EXTENT OF COMMUNITY PARTICIPATION IN THE PROJECT FOR IMPROVING NUTRITIONAL STATUS OF MOTHER AND CHILD IN TANZANIA: A CASE STUDY OF CHILD SURVIVAL PROTECTION AND DEVELOPMENT (CSPD) PROJECT

BY

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ABSTRACT

Malnutrition remains to be a serious problem in most of the developing countries today. It is a problem that affects mostly women and children in a population. Efforts to improve nutrition, therefore, need to focus on this group and address people at the level of the community. There have been tremendous efforts to improve the communities' nutritional status with minimal success. The present study investigates the extent of community participation in the project for improving nutritional status of mother and child. In particular, The Child Survival Protection and Development (CSPD) project was assessed in this study. Two districts in Morogoro region, namely, Morogoro rural and Morogoro urban were selected for this study and three wards implementing CSPD were selected in each district to be included in the study. The study population consisted of community members of selected areas and project officers, who were the key informants. Questionnaire and focused group discussions were used in data collection. The study revealed that 52.2% of respondents were not aware if there was a nutrition project operating in their areas. Also 5 groups out of 12 had shown that they were aware of the CSPD project. The study has also shown that 65.8% of the respondents did not participate in the CSPD project. Results further revealed that there was no statistical significant difference ($P>0.05$) between Morogoro urban and Morogoro rural in involvement in the nutrition project. Also results show that 91.7% of respondents perceived that malnutrition results from lack of balanced diet. According to the results 100% of respondents perceived children were affected most by malnutrition followed by 57.7% of respondents who perceived women were most affected by malnutrition and 7.5% perceived men were most affected by malnutrition. The extent of community participation in the CSPD project is generally far too low. CSPD has not done enough in involving the community in almost all stages of the project. There is a

wide gap between what CSPD advocates and what is actually taking place at the community level. Since CSPD project aims at improving the nutritional status in the society with emphasis on women and children then the issues of awareness and participation at all stages need to be addressed carefully. The low awareness and participation established in this study might explain why the general improvement in nutritional status for the majority in Morogoro region is still insignificant. The study recommends that there is a need to raise community awareness on the nutrition project in order to encourage the local community to participate in the project. People should be encouraged to take the lead in defining their needs, planning and carrying out a course of action.

DECLARATION

I, Eloy Sigalla do hereby declare to the Senate of Sokoine University of Agriculture that this dissertation is my own original work and has not been submitted for any degree award at any other University.

Signature:.....E.Sigalla.....

Date:.....10/06/2024.....

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DEDICATION

This work is dedicated to my parents, Mr. Jactan and Mrs. Lydia Sigalla, who taught me to work hard for the better future.

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LIST OF ABBREVIATIONS

CSPD	-	Child Survival Protection and Development
FGDs	-	Focused Group Discussions
JNSP	-	Joint Nutrition Support Program
MCHA	-	Maternal and Child Health Aids
Nips	-	Nutrition improvement projects
NURU	-	Nutrition Rehabilitation Units
TFNC	-	Tanzania Food and Nutrition Centre
UNICEF	-	United Nations Children's Fund
WHO	-	World Health Organization

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background information

Millions of women and children around the world suffer from malnutrition. Malnutrition is a complex condition that can involve multiple, overlapping deficiencies of protein, energy and micronutrients (UNICEF, 1998). A child or a woman becomes malnourished because of illness in combination with inadequate food intake. Insufficient access to food, poor health services, lack of safe water, poor sanitation and inadequate child and maternal care are underlying causes of malnutrition (Kavishe, 1993). It is widely recognized that breastfeeding is the foundation of good nutrition for infants, therefore inadequate breastfeeding can jeopardize infants health and nutrition, particularly in areas where sanitation and hygiene are poor.

Malnutrition contributes to over 6 million child deaths each year in developing countries, which is 55 per cent of the nearly 12 million deaths among children under five years of age. About half of children under five years of age in South Asia and one third of those in Sub-Saharan Africa are malnourished (UNICEF, 1998).

To reverse the situation, Cerquira (1992) suggested that people should be given the opportunity to participate actively in seeking solutions for their nutritional problems in order to have big long-term impact of any intervention programme. Furthermore, the author recommended that the community-based approach to nutrition improvement should emphasize the importance of active community participation in making decisions and finding solutions to nutritional problems. UNICEF (2002a) calls for the increased

community participation in projects aiming at improving nutritional status of mother and child. It further pointed to the need of widespread training of community workers and members. Furthermore, it underscores the importance of building an indigenous knowledge by incorporating community members as partners in the programme, something which is geared towards transforming the socio-economic conditions of the community.

While peoples' participation approach has been shown to be necessary in reducing malnutrition in the communities, it is still doubtful whether many of the interventions that have been designed and implemented to reverse the worsening situation of malnutrition are following that approach. This might explain why the general improvement in nutritional status for the majority is still insignificant.

1.2 Intervention projects

Nutrition improvement projects (Nips) are sets of planned activities specifically undertaken as interventions to reduce malnutrition and its associated problems in the communities, by channelling additional resources including knowledge, more quickly and specifically to nutritionally needy groups (Msuya, 1998). Furthermore, the author reports that Nips include nutrition surveillance, feeding programmes, nutrition education, food production, and formulation and caring for special groups that are most vulnerable to malnutrition. The Child Survival Protection and Development (henceforth CSPD) is among nutrition improvement project being implemented in Tanzania.

1.3 Child Survival Protection and Development (CSPD)

CSPD is generally a community based programme whose main strategy is to empower communities to assess, analyze, and take appropriate actions on developmental issues especially those pertinent to health and nutrition situation of children and women. CSPD project is mainly replications of the WHO/UNICEF (JNSP) that started in 1983/84 in Iringa region. The programme has successfully expanded to cover other areas and aspects over time. The programme has greatly empowered communities to handle food and nutrition health problems (Jonsson, 1988; Kavishe and Mushi, 1993). This is partly reflected by a significant reduction in child undernutrition, especially severe underweight in areas implementing the CSPD (Kavishe and Mushi, 1993; TFNC, 1994a).

1.4 Problem statement and justification

It has been documented that most of Tanzanian families face malnutrition (URT, 2000a). There have been tremendous efforts to improve the communities' health status with minimal success. For instance, the NURU was reported to have a very minimal impact in the project area. Together with several programmes of improving nutritional status of communities in Tanzania, the situation has remained critical. Data from Tanzania Reproductive and Child Health Survey (TRCHS) show that underfive mortality rate is estimated at 146 per 1000 live births. Tanzanian women and young children are particularly vulnerable to malnutrition (URT, 2000b).

Although it is widely known that most of the nutritional improvement projects would be successful only if the local communities are involved in achieving the required health and nutritional status, their involvement has not yet been examined. Cerquira (1990) argues that

strategies to change nutritional knowledge and behaviour could be more effective if community member's ability to make decisions and solve problems were enhanced. These can be attained through active participation, democratic, empowering and problem posing approach (Freire, 1970b, 1973a,b). A similar approach was used in the Iringa Nutrition Programme whereby the community members were involved in the assessment and analysis of problems and decisions on appropriate actions. Focusing on growth monitoring, the programme used a triple A (Assessment, Analysis, and Action) process as a key element in achieving the social mobilization that contributed to its success. Evaluations indicate that this process has contributed to significant decrease in infant malnutrition and mortality (Ljungqvist, 1988; WHO/UNICEF, 1989).

It was the intention of this study to examine the community participation in the project for improving nutritional status of mother and child in order to suggest to stakeholders how best to improve community participation in the project and hence reduce severe and moderate malnutrition.

The results of this study will be useful to the Ministry of Health; Ministry of Agriculture and Food Security, Ministry of Women, Children and Community Development; communities and other stakeholders whose goal is to ensure provision, accessibility and improvement of nutrition services of mother and child in Tanzania. This study will also contribute to the knowledge base to enable ministries and other stakeholders to develop intervention programmes that involve communities.

1.5 Objective

1.5.1 General objective

The general objective of this study was to assess the extent of community participation in projects for improving nutritional status of mother and child in Tanzania.

1.5.2 Specific objectives

The specific objectives were: -

i. To determine the extent of community involvement in the CSPD project.

ii. To identify the existing gap between what is said at the CSPD project level and what is practised at the community level.

iii. To assess perceptions of community on malnutrition.

1.6 Limitation of the study

The study was intended to cover twelve villages from three divisions in Morogoro urban and rural districts. However, due to limitation of resources namely time, transport and money only three villages in Morogoro rural and three villages in Morogoro urban were covered.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 The concept of nutritional status

Nutritional status of an individual is the level of health resulting from intake and utilization of nutrients by the body. It is an outcome of interaction between the inherited genetic potential and life conditions in the community such as socio-economic conditions, education and income. Nutritional status is a major determinant of child health and survival (Chen, 1980). Also according to Gibson (1990), the nutritional status can be defined as the interpretation of information obtained from the methods of the nutritional assessment. The information obtained is used to determine the health status of individuals or population groups as influenced by their intake and utilization of nutrients by the body.

2.2 Malnutrition situation in Tanzania

Although adequate nutrition is a basic right, globally it remains unmet for many of the children underfive years and women. This results into over 200 million malnourished children in developing countries, which contributes to more than twelve million under five deaths in each year (UNICEF, 1998). In Tanzania, the main types of malnutrition are Protein –Energy Malnutrition (PEM), Iron Deficiency Anemia (IDA), Iodine Deficiency Disorders (IDD) and vitamin A deficiency (VAD). It is observed that all the nutritional disorders affect mainly the under-five children, pregnant and lactating mothers (URT, 1994).

Malnutrition is increasingly recognized as a very prevalent and important health problem in third world countries. This problem has serious long-term consequences for the child and

adversely hinders development of a nation. More than two billion people in the world live at risk of malnutrition (ACC/SCN, 2000).

In Tanzania all population groups are affected by malnutrition especially undernutrition including adults. However, children underfive years of age and women, particularly those who are pregnant and lactating are the most vulnerable (Kavishe, 1993). Malnutrition in its severe form still remains a significant cause and determinant of mortality, short-term morbidity, permanent loss of productivity and intellectual capacity in societies, which cannot afford such losses and costs (Latham, 1997).

Tanzania is among those countries with a high infant and child mortality rate. At least 160,000 under the age of five years die every year, 100,000 of them being infants within first month of life. The major causes of death are prenatal conditions, malaria, pneumonia, diarrhoea and malnutrition, often occurring in combination (URT, 2000b).

