2. No

If "Yes" ask question I10 If "No" ask question I11

I10. How useful is the village register ? [ ]

1.Very useful
2. Useful
3. Sometimes useful
4. Not useful

I11. Are you aware of the Child follow-up form [ ]

1. Yes 2. No

If "Yes" ask question I12 If "No" ask question I13

I12. How useful is the Child follow-up form [ ]

1.Very useful
2. Useful
3. Sometimes useful
4. Not useful

I13. Are you aware of the Minutes of Village council meeting? [ ]

1. Yes 2. No

If "Yes" ask question I14 If "No" ask question I15

I14. How useful is the Minutes of Village council meeting ? [ ]

1.Very useful
2. Useful
3. Sometimes useful
4. Not useful

I15. Are you aware of the Minutes of Village Health Committee meeting ?[ ]

1. Yes 2. No

If "Yes" ask question I16 If "No" ask question I17

I16. How useful are the Minutes of Village Health Committee meeting ? [ ]

1.Very useful
2. Useful
3. Sometimes useful
4. Not useful

I17. Are you aware of the Village Health Committee ? [ ]

1. Yes 2. No

If "Yes" ask question I18 If "No" ask question I19

I18. How useful is the Village Health Committee ? [ ]

1.Very useful

2. Useful

3. Sometimes useful

4. Not useful

I19. Are you aware of the Village Health Worker ? [ ]

1. Yes 2. No

If "Yes" ask question I20 If "No" ask question I21

I20. How useful is the Village Health Worker ? [ ]

1.Very useful

2. Useful

3. Sometimes useful

4. Not useful

I21. Are you aware of the Traditional Birth Attendant [ ]

1. Yes 2. No

If "Yes" ask question I22 If "No" ask question I23

I22. How useful is the Traditional Birth Attendant ? [ ]

1.Very useful

2. Useful

3. Sometimes useful

4. Not useful

APPENDIX 5

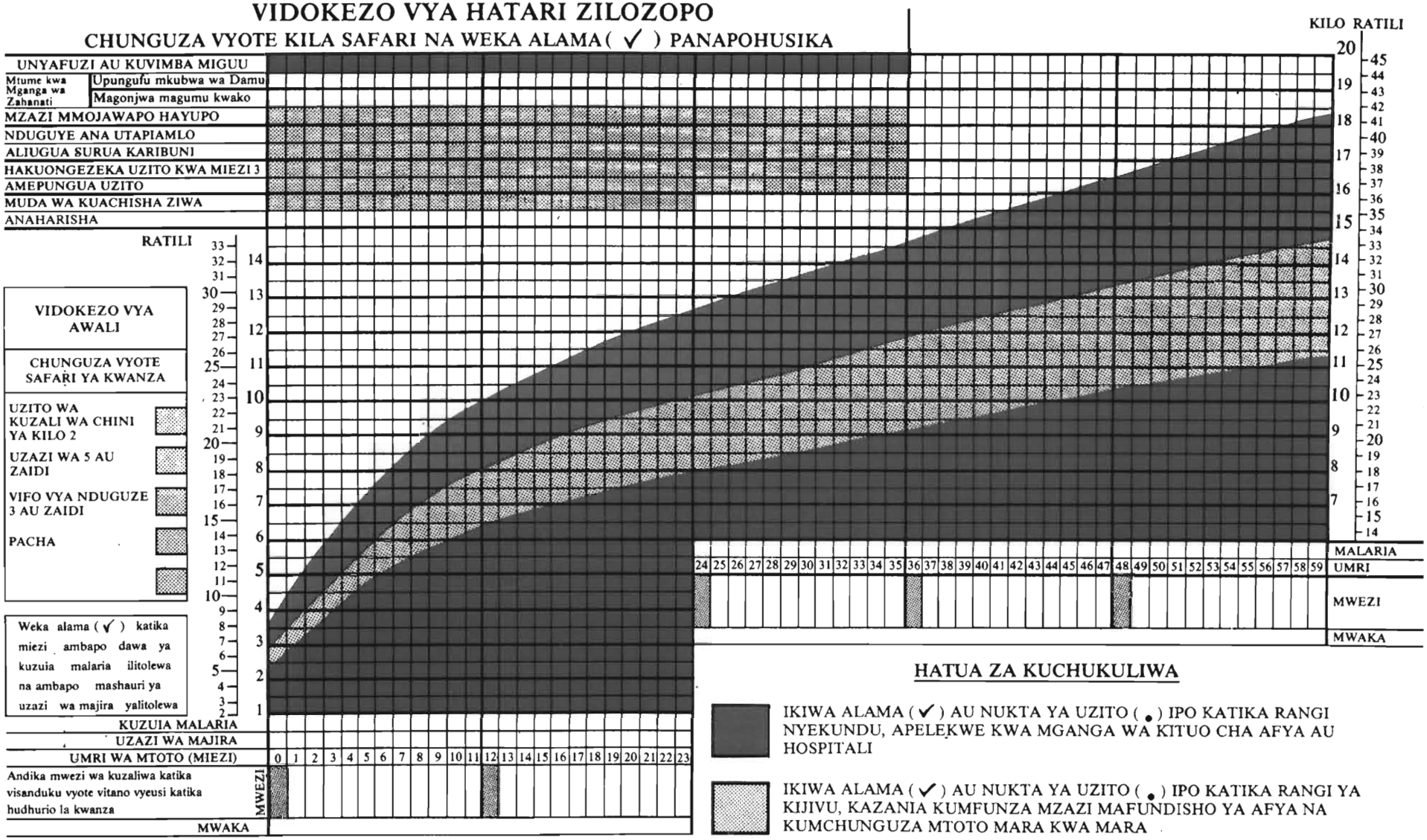
ROAD TO HEALTH CARD USED IN TANZANIA

APPENDIX 5

ROAD TO HEALTH CARD USED IN TANZANIA

VIDOKEZO VYA HATARI ZILOZOPO

CHUNGUZA VYOTE KILA SAFARI NA WEKA ALAMA (✓) PANAPOHUSIKA



HATUA ZA KUCHUKULIWA

IKIWA ALAMA (✓) AU NUKTA YA UZITO (•) IPO KATIKA RANGI NYEKUNDU, APELEKWE KWA MGANGA WA KITUO CHA AFYA AU HOSPITALI

IKIWA ALAMA (✓) AU NUKTA YA UZITO (•) IPO KATIKA RANGI YA KIJIVU, KAZANIA KUMFUNZA MZAZI MAFUNDISHO YA AFYA NA KUMCHUNGUZA MTOTO MARA KWA MARA

APPENDIX 6

THE LINKAGES BETWEEN REGIONAL ADMINISTRATIVE AND THE CSPD PROGRAMME IMPLEMENTATION STRUCTURES

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THE LINKAGES BETWEEN REGIONAL ADMINISTRATIVE AND THE CSPD PROGRAMME IMPLEMENTATION STRUCTURES

Management structures of the CSPD are fully integrated into existing administrative structures. The existing structures are those which are responsible for various decisions regarding the implementation of social and development programmes in the area. Basically the structures can be categorised into two categories namely decision making and technical structures.

At the regional level the decision making structure is called the Regional Development Committee (RDC). This committee is composed of all heads of departments at regional level and members of parliament. The chairperson of the committee is the regional commissioner. This structure is responsible for overseeing all social and development programmes in the region and CSPD is one of them. The Regional Management Team (RMT) is a technical structure and its main role is to facilitate the process of decision making by the RDC. The facilitation role involves preparation of information which will be needed for decision making and understanding of the implications of the decisions which will be made by RDC.