Malnutrition is viewed as an outcome of immediate causes, which include inadequate dietary intake and diseases. Household food security, inadequate access to health services, insufficient education, inadequate care and unhealthy environment are the underlying causes. Basic causes comprise the aspects of economy, political ideology, technology and skills, social conditions and potential resources (Kavishe, 1993).

Poverty, although not being a direct cause is one of the most important causes of malnutrition in various parts of the world (Cook *et al.*, 1990; Hassan *et al.*, 1997). Poverty limits access to adequate diet, availability of education, health services and healthy

environment (Islam, 1997). The causes of nutritional problems and their effects are widely documented (Kavishe, 1993; TFNC, 1997; UNICEF, 1998).

2.3 Intervention programme

Intervention programmes are of varying nature. They can be grouped into four main categories on the basis of approaches used to tackle the problem. These are curative /rehabilitative, promotive, preventive, and facilitative approaches. The ideal programme would attempt to have a balanced combination of the different approaches. Curative or rehabilitative interventions are usually hospital or health centre based like the nutrition rehabilitation units in hospitals. These have little empowerment to households and community as they meet short-term objectives of curing severe malnutrition but do not meet long-term objectives of preventing recurrence of malnutrition especially in other siblings. Community –based programmes that are mainly promotive include the applied nutrition education programme of the Dominican Republic (Pelletier, 1990). However, education in isolation from other interventions has proved to be less effective. Likewise, use of prepacked education materials and messages tended to limit problem oriented actions. Examples of community based intervention programme include the Primary Health Care (PHC) and the CSPD programme in Tanzania (Maneno and Mwanzia, 1991). These programmes combine the different intervention approaches to varying degrees. The CSPD programme encourages community participation in alleviating health and nutrition problems (Mwikongi, 1994).

The unique feature of CSPD programme in Tanzania is its emphasis on capacity building and training at all levels, decentralization of decision making process with effective use of

bottom-up approach and strong integration of programme activities with government, technical and administrative hierarchy, and multisectoral collaboration (URT and UNICEF, 1992; Kavishe and Mushi, 1993).

2.4 Child Survival Protection and Development activities

According to UNICEF (1992) children have the right to survive, develop, be protected and participate in the activities and decisions making that affect their lives. The right to survive implies that children should not die i.e the rates of infant, underfive and maternal mortality should be low. Also children development covers the physical, cognitive, social, emotional and spiritual aspects. Furthermore, UNICEF reports that it is an outcome of a combination of factors that include nutrition, cognitive and emotional and education (formal and non-formal). Inadequate protection of children is often manifested in street children, child labour, child headed households, rape, early pregnancies, etc. Therefore CSPD activities concentrate on maternal and child health, water and environmental sanitation, household food security, child care and development, and income generating activities (URT and UNICEF, 1992; Kavishe and Mushi, 1993; Mwikongi, 1994). In mainland Tanzania UNICEF (1992) and Mwikongi (1994) reported that local community had improved their own capacity to assess and analyse problems affecting children and women and had taken appropriate actions to improve their nutritional status even in the face of economic decline.

2.4.1 The Child Survival Protection Development project in Morogoro region

The project was introduced in Morogoro region in 1988 by the Tanzania government. The project continues to be funded by the United Nations Children's Fund (UNICEF). The project's aim is to improve the welfare of children and their mothers. It intends to combat

malnutrition and provide education to children and women. The programme draws a great deal from approaches whereby rural and urban communities assess and analyse their own development problems, and take actions to solve them (TFNC, 1994a).

2.4.2 CSPD coverage

The programme started in 1988 in 42 villages and was expanded further in 1991 to cover 96 villages. In 1995 the CSPD programme was expanded and covers 457 villages out of 541 villages, which is equal to 84.4%(TFNC, 1997).

2.4.3 CSPD objectives

According to the region's report, project objectives for the year 2002/03 included the following:

a) Early childhood care for survival, growth and development (ECC/SGD).
   - To reduce severe malnutrition from 1.2% to 1% by the year 2003.
   - To reduce moderate malnutrition from 30% to 24% by the year 2003.
   - Reduction of mortality by 40% from 1990 baseline of 770/100 000 to 526/100 000 by the year 2003.
   - To stabilize the immunization coverage above 90%
   - To promote the infants and young child feeding including exclusive breast-feeding.
   - To continue promotion of micronutrient supplementation i.e. vitamin A, use of iodine and iron tablets.
   - Care of women and children affected by HIV/AIDS.

b) Basic education life skills for adolescent child (BELSA): -

Under basic education life skills for adolescent child (BELSA), the region has planned to increase basic educational achievements of children and adolescents through:

- Improved primary school net enrollment rates from 60% in 1995 to 80% by the year 2003.
- Improved primary school completion from 70% in 1995 to 85% for boys and girls (gender balance).
- To enhance life skills for children and adolescent especially on the spread of HIV/AIDS disease.

c) Human rights programming framework: -

- Enhanced consistency between the stipulation of convention of child rights (CRC) and convention of elimination of all sorts of discrimination to women (CEDAW).
- Increase protection of children and women who are most vulnerable.

2.4.4 Impact of the CSPD project in Morogoro region

From the region's report on programme implementation, it appears that there have been considerable achievements since the beginning of the CSPD programme in 1988. The report describes several achievements as follows: -

- CSPD is known to most people in the programme area, through community mobilization, participation and management of the programme. Villagers are now

aware of their responsibilities for initiatives aimed at improving the nutritional status of women and children.

- Children attendance during health day has been raised from 71.2% to 80%
- Reduction of malnutrition (both severe and moderate forms) have been reduced from 1.3% and 31% in October 2000 to 1.2% to 30% respectively, by October 2001.
- Immunization coverage has been raised from 82.3% in June 1996 to 90% in October 2001.

According to the CSPD programme coordinator in Morogoro, people are participating fully in the project from the decision making process to evaluation of the project. During the implementation both women and men are involved because of the fact that they are the beneficiaries. The villagers are supposed to attend village health days in order to assess children and pregnant mothers' nutritional status. However, it has been observed that during these health days more women than men do attend.

2.5 Strategies to overcome malnutrition

According to UNICEF (2002b) families and communities are the key players in the battle against childhood malnutrition, working together to assess, analyse and take action to tackle the problem. Participatory community-based programmes focusing on children's survival, growth and development are used to overcome malnutrition (Cerquira, 1992). UNICEF (2002b) suggest that one of the broad-based strategies to address malnutrition in a systematic manner is to organise intensive action in communities where the majority of the children and women are malnourished. Furthermore, the author reports that families and

communities must be the main players in assessing, analysing, and ultimately in taking action to solve the problem of malnutrition.

Households and communities must therefore be empowered to search for better solutions to the problem of malnutrition by learning about and assessing the existing situation, analysing the causes, and acting as their available resources permit. Working together, they can improve childrens' nutritional status, thereby enhancing their development and learning capacity (UNICEF, 1998).

Many preventive and supportive actions such as monitoring children's growth and promoting breastfeeding do not require a highly trained health professional but can be taken on by groups in the community with some initial support of governmental organizations, need to be in close touch at community level to ensure that their interventions are meaningful. The participatory interactive triple A process is central to a successful community programme. Support for participatory community-based programmes focusing on survival, growth and development outcomes is important in improving the nutritional status of mother and child (UNICEF, 2002b).

2.6 Strategies to improve nutritional knowledge

Strategies to change nutritional knowledge and behaviour could be more effective if community members' ability to make decisions and solve problems were enhanced. To mobilize social energy in grassroots community development, several health and nutrition education programmes have applied an "active-participatory, democratic, empowering and problem-posing" approach (Freire, 1970b, 1973a, and b).

This critical reflexive method involves an approach to teaching and learning that focuses on analysing issues of interest to the learner, reflecting on the causes of the situations and dealing with them in a problem-posing mode to find solutions. Information and knowledge are used as elements for action, to transform food habits or social conditions (Drummond, 1975; Drummond, 1977).

Health and nutrition educators who advocate this critical reflexive method contend that active participation of learners leads to more comprehensive and effective development of problem-posing and decision-making skills to deal with health, food and nutrition issues and needs (Minkler and Cox, 1980; Praun, 1982; Werner and Bower, 1982; Uphoff, 1987a, b).

2.7 Nutrition education

According to Freire (1973a,b), education takes place in the context of people's lives; more than acquiring technical information, learning requires doing. In an intensive learning process of action and reflection, all participants are equal partners. The group has authority to identify issues, determine priorities and design its own curriculum and actions to address the problems in the lives and communities of its members. A nutritional science is one kind of knowledge shared with the group to analyze and solve problems. The group examines the issues, creates objects for discussion and conducts a problem posing dialogue around these issues. Role – play, stories, slides, photographs, songs and other communication methods and materials can be used. A problematic situation that is multifaceted, familiar to participants, open-ended and without solutions should be presented to stimulate critical thinking.

Facilitators lead the group with questions progressing from the personal to the social level of analysis and action. For example, the group members are asked to describe what they see and feel, to define different aspects of the problem and to share similar experiences from their lives. They ask themselves why the problem exists. In developing plans to address the problem, value judgments must be made; to do so require critical and creative thinking and a reflexive practice (Freire, 1970a).

From the problem posing discussion, ideas for action emerge and are tested in the real world. The group begins a deeper cycle of reflection, which encompasses the participant's new experiences. Participants monitor the progress in achieving their goals and objective, identify problems and implement modifications. This process enables participants to learn from their attempts to change and to become more involved in overcoming cultural, social and historical barriers. This level of analysis is essential in identifying barriers and taking actions necessary for long-term change. Many of the problems posed in this process have no immediate solutions. Changes in lifestyle, health and nutrition, as well as culture and policy, require concerted efforts and perhaps long periods (Drummond, 1975; Drummond, 1977; Praun, 1982).

Training community health workers with participatory approaches and in learning by doing situations with community members was observed to increase their skills in facilitating participation of community members in nutrition education activities. In a modular training workshop, the use of participatory approaches increased the involvement of community members in the nutrition education activities developed with the community health workers (Cerqueira, 1990).

2.8 Community based nutrition

Experience with community based nutrition programming, as documented in various syntheses and reviews during the 1990s, does show that malnutrition can be effectively addressed on a larger scale, at reasonable cost, through appropriate programs and strategies, and backed to sustained political support (UNICEF, 2002a). In most cases, successful attempts to overcome malnutrition originate with participatory, community –based nutrition programs undertaken in parallel with supportive sectoral actions directed toward nutritionally at – risk groups (Cerquira, 1992). Such actions are often enabled and supported by policies aimed at improving access by the poor to adequate social services, improving women's education, and fostering equitable economic growth (UNICEF 2002a).

2.9 Importance of health education to community

There is no question that health education is an important element in an overall national strategy for health improvement. The issue is largely on how best to provide health education effectively and efficiently with a view that its outcome can have greater and sustainable impact on people's lives (Keregero and Keregero, 1987). Furthermore, the authors report that initiatives for health education must be community centred, as it is a recipient of the benefits derived from such initiatives. It underscores the need for a more participatory educational approach to health improvement. Also the authors recommend the use of educational approach that facilitate greater people's participation in the identification of problems and needs associated with health in their communities, determination of correct courses of action execution of action plans intended to solve health problems or respond to health issues in the communities.

2.10 The concept of participation

The idea of people's participation in development has evolved as a result of failure of rural development models based on the dominant paradigm of development which assumes that, rural development in the developing countries would be achieved through technology transfer from the developed countries or modern societies. Therefore, rural development experts have designed programmes and projects based on technologies available in industrialized countries and third world research centers focusing on western technology. When such technologies were not adopted by third world people, the latter were assumed to possess anti-development characteristics (Sicilima, 1996).

In principle, many leaders and officials working with people now support the idea of peoples' participation in development (Rudqvist, 1991). The author argues that participation means that people are actively involved in the design and long-term management of projects, not only in terms of their time and labour, but also through their knowledge of local resources. They share the costs of project by making contributions to both initial and the long-term running costs. Water – Bayer and Wolfgang (1995) pointed out that, this approach to people development participation grew out of the realization that:-

- It is generally not possible for outsiders to identify the needs of people; these can be identified only with active involvement of the "beneficiaries" themselves;
- The primary responsibility for implementing solutions to people's problems has to lie with these people: only in this way can a sense of ownership be created and local institutions developed which can continue activities after external support has ceased;

- Outsiders with primarily technical skills should relinquish control and serve as catalyst or facilitators in a process of indigenous development rather than as managers of technical innovation.

This implies that, participation involves joint planning and self-analysis. In this way local peoples' knowledge and views are actively sought. Community members explain their priorities and identify available skills, resources and appropriate contributions to the project. This process motivates people to take action to bring about changes in their lives (Rudqvist, 1991).

According to Oakley and Marden (1985), genuine participation of people is non- directive and does not impose ideas on them; it is based on a dialogical process; it is educational; empowering and starts from what people know and from where they are; is based on resources mobilized by them; relies on collective action to go beyond the reach of individual; promotes self–reliance, but acknowledges the partnership among individuals and with their change agents as co-learners.

Therefore, contrary to the general practice in development, genuine peoples' participation is not limited to people attending meetings, or contributing their labour and time to the implementation of the programme signed by officials Genuine participation entails the active involvement of people in the planning process; and is enhanced by their interaction with experts through educational methods that increase the influence people can exert upon the programme planning process Spring (1995).

The participatory programme planning process centers on people and their system. The key feature of all participatory programming is not planning for, but with people. According to UNICEF (1982) highly participative development programme will have the following elements: -

- Project planning process through initial open discussions with the community of its problems and solve them;
- Identification of the need done by the people themselves;
- Resource mobilization for the project made by the community;
- Identification of the project workers done by the community using its own criteria;
- Development of social and /or technical skills using trainers from within the community;
- Project implementation under community control; and periodic evaluation / monitoring of progress conducted by the community.
- Periodic monitoring and evaluation of progress conducted by the community.

This implies that, by basing projects on communities' needs and preferences it is possible to make the project sustainable. People will be committed to a project, which solve their problems in a way, which is most appropriate for them. People will not be committed to a project that has been imposed by outsiders with minimum consultation. The commitment translates into the day to day work necessary to maintain and manage projects in the long term, a much harder task than the initial project formulation. Through their active involvement in projects, communities can gain skills and confidence, which will enable tackling other problems that they face.

Also community participation as an approach has been defined differently by various scholars. Rifkin *et al.* (1988) conceptualize community participation as a social process whereby specific groups with shared needs living in a defined geographic area actively pursue identification of their needs, take decisions and establish mechanisms to meet these needs. Bennet and Maneno (1986) define community participation to include the aspect of resource mobilization by the community, an aspect which is crucial in the approach. They conceptualize community participation as a process by which a community mobilizes its resources, initiating and taking responsibility for its own development activities and sharing in decision making for and implementation of all other development programmes for overall improvement of its health status.

This study considers participation as the active involvement of people in the planning process, decision-making, implementation, monitoring and evaluation of the programme by the villagers or people themselves.

2.11 Experiences of community involvement: Kibwezi's experience

In Kibwezi, Kenya, an integrated approach was taken to address health, nutrition, and household food security and income-generation objectives, using the following strategies: inter-sectoral collaboration; information, education and communication (IEC); capacity building of the community's own resource people and a revolving loan fund. Community involvement was a guiding principle in implementing activities to reduce malnutrition. Through participation, people develop their capabilities and feel more self-reliant; thus activities can be sustained overtime. In tackling Kibwezi's nutrition problems, the communities participated in all stages of programme development and implementation and

there was a reduction in malnutrition because people were mobilized to identify problems related to poor nutrition and determine the magnitude of malnutrition and suggested how to overcome it. Therefore community participation should be promoted right from the initiation of a nutrition programme so as to reduce malnutrition (Rifkin *et al.*, 1988).

2.12 Community-based and people's empowerment approach

In recent years, international donor agencies have recognised the importance of people's empowerment, through community participation, for the success of development programmes (World Bank, 1996).

Empirical studies have proved that community participation improves performance of development projects. People's empowerment and the community-based approach to planning and implementing project have a lot in common, although they are not necessarily interchangeable. The concept of empowerment reflects more on ownership and ability. When applied to nutrition projects it means that the beneficiaries are made to own the project by having a lot of say on the project. It may be initiated by government or a donor agency but the people in the community are greatly involved in deciding how the project should be operated and who should be involved (Narayan, 1995).

2.13 Limitations of a participatory theory for nutrition education

Community participation changes the structure and relations of power in decision-making about the use and control of resources. The participation of community members in decisions about activities and resources use can be very threatening to existing groups as well as to the health system or other organizations. Changes from an authoritarian to a

consultant style of leadership require basic and continued training. If community members have little authority over the decision made about the allocation of resources they may lose interest and not participate in the activities planned (Paul and Demarest, 1984).

2.14 Top –down *versus* bottom –up *approach*

Another issue that emerges in the course of discussing the approaches to planning and implementing nutrition improvement programmes and projects is the question of *top-down* or *bottom-up* approaches to development. The former means the government or agency takes full control of responsibility of planning and deciding without involving the beneficiaries. However, the degree can vary greatly between centrally–planned economies and decentralized economies. While in bottom-up approach, the community is involved in every stage from preliminary stages of planning to decision making. This approach takes into account the community's needs, hence improves the extent of community participation in the programme activities (Chambers, 1983).

2.15 Evaluation of community health programmes

It is important to find out whether community health programmes do what they have set out to do. The ultimate aim of any community health programme is to improve the health of the community by reducing the incidence of new cases to a point where a disease is no longer a major problem. It is assumed that they reduce the morbidity and mortality. This is a dangerous assumption and we must always try to measure, as nearly as we can, whether the specific aims of the programme are being met (UNICEF, 2002a).

CHAPTER THREE

3.0 METHODOLOGY

3.1 Introduction

This chapter attempts to present the methodology of the study. It discusses approaches utilized in data gathering and data analysis.

3.2 Research area selection

3.2.1 Location of the study area

The research was conducted in two districts of Morogoro Region, namely, Morogoro Rural and Morogoro Urban because Morogoro was one of the first regions to receive special support from UNICEF in the form of a basic service programme started in the late 1970s. This programme was restructured into a community based CSD programme in 1987. Morogoro Region is one of twenty regions in Tanzania mainland and is located in eastern zone of Tanzania. The region lies between latitude 5° 58" and 10° 0" to the south of the equator and longitude 35° 25" and 38° 30" to the east of Greenwich. The region is bordered by seven other regions namely Arusha, Tanga and Coast regions to the east, Dodoma and Iringa to the west, and Ruvuma to south and Lindi to the southeastern.

Three wards were selected purposively from each of the two mentioned districts. While in Morogoro rural, Kiroka, Mikese and Mkambarani were selected, in Morogoro urban, Boma, Kilakala and Kingolwira were selected for this study. These wards are among the wards in Morogoro Region implementing Child Survival Protection and Development (CSPD) supported by UNICEF since 1988 when CSPD project was started. One village was randomly selected from each ward. This is summarized in Table 1.

Table 1: Area of the study

District	Ward	Village/ Area
Morogoro rural	Mkambarani	Mkambarani
	Mikese	Fulwe
	Kiroka	Kiroka
Morogoro urban	Kingolwira	Mahakamani
	Kilakala	Ng'atigwa
	Boma	Mzigila (Madizini)

3.3 Research design

This study adopted a cross-sectional survey design. According to Babbie (1990), this design allows collection of data at one point in time. It employed a survey method. The design is useful for description purposes as well as the determination of relationships between variables.

3.4 Sampling procedures

3.4.1 Population

The study population consisted of community members of selected project areas in Morogoro rural and Morogoro urban districts and key informants from CSPD project.

3.4.2 Sample

Sample sizes of 120 respondents were selected with 20 respondents from each village. Out of the 20 respondents of each village, 10 were men and 10 were women. Also two focused group discussions (FGDs) were organised for discussion in each village and in each village one FGD was for men and the other for women comprising 10 people per group. In each village questionnaire and focused group discussion were used. Also in this study three key informed project officers were interviewed.

3.5 Sampling

Method for selecting participants was "purposive" sampling. The categories of participants in this study were as follows: -

i. Adult father (20 years and above with at least two children of zero to five years).

ii. Adult mother (20 years and above with at least two children of zero to five years).

The categories of participants were used in interview survey and in focused group discussion. Participants who were used in interview survey were also selected randomly to form focused group discussion. The main issues to be discussed were prepared in English but translated into Kiswahili.