The CSPD structures are well integrated into these structures. The technical structure of the programme which is the Regional Task Force (RTF) is formed by RMT to ensure adequate responsibility and accountability. The decision making structure for the CSPD programme which is the Regional Steering Committee (RSC) is composed of all

members of RDC together with religious leaders. The formation of CSPD structures as part of the existing administrative structures indicate that there is a linkage between the two structures.

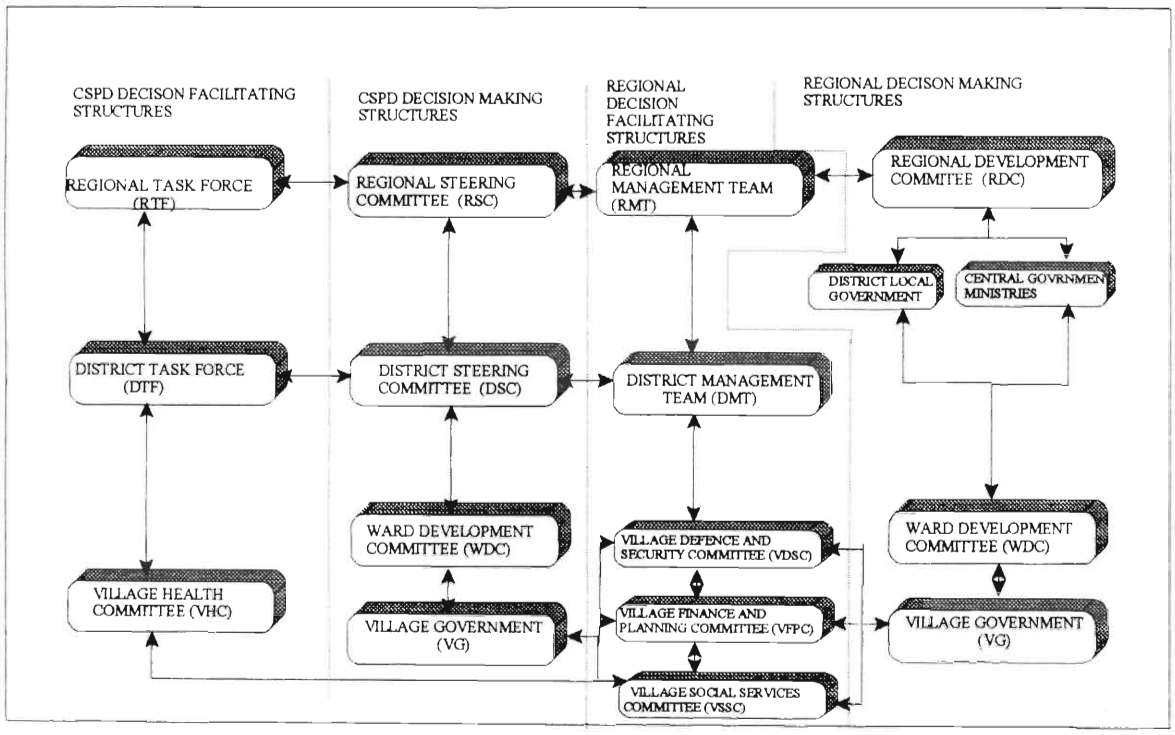
At the district level the structures which are responsible for all programmes implemented in the district are District Council (DC) as the decision making structure and District Management Team (DMT) as the technical structure. The programme structures are similar to those described for regional level. The technical structure is called District Task Force (DTF) and is formed by District Management Team (DMT) while the decision making structure is District Steering Committee (DSC) and is formed by some members of the District council.

At ward level the only conspicuous structure is the Ward Development Committee (WDC). The committee draws members from all villages (usually 2 - 5) which are under that particular ward. Members of this committee are ward secretary, all extension staff, all village chairpersons, secretaries and village executive officers. The responsibility of the committee is to coordinate all programmes which are implemented in the villages and also to act as a link between villages and district.