For focused group discussions, in order to be able to hold discussions with all selected 12 groups, each group had a facilitator and recorder. Focused group discussions were held separately to these 12 groups. This encourages a group to speak more freely about the subject without fear of being judged by others thought to be superior, more expert or more conservative. For example, young women may not be as forthcoming in their ideas and opinions in the presence of their mothers or mothers-in-law, as they might be if they participated in a group that excluded older women (Morgan and Kreuger, 1993).

The already prepared open- ended questions were used by the facilitator to guide the group through the discussion on various aspects. Prior to discussion the objectives of the study were explained to the respondents in order to make them aware.

3.6 Pre-testing

Prior to preparation of an interview schedule, ideas from Sokoine University of Agriculture professionals and those who work in the field of nutrition particularly those working with the CSPD programme were sought. The survey instrument was developed and submitted to the members of Food Science and Technology Department to check for content validity. Pre-testing was done under field conditions. Ten respondents were randomly selected from Mji Mpya village, one of the programme areas. The village was not part of the sampled villages. Each interview was accompanied by the introductory remarks pertaining to the purpose of the study, and the respondents' cooperation was solicited. The aim for pre-testing was to judge if the questions were clear, specific and pertinent to the study objectives.

After pre-testing, it was found that no major changes in content were necessary, except that there were certain items that were not clear and, at the suggestion of some respondents, these were modified. The interview schedule was revised and used for data collection.

3.7 Data collection

3.7.1 Primary data

Primary data were obtained through questionnaire and focus group discussions. One set of semi-structured interview schedule was used to obtain information from respondents in the project areas. The interview schedule consisted of closed-ended questions for items like age, educational level and marital status. The open-ended questions were used for items soliciting respondents views and / or opinions pertaining to the participation in the project and nutrition knowledge. More experienced people in the project (who are known as key

informants) were also interviewed. Additional data were obtained through checklists in a focus group discussion.

For comparison purposes two methods of obtaining data were used. Structured interview survey and focus group discussion. According to Morgan and Kreuger (1993) focus group discussion has the following advantages: testing ideas about new programme, solving specific programme problems, and evaluating programmes. However, focused group discussion also has some drawbacks, which are: -

- Results from focus groups cannot usually be used to make statements about the wider community, that is, they can indicate a range of views and opinions, but not their distribution.
- Participants often agree with responses from fellow group members (for many different reasons) and so caution is required when interpreting the results.

The interview survey (questionnaire) has been used to overcome the disadvantages of focus group mentioned earlier. Moreover, the second method caters as a means of checking the reliability of FGD. For that matter the same set of questions were administered in both methods.

Method of judging community participation was through community involvement in the project onset and planning, implementation, monitoring and evaluation phase. Perception of community on malnutrition was assessed by asking each respondent and in a focused group to define term malnutrition, perceived causes and how to overcome malnutrition.

3.7.2 Secondary data

Secondary data were collected from different sources. These were Sokoine University of Agriculture in Morogoro, UNICEF and TFNC in Dar es Salaam. Various reports related to community participation in improving nutrition of mother and a child were reviewed. Specific data that were collected are those related to projects, which gear towards improving nutritional status of a mother and a child.

3.8 Data analysis

The completed interview schedule was coded and where applicable data from open-ended responses were sifted and categorised for further analysis. Similarities as well as differences in responses were noted and reviewed. These were compiled and analysed in preparation for writing report. All quantitative analyses reported in this study were conducted using Statistical Package for Social Science (SPSS). Descriptive and inferential statistics were used in this study to describe the extent of community participation in the CSPD programme. Responses of the focused group discussion were recorded and data from each group was summarised and broken down into smallest meaningful units of information.

CHAPTER FOUR

4.0 RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents the major findings of the study. In the first part findings with respect to education, marital status, and age are presented. The chapter also presents findings on the extent to which the community participate in the CSPD project, whose objectives are to improve the nutritional status of mother and child. The community perceptions on malnutrition are also presented.

4.2 General characteristics of the study population

This section describes the general characteristics of the study population. In particular, the age structure, marital status and education level of the respondents are described.

4.2.1 Marital status

Table 2 shows marital status of respondents. Most of the respondents (79.2%) were married while the remaining were widowed (5.0%), single (15.0%) and divorced (0.8%). This shows that about 80% of respondents in the study were family people who are either raising children or are expecting to raise in future. Also married group participated more than single. However, Haverkort (1991) in his study found that majority of people, mainly women face special obstacles, which prevent them from participating in rural development. It is common phenomena in rural areas to find most married women spending their time taking care of the family while husbands attending development meetings with the expectation that they will deliver what has been taught to their wives.

4.2.2 Age

The distribution of the respondents according to age and location is shown in Table 2. The majority of the respondents (66.7%) in the study were between 31-40 years of age. It was also observed that 19.2%, 10.0% and 4.2% were between 21-30, 41-50 and 51-60 years of age respectively. It is further shown that there were very few respondents between the age group of 51-60 years in both Morogoro rural and urban. This could be attributed to the fact that majority of people at this age group have children above five years. Age group between 31-40 participated than younger and elders. Literature for example Nanai (1993) shows that young people are less conservative than old people, hence are likely to participate in programme. Likewise, Rwambali (1990) in his study found that mature people are more likely to participate. The decline in participation by respondents aged 51-60 could be attributed to old age and pre-occupation with home based obligations. People in this group are likely to delegate community based obligation to others (Nanai, 1993).

4.2.3 Education

Respondents in this study were categorized into five groups namely,those who had never attended school, those who had gone to adult literacy classes, those who had completed primary school education, those who had completed secondary school education and those who had attended colleges. Results show that 25.8% of respondents had no formal education, 53.3% had completed primary school education while 11.7% had attended adult literacy classes. Of the 120 respondents 5.0% had completed colleges (had gone beyond form four) and 4.2% had completed secondary school education (form four). People who attended formal education participated high. It has been argued that, education broadens horizons beyond habits and traditions of individuals, encouraging involvement of an

individual in development activities (encourage participation) (Madulu, 1995). Through education an individual becomes more critically aware of the need and scope of social change. However, Luhasi (1998) argued that education imparts desire of individual to learn more, attending training, and seek information regarding agriculture especially nutrition.

Table 2: General characteristics of the study population

Variables	Location		
	Morogoro urban n=60	Morogoro rural n=60	Total N=120
Marital Status			
Married	46(76.7)	49(81.7)	95(79.2)
Widowed	3(5.0)	3(5.0)	6(5.0)
Single	11(18.3)	7(11.7)	18(15.0)
Divorced	0(0.0)	1(1.7)	1(0.8)
Age of respondent (years)			
20-30	14(23.3)	9(15.0)	23(19.2)
31-40	38(63.0)	42(70.0)	80(66.7)
41-50	5(8.3)	7(11.7)	12(10.0)
51-60	3(5.3)	2(3.3)	5(4.2)
Education Level			
No formal education	15(25.6)	16(26.7)	31(25.8)
Adult education	10(16.7)	4(6.7)	14(11.7)
Primary education	33(55.0)	31(51.7)	64(53.3)
Secondary education	1(1.7)	4(6.7)	5(4.2)
Colleges	1(1.7)	5(8.3)	6(5.0)

Note: Figures inside brackets indicate percentage.

4.3 Awareness of local community on the existence of the nutrition project

4.3.1 Project awareness by location

The results of this study indicate that 52.5% of respondents did not have any idea about CSPD project operating in their areas while 47.5% of respondents reported to have an idea about CSPD project (Table 3). It is worth noting that out of 63 respondents who were not aware, 68.3% of them were from Morogoro urban and 36.7% from Morogoro rural. This shows that people from rural areas were more aware than those in urban areas. The chi-

square test of significance shows that there was a significant difference ($P<0.001$) in awareness of the nutrition project (CSPD) between Morogoro rural and urban. This could be attributed to the fact that respondents of age group between 31-40 years and respondents who had attended formal education were many in Morogoro rural than in Morogoro urban. These results are not in line with other studies, which have been conducted in different areas but with similar objectives e.g. the study by TFNC (1994a), Msuya (1998) and Leveri (1995).

TFNC (1994a) findings show that people from rural and urban areas were aware of CSPD project. A study by Msuya (1998) conducted in Morogoro rural and urban to assess awareness on community leaders showed that in urban areas 100% of community leaders were aware of the CSPD project whereas in rural 80% were aware of the project. However, Leveri (1995) showed that respondents in Morogoro rural and urban were equally aware of CSPD project.

From Table 3 majority of respondents (84.2%) reported that the main objective of CSPD project is to make follow-up on the nutritional status of mother and child, while 36.8% reported that the project objective is to provide vaccination to children, 14% reported that the project objective is to make follow-up on child nutritional status only and 33.3% mentioned the provision of extension service on health issues to women as the objective of the project. These results clearly indicate that the project objectives were not clear to most of the respondents, which implies that not all project objectives are known to the community. A study conducted at Kibwezi in Kenya by Rifkin *et al.*(1988) reported that the Kibwezi community was aware of the nutrition projects and its objectives because the

community participated fully in all stages of program development. Also a study conducted among the Maasai community on awareness of the Maasai health services project in Tanzania by Nangawe (1987) had similar findings to that of Rifkin *et al.*,(1988). The Maasai health services project in Tanzania is a community-based project.

Table 3: Project awareness by location

Variables	Location			
	Morogoro urban	Morogoro rural	Total	χ^2 value
Aware of existence of CSPD project in the area	(n=60)	(n=60)	(n=120)	
Aware	19(31.7)	38(63.3)	57(47.5)	12.06***
Not aware	41(68.3)	22(36.7)	63(52.5)	
Objective of the project[1]	(n=19)	(n=38)	(n=57)	
To educate women on health issues	5(14.3)	14(36.8)	19(33.3)	
Make follow up on the health of child and mother	17(89.0)	31(81.6)	48(84.2)	
Vaccination to child	5(26.5)	16(42.1)	21(36.8)	
Follow up on child health only	2(10.5)	6(15.8)	8(14.2	

Note *** = Significant at (P<0.001).
1 = Some of respondents gave more than one options, percentages would not necessarily add 100% i.e. percentages were calculated within type of options. Figures inside brackets indicate percentage.

4.3.2 Project awareness by gender

The study has revealed that 78.3% of women were not aware of the CSPD project existence while only 26.6% of men were not aware of the project (Table 4). This shows that access to information about the project was not equal between the sexes. Men were more aware than women. TFNC (1994a) and Nanai (1993) emphasize that for any programme to be successful the beneficiaries have to be aware of it. The fact that women have remained unaware of CSPD project has made their participation to be minimal. A study conducted in

Newala (Mtwara region) (URT, 1996) also shows that many people were not aware of CSPD project especially women and it was recommended that there was a need to have community based planning by communities themselves to empower and create awareness of CSPD project among women and men.