At village level Village Government (VG) is the decision making body in a village. The responsibility of VG is to oversee the implementation of all social and development programmes in a village. VG is made of three main committees namely Defence and Security Committee (DSC), Finance and Planning Committee (FPC) and Social Service

Committee (SSC). The implementation of the programme is under the SSC. In order to have more focus and accountability, Village Health Committee (VHC) has been formed as part of SSC. As far as the implementation of the programme is concerned VHC is a technical structure for the programme. The composition of VHC also includes VHW and a person in charge of the nearest health facility. Figure 5.1 shows the linkage between the CSPD and existing administrative structures.

Figure 5.1: The CSPD implementation structures and the linkages with



administrative structures

APPENDIX 7

LIST OF PEOPLE INVOLVED IN THE STUDY

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LIST OF PEOPLE INVOLVED IN THE STUDY

1.0 Regional level

Mara Regional Task Force

Mr. Zedekiah (Regional CSPD Coordinator) - Planning Officer
Mr. Vitalis Ngonyani (member) - Community Development Trainer
Mrs. Jalia . Mtani (member) - Social welfare Officer
Mr. Felix Oning'o (member) - Health officer
Mr. Julius M. Sonoko (member) - Agricultural officer

Singida Regional Task Force

Mr. A. S. Mshamu (Regional CSPD Coordinator) - Planning Officer
Mr. B. N. Chande (RTF member) - Agriculture Officer

2.0 District level

Musoma Rural District Task Force

Ms. Elizaberth Kitundu (District Coordinator) - District Planning officer
Ms. Shella Tanda (member) - Health officer
Mr. Gozibert Nyambelwa (member) - Education officer
Ms. Caroline Wazagi (member) - Community development officer
Mrs. Benadetha Macha (member) - Agricultural officer

Manyoni District Task Force

Mr. Adrian P. Kimamba (CSPD Coordinator) - Community Development Officer
Mrs. Tuponile Nyaki (member) - Primary health care nurse
Mrs. Emelta C. Kyenga (member) - Agricultural Officer
Mr. John Minja (member) - Health Officer
Mr. Musa Swedi (member) - Water Technician

3.0 Village level

Villages from Mara Rural district
Butiama village
Leaders

Mr. Zakaria Wambura (Village chairman)
Mr. Raphaeli Nyamono (Village executive officer)
Mr. Emil M. Nyerere (Member of village government)
Mr. Marwa Magesa (Member of village government)
Mr. Joseph Kyabwasi (Member of village government)
Mr. William Itale (Member of village government)
Mrs. Pilly Makega (VHW and Member of village government)
Ms. Pilly Bernard (Member of village government)
Mrs Wakuru Nyerere (Traditional Birth Attendant- TBA)
Mr. Edward Makega (Member of village government)

Non Leaders

Mr. Wambari Chacha
Mr. Zakaria Obure
Mrs. Maria Kariuwa
Mrs. Vicky Msuguri
Mr. Damian Otero
Mr. Paul Odiero
Ms. Anastasia Mwita

Mazama Village

Leaders

Mr. D. Meja (Village Chairman)
Mr. Charles Nyanswano (Village executive officer)
Mr. Richard Chacha (Member of village government)
Mr. Abdallah Mbunda (Member of village government)
Mr. Paulo Makabi (Member of village government)

Non Leaders

Mrs. Fatuma Kilahuka
Ms. Mariam Joseph
Mr. Hassan Kituturi
Mr. Matoke Kilosa
Mr. Joshua Nyatori
Mrs. Blandina Mkuki
Mr. Maiga George

Kiabakari Village

Leaders

Mr. J. Nyamsana (Village Chairman)
Mr. A. Kabucha (Member of village government)
Mr. M. Buyaru (Member of village government)
Ms. A. Ibrahimu (VHW)

Non leaders

Mr. Petro Mwita
Mr. Kakuru Wambari
Mrs. Paulina Wambura
Ms. Celina Kaginah
Mr. Vitalis Otieno

Kisamwene village

Leaders

Mr. Paulo Wambura (Village Chairman)
Mr. Patric Gwijo (Village executive officer)
Mrs. Marithe Gathi (TBA)
Mrs. Angelina Richard (TBA)
Mr. George Ranga (Member of village government)
Mr. Jiseph Itozya (Member of village government)
Mr. Charles Mabanda (Member of village government)
Mr. Daudi Hussein (Member of village government)
Mr. Lameck Jungu (Member of village government)
Mr. Mange Nyamazambili (Member of village government)
Mr. Philip Kyarano (Member of village government)
Mr. S. Lazaro (Rural medical aider)
Mr. Makuta Mzizima (Member of village government)
Mr. Shaffi Hussein (Member of village government and traditional healer)
Mrs Pli Izimbura (Member of village government)

Non leaders

Mr. Rutha Kyagunya
Mrs. Beatrice, P.
Mrs. Elen Chimoyo
Ms. Pili Ndike
Mr. Deusi Kinusu

Mr. Meshack Masille

Villages from Manyoni district

Mhalala village

Leaders

Mrs. Sara Simoni (Village Chairperson)
Ms. Blandina George (Village executive officer)
Mr. Mathei Ndali (Member of village government)
Ms. Telezia Chimwaga (Member of village government)
Mr. Elias Yolamu (Member of village government)
Ms. Dorica Edward (Member of village government)
Ms. Merry Hassan (Member of village government)
Mr. Abinery Maganga (Member of village government)
Ms. Melina Nason (Member of village government)
Mr. Devid Mesomapia (Member of village government)
Mr.Aidan Njalika (Member of village government)
Mr. Charles Mcheka (Member of village government)
Mr. Manase Mlemeka (Member of village government)
Ms. Dora George (Member of village government)
Ms Johana Msigala (Member of village government)
Mr. Hongoa Msigala (Head teacher)
Ms. Eda George (Village Health worker)

Non Leaders

Mr. Charles Ngelika
Mr. James Mtani
Mrs. Anita Lwambari
Ms. Leonila Kaliko
Mr. Stevene John
Mr. Edward Kizigo

Sanjaranda Village

Mr. Festo Itogwe (Village Chairman)
Mr. George Sudi (Ward executive officer)
Mr. David Irunde (Village executive officer)
Mr. Francis Itina (Member of village govenment)
Mr. Said Sharagu (Member of village government)
Mr. Amos Manundu (Member of village government)
Mr. Naphtal Alute (Member of village government)

Mr. Samweli Myamyowani (Member of village government)
Mr. Leo Joel (Member of village government)
Mr. Yona Myabahi (Member of village government)
Mr. Richard Shabani (Member of village government)
Mr. Yona Sulley (Member of village government)
Mr. Mganga Hema (Member of village government)
Mr. William Juma (Member of village government)
Mr. Jeramiah Suna (Member of village government)
Mr. John Chao (Agriculture extension officer)
Mr. Simbu Mduhu (Opinion leader)
Mr. Issa Mnyangwuna (Extension officer)

Non Leaders
Mr. Thomas Malechela
Mr. Benedict Msopini
Mr. Abdallah Mohamed
Mr. Seif Hassan
Mrs Halima Yusuph Abdallah
Mrs Mariam Abdurahaman
Mr. Damian Kiboko

Kitopeni village
Leaders
Mr. Shaban Mohamed (Village Chairperson
Mr. Yasini Ntolela (Village executive officer)
Mrs. Amina Yusufu (Member of village government)
Mr. Augustino Ngandi (Member of village government)
Mr. Ramadhani Ali (Member of village government)

Non Leaders
Ms. Anastastia Shauri
Mr. Yakobo Mfunalina
Mr. Juma Hamisi
Mr. Simeon Laurent
Mr. Shauji Weja