Table 4: Project awareness by gender

Variable	Gender		
	Women	Men	Total
	n=60	n=60	N=120
Awareness of the CSPD project			
Aware	15(25)	42(70)	57(47.5)
Not aware	47(78.3)	16(26.6)	63(52.5)

Note: Figures inside brackets indicate percentage.

In focused group discussions, only members of 5 groups had shown that they knew that the nutrition project (CSPD) exists, but 4 of them did not understand the project objectives clearly. They mentioned that the objectives were to make follow-up on child nutritional status only and to provide vaccination to the child. In Morogoro urban 1 group was aware about the nutrition project while in Morogoro rural 4 groups were aware of the same. Also only 1 group of women was aware while in men 3 groups were aware of CSPD project.

These findings are contrary to what Gillespie *et al.*(1996) reported on community nutrition programmes. The authors indicated that the community nutrition programmes are implemented equally in both urban and rural settings, and the participation of both men and women is equal. The authors further reported that these projects view members of the community more as target beneficiaries, active partners and key players in the nutrition

project therefore they should be aware of the nutrition project. Basing on the information collected from CSPD project, by 2002 the project had covered 457 villages out of 541 in Morogoro region and the majority of people were aware of their responsibilities for initiative aimed at improving the nutritional status of women and children. It was further reported that CSPD is known to most people in the covered area through community mobilization, participation and management of the programme. Mtama (1997) emphasizes that for any programme to be successful beneficiaries have to be aware and involved at all levels that is from planning to evaluation phase.

The assessment of project awareness at the communities has revealed that majority of people in the covered communities were not aware of the CSPD project. Moreover, the situation is worse for women. This is contrary to the understanding of the project management, which reports that CSPD is well known to most people in the area it has covered.

4.4 Level of community participation in the CSPD project

4.4.1 Community participation in the CSPD project by location

The extent to which individuals participate in the project was determined by asking respondents to indicate their levels of participation in the CSPD project. Four phases of project implementation were examined; these are planning, implementation, monitoring and evaluation. The summary of results is presented in Table 5.

The results of this study with respect to the level of community participation in the CSPD project show that 65.8% of the respondents were not involved at all in the project. Out of

120 respondents only 41 respondents (34.2%) were involved in the project implementation. It is worth noting that majority of these (78%) reported to have been involved in the implementation phase while only 2.4% were involved in planning phase. Furthermore, it has been revealed that about 9.8%, and 22% of respondents were involved in monitoring and evaluation respectively. The results further indicate that majority of respondents (58.3%) from Morogoro urban were not involved in the CSPD project whereas about 23.3% in Morogoro rural were not involved. It was also found that only about 6.3% of respondents from Morogoro rural were involved in planning while in Morogoro urban the communities were not involved in the planning phase. The formal statistical (chi-square) test of difference in participation between rural and urban shows that there was no significant difference ($P>0.05$) between Morogoro rural and Morogoro urban in involvement of community in the nutrition project.

Results from focused group discussions indicate that members of the 11 groups were not involved in the nutrition project. Only 1 group from Morogoro rural reported to have members being involved in the implementation, monitoring and evaluation of the project. Many respondents had reasons for not being involved in the nutrition project. Some of these are listed below: -

- leaders being biased (4 groups)
- communities were not informed (4 groups)
- lack of trust to the leaders (1 group)

As it has been observed in this study, lack of involvement of respondents in planning and decision making might have made people unaware of the project and fail to identify

themselves with that programme. There could be some other reasons hindering communities from involving themselves in the project apart from those mentioned in focused group discussions. One possible reason is that programme leaders and facilitators adopt a top-down approach whereby people participate at the implementation stage and mainly perform such activities as feeding children, sending children to dispensaries for drugs, nutritional status assessment, immunization and cleaning of the household premises. Burkey (1993) observed that until fairly recently, programmes and projects aimed at improving the socio-economic and health conditions of the poor tended to be initiated, designed and implemented basing on the 'Top-down' approach by agencies and institutions without systematic consultation and involvement of the intended beneficiaries.

Table 5: Levels of community participation in the project by location

Variables	Location			
	Morogoro urban	Morogoro rural	Total	χ^2 value
Involvement in the nutrition project	(n=60)	(n=60)	(n=120)	
Involved	16(26.7)	25(41.7)	41(34.2)	3.00 n.s
Not involved	44(23.3)	35(58.3)	79(65.8)	
Stages of involvement[1]	(n=16)	(n=25)	(n=41)	
Planning	1(6.3)	0(0)	1(2.4)	
Implementation	11(68.8)	21(84.0)	32(78.0)	
Monitoring	1(6.3)	3(12.0)	4(9.8)	
Evaluation	3(18.8)	6(24.0)	9(22.0)	

Note 1 = Some of respondents gave more than one option, percentages do not necessarily add to 100% i.e. percentages were calculated within type of options.
n.s= non significant (P>0.05).
Figures inside brackets indicate percentage.

4.4.2 Community participation by gender

It was observed that 46.7% of men were involved in the project while 21.7% of women were involved in the project. The chi-square test of significance shows that there was

significant difference ($P<0.001$) between men and women involvement in the nutrition project (Table 6). Furthermore, results show that in introduction and planning phase women were not involved while 7.1% of men were involved in introduction and 3.6% in planning phase. Findings of this study show that majority of women (76.9%) and men (78.6%) were involved in the implementation phase. In monitoring, 7.7% of women and 10.7% of men were involved. Also 38.5% of women and 14.3% of men were involved in evaluation stage. These findings show that men are more involved in the CSPD project than women. The situation is worse in the initial stages of a project, (i.e in the introduction and planning stages) where it has been found that women are not involved at all. This is contrary to the information obtained from the nutrition project (CSPD). The project perceives that most people (communities) are aware of their responsibilities for the initiative aimed at improving the nutritional status of the mother and child. It is also perceived by the project leaders that there is an effective community participation in all stages of the project. However, the results from the communities contradict with these perceptions. The study has revealed that there is a minimal participation of community to the CSPD project.

Table 6: Levels of community participation in the project by gender

Variable	Gender			
	Women	Men	Total	χ^2 value
Involvement in the nutrition project	n=60	n=60	n=120	
Involved	13(21.7)	28(46.7)	41(34.2)	8.33***
Not involved	47(78.3)	32(53.3)	79(65.8)	
Stages of involvement[1]	n=13	n=28	n=41	
Introduction	0	2(7.1)	2(4.9)	
Planning	0	1(3.6)	1(2.4)	
Implementation	10(76.9)	22(78.6)	32(78.0)	
Monitoring	1(7.7)	3(10.7)	4(9.8)	
Evaluation	5(38.5)	4(14.3)	9(22.0)	

Note 1= Some of the respondents gave more than one option, percentages do not necessarily add to 100% i.e. percentages were calculated within type of options.

*** = Significant at (P<0.001).

Figures inside brackets indicate percentage.

These findings are in line with those of Mtama (1997) who reported that women did not participate in planning activities of the Sasakawa Global 2000 project. The author found that 100% of interviewed women were not involved in planning and decision making of the project.

Lack of community involvement especially women in planning and decision making might have made people unaware of the project. Low degree of involvement among women could be attributed to the fact that they have comparatively a heavy workload, which reduces their participation in most community development activities because they fail to get enough time for other activities. In literature (e.g. Mtama, 1997) emphasis has been made that for any programme to be successful beneficiaries have to be involved at all project levels.

Also it is possible that programme leaders and facilitators have myopic view on the concept of community participation. In this narrow view the community participation includes

participation of people in terms of labour and time. This type of participation with all its good intentions has led to serious problems in execution of programmes because without active participation of the beneficiaries especially at preliminary stages, there is a danger of failing to address the complex nature of the people. Genuine people's participation is not limited to people attending meetings, or contributing their labour and time to the implementation of programme designed by officials.

Spring (1995) argues that genuine participation entails active involvement of people in the planning process and is enhanced by their interaction with experts through educational methods that increase the influence people can exert upon the programme planning process. The importance of community involvement is also emphasized by Nanai (1993), TFNC (1994b) and Mtama (1997).

4.5 Stages of the project

4.5.1 Project onset and planning

The study revealed that members of the communities were not actively involved in the project onset and planning. Table 7 shows that majority of respondents (69.2%) were not involved in the identification of community health problems. Results also show that 80% of respondents in Morogoro urban and 58.3% of respondents in Morogoro rural were not involved in the identification of health problems. The chi-square test of significance shows that was a significant difference ($P<0.01$) between Morogoro urban and rural with respect to involvement in the identification of community health problems. Furthermore, it has been found that communities in both locations are not involved at all in the conceptualization of the project. In focused group discussion, members from 11 groups

reported to have not been involved in the identification of community health problems of which, 6 of them were from Morogoro urban and 5 from Morogoro rural. The study has revealed that it is not very clear to most of the people (42.5%) on who conceptualized the CSPD projects. Thirty three percent of respondents mentioned a special committee to be responsible for conceptualisation of the project whereas 28.3% reported that people who are working in the CSPD project were responsible for conceptualization and 17.5% of respondents reported that health officers were responsible for the conceptualisation of the CSPD project. Only few (8.3%) reported that women were responsible for conceptualization. In focused group discussion members from 4 groups reported that the Ministry of Health officials were responsible for conceptualization of the project. Also 3 groups said, "Village leaders are very biased that is why we are not involved in the conceptualisation".

Table 7: Project onset and planning

Variables	Location			
	Morogoro urban (n=60)	Morogoro rural (n=60)	Total (n=120)	χ^2 value
Identification of community health problems				
Involved in the identification	12(20.0)	25(41.7)	37(30.8)	6.60**
Not involved in the identification	48(80.0)	35(58.3)	83(69.2)	
Involved in the conceptualization	60(0)	60(0)	120(0)	
Not Involved in the conceptualization	60(100)	60(100)	120(100)	
Responsible for conceptualization				
Health officer	11(18.3)	10(16.7)	21(17.5)	
A special committee	3(5.0)	1(1.7)	4(3.3)	15.42**
People in the office	14(23.3)	20(33.3)	34(28.3)	
Don't know	32(53.3)	19(31.7)	51(42.5)	
Women	0	10(16.7)	10(8.3)	

Note: **=Significant at (P<0.01)
Figures inside brackets indicate percentage.

Results in this study show that majority of respondents were not involved fully in the project onset and planning. This is because of the use of top-down approach adopted by CSPD project. However, in a study by Linkages (2002) conducted in Uganda to assess community involvement in the CSPD project, it was found that majority of people were involved in the initial stages of the project, something which gave them an opportunity to vocalize their needs.

According to URT and UNICEF (1992), a unique feature of CSPD project in Tanzania is its emphasis on decentralization of decision making process with effective use of bottom-up approach. The importance of this feature has also been pointed in literature for example, FAO (1993) which emphasizes that the community should be fully involved in identification of project activities, setting project goals and objectives, discussing feasibility and cost effectiveness of the activities and establishing time frame for each activity. The advantages of community participation particularly in decision making have been widely reported. For example Jonsson (1988) reported such advantages while assessing the community based nutrition programme in Southern Asia. The consequences of failure to allow the community participation have as well been reported in the literature. For instance Gillespie *et al* (1996) reports that many projects do not have the impact to the community because they lacked community involvement especially in decision making.

In this study, CSPD leaders have reported that communities (respondents) are involved fully in the identification of health problems, conceptualization and in decision of the type of nutrition project to be undertaken. The project involves the community through village health committees; these committees, which meet quarterly to discuss the nutritional status arrange and forward the strategies to the ward development committees.

However, this study has found that the communities (respondents) are not involved fully in the project onset and planning. Many of them had not been given an opportunity to decide which nutrition project to be undertaken.

4.5.2 Project implementation

Results show that majority (73.3%) were not involved in the project implementation (Table 8). In focused group discussion many respondents (9 groups) were not involved in the implementation of project activities. Furthermore, results show that 80% of respondents in Morogoro urban and 66.7% of respondents in Morogoro rural were not involved in the implementation phase. In focused group discussions it was found that in Morogoro urban, 1 focused group was involved in the implementation of the project while in Morogoro rural, 2 groups were involved. These results show that respondents in Rural areas were more involved in the CSPD project than respondents in urban areas. This might be due to the fact that more respondents in Morogoro rural were involved in project onset and planning.

Several reasons were given by the community for not making decisions on how to run project activities. The frequently mentioned reasons were:

(i) People were not involved in implementation phase (54%)

(ii) People were not aware if the project exists (25.7%).

The chi-square test of significance shows that there was a significant difference ($P<0.05$) between Morogoro urban and rural with respect to reasons for not making decisions on how to run project activities.

Table 8: Project implementation

Variables	Location			
	Morogoro urban	Morogoro rural	Total	χ^2 value
	(n=60)	(n=60)	(n=120)	
Involved in the implementation of the project	12(20.0)	20(22.0)	32(22.9)	2.72 n.s
Not involved in the implementation of the project	48(80.0)	40(66.7)	88(73.3)	
Reasons for not making decision on how to run the activities project	(n=40)	(n=30)	(n=70)	
There is no such kind of project	12(30)	2(6.7)	14(20)	6.16*
We are not involved	20(50.0)	18(60.0)	38(54.3)	
We are not a aware if the project exist	8(20.0)	10(33.3)	18(25.7)	

Note: n.s=non significant at (P>0.05)
*=Significant at (P<0.05).
Figures inside brackets indicate percentage.

While interviewing CSPD leaders, it was reported that communities have been involved in the implementation of the project activities especially in construction of dispensaries and provision of materials for making fortified porridge for under five children during village health day. These findings on participation in project implementation from communities and CSPD leaders seem to contradict each other.

Although participation is defined as involvement of people or target group in various stages of a particular development activity (UNICEF, 2000b), this study has found that in practice the definition is not honoured by the CSPD nutrition project which advocates the bottom-up approach but practices top-down approach, something which cannot help in empowering people so that they can be able to determine their destiny (Freire, 1970b).

4.5.3 Monitoring and evaluation of the project

The results of this study revealed that communities in both Morogoro urban and rural were not involved in judging whether the project objectives have been met or not (Table 9). Also results show that formulation and identification of project objectives were mostly done by project leaders (79.4%). These were equally responsible in rural and urban. The chi-square test of difference in responsibilities of objectives formulation between rural and urban shows that there was no significant difference ($P>0.05$) between locations. Furthermore, it has been revealed that once the leaders set project objectives communities cannot modify them.

The focused group discussion indicated that in Morogoro urban no group reported to judge whether the project objectives were met or not. Only one group in Morogoro rural helped planners to judge whether project objectives were met. All respondents had no reason for not being involved in helping planners to judge whether the project objectives had been met or not.

With respect to measurement of objectives, no single group reported to have been involved in deciding how to measure project objectives or how to monitor project activities. This could be attributed to the fact that majority of respondents were not aware of any nutrition project operating in their areas. This is contrary to the stand of CSPD project which shows that communities were helping planners to judge whether the project objectives have been met and if not why. Also the project responded that the communities were fully involved in evaluation of the project during public meeting in village health days. The presented

findings show that there are contradictions between community and project managements' responses with respect to monitoring and evaluation of the project.

FAO (1993) reported that participatory monitoring and evaluation is an essential aspect of a community based nutrition project. It enables the community to assess the progress of the activities and to take steps to resolve problems, changing objectives and adjusting activities if necessary but in case of CSPD this is not practised. This could be attributed to the fact that leaders were not well trained in participatory approaches, therefore they failed to work basing on community participation principles.

Table 9: Monitoring and evaluation of the project

Variables	Location			
	Morogoro urban	Morogoro rural	Total	χ^2 value
	n=60	n=60	n=120	
In a position to judge whether the project activities have been done	60(0)	60(0)	60(0)	
Not in a position to judge whether the project activities have been done	60(100)	60(100)	120(100)	
Responsible for formulations and identification of project objective	(n=28)	(n=40)	(n=68)	
Project leaders	24(85.7)	30(75.0)	54(79.4)	1.15 n.s
Health officer	4(14.3)	10(25.0)	14(18.5)	

Note: n.s= non significant (P>0.05).
Figures inside brackets indicate percentage.

Figure 4.1 summarizes the community participation in each stage of CSPD project. If the participation level was to the desired level then the community responses were supposed to be approaching 100%, the level which CSPD believes to have attained.

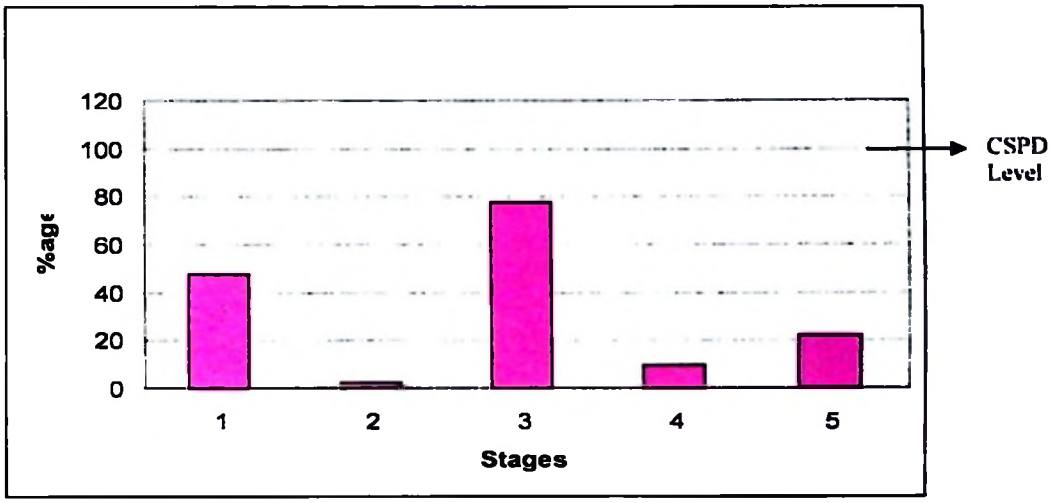

Figure 4.1 Community involvement in CSPD project

Note that in Fig.4.1 : 1=Awareness ; 2=Project onset and planning ;
3=Project implementation ; 4=Project monitoring
5=Project evaluation

On awareness and participation, this study has revealed the following: -

- The extent of community involvement in the CSPD project is generally far too low. CSPD has not done enough in involving the community in almost all stages of the project.

There is a wide gap between what CSPD advocates or perceives and what is actually taking place at the community level. The study has found that there is a big gap of community involvement in the project onset and planning stages and in the project monitoring and evaluation stages. The community has been comparatively

involved more in implementation stage. This implies that while in theory, CSPD advocates bottom-up approach, in practice top-down approach is used.

- The study has also revealed that almost 50% of people in surveyed communities are not aware of CSPD existence and its functions.

Since CSPD aims at improving the nutritional status in the society with emphasis on women and children then issues of awareness and community participation in all stages of a project need to be carefully addressed. As it has been shown already, several authors have pointed out the importance of these aspects in achieving the nutritional project goals. The low level of awareness and community participation established in this study might explain why the general improvement in nutritional status for the majority in Morogoro region is still insignificant.

4.6 Perceptions of community on malnutrition

4.6.1 Perception of community on malnutrition by location

This study also assessed perceptions of communities on malnutrition. Many respondents (91.7%) perceived that malnutrition is a condition resulting from lack of balanced diet (Table 10). Field observations revealed that 16.7% of respondents in Morogoro urban perceived malnutrition to be a disease. In Morogoro rural 100% of respondents perceived that malnutrition results from lack of balanced diet, whereas in Morogoro urban majority of respondents (83.3%) said that malnutrition is a resulting condition when a child lacks balanced diet. During this study it was also found that all respondents were not able to mention types of malnutrition found in Tanzania. This implies that respondents were

getting inadequate information on malnutrition. In literature (e.g. Kavishe, 1993) malnutrition is defined as an outcome of immediate causes, which include inadequate dietary intake and disease. Malnutrition also is a result of underlying causes, which are food insecurity at household level, inadequate access to health services, insufficient education, inadequate care and unhealthy environment. Basic causes of malnutrition comprise of aspect of economy, political ideology, technology skills, social conditions and potential resources. Results show that the definitions of malnutrition given by respondents were incomplete and thus they needed more education. Most of the respondents (80%) perceived malnutrition to be a problem in their respective locations. The chi-square test of difference shows that there was a significant difference ($P<0.001$) between Morogoro rural and urban in perception of malnutrition as a problem.

During the focused group discussions, it was found that, in Morogoro urban five groups perceived malnutrition as a lack of balanced diet and was a problem in their areas and the group which was most affected were children and women. In Morogoro rural seven groups raised the same issue. Msuya (1998) while researching in Morogoro region found that the community leaders perceptions were that malnutrition was mainly a problem, which affected children.

According to the results of this study, the highest percentage (100%) of respondents perceived children were affected most by malnutrition, followed by 57.5% of respondents who perceived women were most affected by malnutrition and only few respondents (7.5%) perceived men were most affected by malnutrition. These results are in line with other results in literature. TRCHS shows that there is malnutrition in Tanzania (URT, 2000).

Kavishe (1993) reports that in Tanzania all population groups including adults are affected by malnutrition, especially under-nutrition. However, children underfive years of age and women, particularly those who are pregnant and lactating are the most vulnerable. These results show that communities are aware of malnutrition problem. UNICEF (1998) has also observed that millions of the women and children around the world suffer from malnutrition.

Table 10: Community perception on malnutrition by location

Variables	Location			
	Morogoro urban	Morogoro rural	Total	χ^2 value
Perception on malnutrition[1]	(n=60)	(n=60)	(n=120)	
Lack of balanced diet	50(83.3)	60(100)	110(91.7)	
A condition resulting from eating little food	10(16.7)	0	10(8.3)	
A condition resulting when a child lacks proper caring	32(94.1)	31(77.5)	63(85.1)	
It is a disease	10(16.7)	0	10(8.3)	
Malnutrition in the village	(n=60)	(n=60)	(n=120)	
Perceived as a problem	40(66.7)	56(93.3)	96(80.0)	13.33***
Not perceived as a problem	20(33.3)	4(6.7)	24(20.0)	
Group affected most by malnutrition[1]	(n=60)	(n=60)	(n=120)	
Children	60(100.0)	60(100.0)	120(100.0)	
Women	39(65.0)	30(50.0)	69(57.5)	
Men	2(3.3)	7(11.7)	9(7.5)	

Note 1 = As some of the respondents gave more than one option, percentages do not necessarily add to 100% i.e. percentage were calculated within type of option.
***=Significant at (P<0.001).
Figures inside brackets indicate percentage.

4.6.2 Perception of community on malnutrition by gender

The perception of communities regarding malnutrition by gender show that 21.7% of women and 18.3% of men perceived that there was no problem of malnutrition in their respective locations. There was no significant difference (P>0.05) between men and women in reporting that there is a problem of malnutrition in their respective locations (Table 11). Also this study clearly indicates that all men and women perceived that the children group is the most affected. Most women (81.7%) perceived that they were the most affected by malnutrition while 33.3% of men reported women group to be the most affected. Only 10% of men reported that they were the most affected group. All respondents did not perceive that the youth were affected by malnutrition. These results conform with results of UNICEF (1998), which report that millions of women and children around the world suffer from malnutrition. This shows that respondents were aware that there was a problem of malnutrition and the group which was most affected was clear to them.

Table 11: Community perception on malnutrition by gender

Variable	Gender			
	Women n=60	Men n=60	Total n=60	χ^2 value
Malnutrition in the village				
Problem	47(78.3)	49(81.7)	96(80.0)	0.208 n.s
Not a problem	13(21.7)	11(18.3)	24(20.0)	
Group most affected by malnutrition				
Children	60(100)	60(100)	120(100)	
Women	49(81.7)	20(33.3)	69(57.5)	
Men	3(5.0)	6(10.0)	9(7.5)	

Note: n.s = non significant at (P>0.001).
1 = Some of the respondents gave more than one option, percentages do not necessarily add to 100% i.e. percentages were calculated within type of options.
Figures inside brackets indicate percentage.

4.6.3 Perception of community on causes of malnutrition

In this study several perceived causes of malnutrition were mentioned (Table 12). The study revealed that few respondents (8.3%) mentioned lack of balanced diet as a cause of malnutrition. Half of the respondents reported that poverty is a cause. This conforms to the results obtained by Cook *et al.* (1990), who reported that poverty, although not being a direct cause is one of the most important cause of malnutrition in various parts of the world. Poverty limits people to adequate diet, availability of education, health services and healthy environment (Islam, 1997). Birth at younger age (8.3%) and lack of proper cleanliness (8.3%) were also mentioned as causes of malnutrition. Women's workload was as well mentioned by 16.7% of respondents as a cause of malnutrition.

In focused group discussions, 6 groups of women reported that apart from lack of balanced diet as a cause of malnutrition, women had a lot of work to do at the household such as cooking, washing clothes, collecting fire wood and collecting grass. Therefore this might contribute to malnutrition because women sometimes fail to get enough time even to attend training or seminars, which would help them to get more nutrition knowledge. TFNC (1997) reported that workload of the women can be a factor in influencing nutritional status.

Also results from focused group discussions (2 groups) shows that lack of proper cleanliness and birth at younger age were again mentioned to cause malnutrition. One group from Morogoro urban believed that malnutrition was caused by witchcraft. Msuya (1998) shows that main causes of nutritional problems were low agricultural production, poor knowledge and low incomes. Sserunjogi (1994) shows that inadequate intake of food,

poor health services, lack of nutritional education, women workload and inadequate childcare were among frequently mentioned causes of malnutrition. However, it has to be noted that food availability in Morogoro is generally favourable considering the good ecological conditions with exceptions of areas of Kilosa and Morogoro rural ditricts which have been reported to be fairly dry.

According to the present study, malnutrition might have been caused by a combination of factors that can all be linked to poverty. Such factors are inadequate feeding habits, poor access to health and education, low agricultural production, unsanitary environments, poor education, women heavy workload and low income.

Table 12: Perception on community on causes of malnutrition

Variable	Location		
	Morogoro urban n=60	Morogoro rural n=60	Total n=120
Causes of malnutrition[1]			
Lack of proper cleanliness	0	10(16.7)	10(8.3)
Lack of balanced diet	0	10(16.7)	10(8.3)
Poverty	40(66.7)	20(33.3)	60(50)
Women workload	10(16.7)	10(16.7)	20(16.7)
Birth at younger age	0	10(16.7)	10(8.3)

Note: 1 = Some of the respondents gave more than one option, percentages do not necessarily add to 100% i.e. percentages were calculated within type of options.
Figures inside brackets indicate percentage.

4.6.4 Perception of community on how to overcome malnutrition

In this study respondents were asked on different ways to overcome malnutrition. A number of respondents (58.3%) perceived the provision of adequate nutrition education to be the best way in overcoming malnutrition (Table 13). Some (25%) said that men should increase household income to reduce malnutrition, while others (25%) perceived

that men should provide adequate food for the family in order to get a balanced diet. Keeping livestock to get sources of animal protein like milk and meat was mentioned by a number of respondents (16.7%). In focused group discussions, 7 groups perceived that adequate nutrition education should be provided in order to overcome malnutrition. Participants in 3 groups reported that through balanced diet malnutrition can be contained. 2 groups reported that malnutrition can be contained by increasing the household income and 3 groups raised the issue of proper use of money in buying food can overcome malnutrition.

Table 13: Perception on community on how to overcome malnutrition

Variable	Location		
	Morogoro urban n=60	Morogoro rural n=60	Total n=120
To overcome malnutrition[1]			
Men should provide adequate food at household level	30(50.0)	0	30(25)
Nutrition education	30(50)	40(66.7)	70(58.3)
Keeping livestock	10(16.7)	10(16.7)	20(16.7)
Men should increase household income	20(33.3)	10(16.7)	30(25)
Women should use money properly	15(25)	10(8.3)	25(20.8)

Note :1 = Some of the respondents gave more than one option, percentages do not necessarily add to 100% i.e. percentage were calculated within type of option.
Figures inside brackets indicate percentage.

In order to overcome malnutrition, adequate dietary intake and prevention of disease are required. Also household food security, adequate access to health services, sufficient education, adequate care and healthy environment are required. Good aspect of economy, appropriate political ideology, technology skills, favourable social conditions and resources would help to improve malnutrition. This study however, has revealed that the communities have little nutrition education in fighting against malnutrition. Therefore, there is a need for

enhancing the provision of education on nutrition. Also as observed by Skjonsberg (1989) there is a need to improve the income of women as this is directly related to children is health and nutritional status.

CHAPTER FIVE

5.0 CONCLUSIONS AND RECOMMENDATIONS

This chapter presents a summary of the main findings from the study. It relates the findings to the research objectives posed in chapter one. Conclusions and recommendations on the extent of community participation in project for improving nutritional status of mother and child.

5.1 Conclusion

The following are major conclusions drawn from the findings of this study:

The extent of community participation in the CSPD programme was found to be low. This is because of the use of top-down approach; whereby the people at the headquarters of CSPD do the planning and decision making. Lack of community participation in planning and decision making can also be attributed to the fact that people were not informed of the nutrition project (CSPD). Also the study revealed that community based programme (CSPD) whose main strategy is to empower communities to assess, analyse and take appropriate actions on development issues especially nutrition situation of children and women in reality is not practised. Also this study found that majority of respondents were not aware if there was a nutrition project operating in their respective locations. It was further found that most of the women were not aware of the CSPD project. This implies that there is a poor communication between change agents and beneficiaries.

Perception of community on malnutrition shows that majority of respondents perceived that it is caused by lack of balanced diet and few respondents reported that it is a disease. Majority of respondents perceived that malnutrition is a problem in their respective

locations and all respondents perceived that group most affected by malnutrition were children. This implies that respondents had an idea on malnutrition but they need more nutrition education on malnutrition.

5.2 Recommendations

1. CSPD programme should adopt participatory approaches whereby the community should be involved at every stage including the preliminary stages of planning and decision making. If participatory approach is adopted it will be possible for the programme to take care of community's felt needs, hence improve the extent of community participation in the programme activities. This is because, the approach helps in eliciting local knowledge to provide a common ground for community in communication, thus creating a more effective dialogue between beneficiaries and external development agents and to help make plans more appropriate for the local situation. This will also increase their commitment and feeling of responsibility, and will help maintain continuity through all programme phases, because plans made together with them are more likely to be put into practice and continued even after the end of programme support.

2. Also in adopting the participatory approaches, the CSPD programme should conduct seminars and meetings in the villages to sensitize and educate the community about the programme. This will help in creating awareness, so that more people (men and women) can actively participate at every stage of the programme activities.

3. The CSPD project should allow strong participation and equal involvement for all parties. This can be achieved by providing health workers with transport facilities, training and other incentives such as reasonable salaries to allow them make their ends meet.

4. The programme facilitators need to be sensitised and trained in participatory approaches so that they can learn to work in participatory ways. The training will expose them to levels of consciousness raising, empowerment issues and leadership development in community.

5. Encouraging parent participation in rehabilitation of malnourished children and increasing nutrition education to parents both women and men will help to reduce malnutrition in the community.

6. The CSPD project should remove the gap between what is planned and what is practised in relation to community based approach. CSPD should try to do and achieve what has been planned for the community.

7. Also the government should do the following: to introduce more income generating projects, which need low capital and management skills in the study area, which can enable household to increase their income especially women. Also increase loans provision and increase budget for community services or social services e.g. school, health, etc.

8. Since the survey was only conducted in Morogoro rural and Morogoro urban districts of Morogoro region, it is recommended that the study should be conducted in other regions where the CSPD project is being implemented in order to corroborate the findings of this study.

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APPENDICES

A.1 Appendix A:Questionnaire for Interview Survey

The purpose of this Questionnaire is to assess the extent of community participation in the projects for improving nutritional status of mother and child in your ward. Of course, we do understand you have a busy schedule but your participation to this exercise will be valuable in improving the nutrition status of a mother and a child. Please provide the information required and be assured that your response will be treated as confidential.

1.0 General information

1.1 District.....

Village.....

Name.....

Sex.....

Age.....

Marital status.....

Education.....

2.0 The project

2.1 Do you know any of the nutrition project operating in your district or village?

Yes ☐ No ☐

2.2 If the answer for question 2.1 is yes what is the name of the nutrition project

_____

2.3 What are the objectives of the project?

_____

_____

3.0 Perception of community on malnutrition

3.1 What do you know about malnutrition?

_____

_____

3.2 Do you have any idea about types of malnutrition? Yes_____No___

3.3 If the answer to question is yes, explain

_____

_____

3.4 Which group do you think is most affected by malnutrition? (tick the correct group)

i. Children_____

ii. Youth_____

iii. Women_____

iv. Men_____

3.5 What do you think are the causes of malnutrition?

_____

_____

3.6 Do you think malnutrition is a problem in your village? Yes_____No____?

3.7 How can you overcome malnutrition?

_____

_____

4.0 Levels of community participation in the project

4.1 Are you involved in the nutrition project?

Yes _____ No_____

4.2 If the answer to question **4.1** is yes, how? (tick the correct item)

(a) In the introduction of the project _____

(b) In the planning of the project _____

(c) In the implementation of the project _____

(d) In the monitoring of the project _____

(e) In the evaluation of the project_____

4.3 If the answer to question 4.1 is no, explain why?

_____

5.0 Project onset and planning

5.1 Are you involved in the identification of community health problems?

Yes _____ No _____

5.2 Are you involved in the conceptualization of the project?

Yes _____ No _____

5.3 If the answer to question 5.2 is no, who conceptualizes the project?

_____

_____

5.4 Have you ever been given an opportunity to decide on the type of the nutrition project to be undertaken?

Yes_____ No_____

5.5 If the answer to question 5.4 is yes, explain how

_____

_____

5.6 If the answer to question 5.5 is no, explain why.

_____

_____

5.7 Are you involved in the formulation or identification of project objectives?

Yes_____ No_____

5.8 If the answer to question 5.7 is yes, explain how?

_____

_____

5.9 If the answer to question 5.7 is no, who formulates or identifies them?

_____

_____

5.10 Are you in a position to modify project objectives?

_____

_____

5.11 Are you involved in choosing the site of a clinic or area of providing nutrition services?

Yes_____ No_____

6.0 Project implementation

6.1 Are you involved in the implementation of project activities?

Yes_____ No_____

6.2 In what activities are you involved?

_____

_____

6.3 Do you make any decisions about how these activities are to be run in the project?

Yes _____ No_____

6.4 If the answer to question 6.3 is yes, explain how?

_____

_____

6.5 If the answer to question 6.3 is no, explain how?

_____

_____

7.0 Monitoring and evaluation of the project

7.1 Are you helping planners to judge whether the project objectives have been met?

Yes_____ No_____

7.2 If the answer to question 7.1 is yes, explain

how?_____

_____

7.3 If the answer to question 7.1 is no, explain why?

_____

_____

7.4 Are you involved in deciding how to measure objectives and in systematically monitoring activitives?

Yes_____ No_____

7.5 If the answer to question 7.4 is yes,explain how

_____

_____

7.6 If the answer to question 7.4 is no, explain why?

_____

_____

Appendix B: Interview schedule for focused group discussion at the communities

The purpose of this discussion is to assess the extent of community participation in the projects for improving nutrition of mother and child in your ward. Of course, we do understand you have a busy schedule but your participation to this exercise will be valuable in improving the nutrition status of a mother and a child. Please provide the information required and be assured that your response will be treated as confidential.

1.0 Group profile

1.1 District.....

1.2 Village.....

1.3 No. of participants_____

1.4 Participants identification _____

1.5 Names (optional)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

1.6 Gender Women Group ☐ Men Group ☐

2.0 The project

2.1 Do you know any of the nutrition project operating in your district or village?

2.2 What is the name of the nutrition project?

2.3 What are the objectives of the project?

3.0 Perception of community on malnutrition

3.1 Have you ever attended any training conducted by the nutrition project?

3.3 What do you know about malnutrition?

3.4 Do you have any idea about types of malnutrition?

3.5 Which group do you think is most affected by malnutrition? (tick the correct group)

Children_____

Youth_____

Women_____

Men_____

3.6 What do you think are the causes of malnutrition?

3.7 Do you think malnutrition is a problem in your village?

3.8 How can you overcome malnutrition?

4.0 Levels of community participation in the project

4.1 Are you involved in the nutrition project?

4.2 If you are involved indicate the correct stage (tick the correct item)

i. In the introduction of the project _____

ii. In the planning of the project _____

iii. In the implementation of the project _____

iv. In the monitoring of the project _____

v. In the evaluation of the project_____

4.3 If you are not involved explain why?

5.0 Project onset and planning

5.1 Are you involved in the identification of community health problems?

5.2 Are you involved in the conceptualization of the project?

5.3 Who conceptualizes the project?

5.4 Have you ever given an opportunity to decide on the type of the nutrition project to be undertaken?

5.5 If you are not given an opportunity to decide on the type of the nutrition project to be undertaken, explain why.

5.6 Are you involved in the formulation or identification of project objectives?

5.7 If you are not formulating who formulates or identifies them?

5.8 Are you in a position to modify project objectives?

5.9 Are you involved in choosing the site of a clinic or area of providing nutrition services?

6.0 Project implementation

6.1 Are you involved in the implementation of project activities?

6.2 In what activities are you involved?

6.3 Do you make any decisions about how these activities are to be run in the project?

6.4 If the answer to question 6.3 is yes, explain how

6.5 If the answer to question 6.3 is no, explain how

7.0 Monitoring and evaluation of the project

7.1 Are you helping planners to judge whether the project objectives have been met?

7.2 If the answer to question 7.1 is yes, explain how?

7.3 If the answer to question 7.1 is no, explain why?

7.4 Are you involved in deciding how to measure objectives and in systematically monitoring activitives?

7.5 If the answer to question 7.4 is yes, explain how?

7.6 If the answer to question 7.4 is no, explain why?

A.3 Appendix C: Questionnaire for nutrition project

The purpose of this questionnaire is to assess the extent of community participation in the projects for improving nutrition of mother and child in your ward. Of course, we do understand you have a busy schedule but your participation to this exercise will be valuable in improving the nutrition status of a mother and a child. Please provide the information required and be assured that your response will be treated as confidential.

1.0 Background information

1.1 Name of the Institution _____

1.2 Name of the nutrition project _____

1.3 Project/program district _____

2.1 Project objectives _____

2.2 Respondent's Information

2.3 Post/Position of the Respondent_____

2.4 Sex ( ) Male ( ) Female

3.0 Levels of community participation in the project

3.1 Does the community participate in nutrition project?

Yes _____ No_____

3.2 If the answer to question 3.1 is yes, how? (tick the correct item)

i. In the introduction of the project _____
ii. In the planning of the project _____
iii. In the implementation of the project _____
iv. In the monitoring of the project _____
v. In the evaluation of the project_____

3.3 If the answer to question 3.2 is no, explain why?

_____

_____

4.0 Project onset and planning

4.1 Do you involve community members in the identification of community health problems?

Yes_____ No _____

4.2 Do you involve communities in the conceptualization of the project?

Yes _____ No_____

4.3 If the answer to question 4.2 is no, who conceptualizes the project?

_____

_____

4.4 Have you ever given an opportunity to the communities to decide on the type of the nutrition project to be undertaken?

Yes _____ No_____

4.5 If the answer to question 4.4 is yes, explain how

_____

_____

4.6 If the answer to question 4.4 is no, explain why.

_____

_____

4.7 Do you involve communities in the formulation or identification of project objectives?

Yes_____ No_____

4.8 If the answer to question 4.7 is yes, explain how?

_____

_____

4.9 If the answer to question 4.7 is no, who formulates or identifies them?

_____

_____

4.10 Are the community members in a position to modify project objectives?

_____

_____

4.11 Do you involve women in choosing the site of a clinic or area of providing nutrition services?

Yes_____ No_____

5.0 Project implementation

5.1 Do you involve communities in the implementation of project activities?

Yes _____ No_____

5.2 In what activities are they involved?

_____

_____

5.3 Do the communities make any decisions about how these activities are to be run in the project?

Yes _____ No_____

5.4 If the answer to question 5.3 is yes, explain how?

_____

_____

5.5 If the answer to question **5.3** is no, explain how?

_____

_____

6.0 Monitoring and evaluation of the project

6.1 Are the communities helping planners to judge whether the project objectives have been met and if not why not?

Yes _____ No_____

6.2 If the answer to question **6.1** is yes, explain how?

_____

_____

6.3 If the answer to question **6.2** is no, explain why?

_____

_____

6.4 Are they involved in deciding how to measure objectives and in systematically monitoring activitives?

Yes_____ No_____

6.5 If the answer to question **6.4** is yes, explain how?

_____

_____

6.6 If the answer to question 6.4 is no, explain why?

_____

_____