End of Project Evaluation
Matching Grant 1985-1988
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Ghana - Health

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1.0 The Introduction

1.1 The Evaluation

Adventist Development and Relief Agency International (ADRA/International) sent two representatives to Ghana to work with the field workers for the Matching Grant Maternal and Child Health (MCH) Program Evaluation. The evaluation team consisted of six members. The team conducted its evaluation from August 25 to 29, 1988.

Three evaluation team members visited the northern region of the district of Walewale where the Matching Grant funds the MCH program. The team had a very tight schedule. The Regional Program Manager arranged very good contacts and appointments for the team.

On August 25, the team made detailed plans for the evaluation with the Regional Program Manager. On August 26, the team oriented the six surveyors. The survey was conducted on August 26 and 28 at two of the three villages where ADRA runs the MCH programs. The team visited the village chiefs of Gbimsi and Kparigu (see Appendix A) and evaluated the MCH centers at the two villages (see Appendix B). The team talked to all six Nutrition Agents from the three villages (see Appendix C). The regional Ministry of Health Officer was visited on August 28 (see Appendix D). We completed our two day survey with 430 mothers at the two villages on August 28 (see Appendix E). The team met three government local district officers on August 29 (see Appendix F). The team completed the evaluation work by meeting with the MCH District Program Supervisor and the Regional Program Manager and briefing them with the findings and recommendations of the evaluation team (see Appendix G).

1.1.1 Purpose and Scope

The purpose of the evaluation team was to appraise the success of the matching grant program in Ghana. This purpose was defined as follows:

a. To assess the overall development of ADRA's ability to plan and implement primary health care programs in the village community setting and in collaboration with government services.

b. To assess the degree to which project objectives were achieved.

c. To review the implementation process with particular attention to the relationship of ADRA health project management and activities to other organizational entities involved.
d. To identify constraints, both internal and external to the project, that have impeded effective implementation and lessons learned.

e. To derive recommendations based on the lessons learned from the evaluation.

1.1.2 Methodology

ADRA/International has adapted Krishna Kumar's *Rapid, Low-Cost, Data Collection Methods for A.I.D.* in an attempt to make it useful to development workers managing projects funded by USAID. The following rapid, low-cost methods are used in the evaluation of this Matching Grant MCH Project:

a. Key informant interviews--these interviews involve discussions on specific topics with knowledgeable persons in order to obtain data, opinions, and perspectives on the topics. The evaluation team used this method to interviewed the nutrition agents, the village chiefs, the Ministry of Health Officer, and the Government District Officers.

b. Informal surveys--informal surveys differ from sample surveys in four respects: (1) they focus on only a few variables, (2) use a small sample size, (3) use non-probability sampling, and (4) permit more flexibility to the interviewers in the field. Informal surveys generate data that can be statistically analyzed. The evaluation team used this method to survey the MCH program beneficiaries--the mothers.

c. Direct observation--this method involves systematic observation of a phenomenon or process in its natural setting. It usually requires the interviewing of key informants as well. The evaluation team visited the MCH centers and interviewed the nutrition agents.

1.2 Historical Background

1.2.1 Regional Background

Ghana lies on the southern side of the bulge of West Africa. Its coast faces the Gulf of Guinea in the Atlantic Ocean. It shares borders with the Ivory Coast on the west, Upper Volta on the north, and Togo on the East. Accra, the capital, is on the east central coast. It is only a few degrees north of the Equator. The climate is tropical. The eastern coastal belt is warm and comparatively dry; the southwest corner, hot and humid; and the north, hot and dry. Its terrain consists of plains and scrubland, rain forest, and savanna.

ADRA's Matching Grant Project is located in the northern region in the district of Walewale, which falls within the savanna zone of the country.
The project started in the rural village called Zangum, and later expanded to the near by villages of Gbimsi and Wungu (Kparigu took the place of Wungu later).

1.2.2 ADRA's experience in the Northern Region of Walewale

ADRA/Ghana signed an agreement with the Government of Ghana in 1983 which guarantees the Government of Ghana's recognition and support for ADRA/Ghana's development and relief projects in all the ten regions of the country.

Through the experience gained under the Matching Grant of 1982-85, ADRA/Ghana was able to extend its services to a wider circle of villages in Walewale. (2)

ADRA/Ghana has adapted an integrated approach to accomplish its goal. A three-prong approach is envisioned. It involves agriculture, maternal and child health, and community development.

1.2.3 Other Organizations' Development Activities in the Region

The Government finds it hard to provide proper health care services and agricultural technical support in the northern region because of the vast and dry rural areas. Transportation and communication are very difficult to the scattered villages.

The UNICEF has been very active in supporting the government in immunization and providing the vaccines. The Catholic Agriculture Project has recently started their immunization program.

1.2.4 The Project's Base

ADRA/Ghana Matching Grant MCH Program works very closely with the village communities. The building of the MCH centers formed part of the community development program. The MCH centers are the bases for the promotion of maternal and child health.

1.2.5 The Specific Project

ADRA/Ghana has adopted an integrated approach in helping to improve the health status of children aged five and below, and the health and socio-economic well-being of the general population in the three targeted villages. The approach involved agriculture, health, and the provision of some basic infrastructure for the benefit of the village communities. Since this evaluation project is geared only to the MCH program, the agriculture and community development programs will not be covered in this report.

The major emphasis of the present Matching Grant Program is on the improvement of the health status of children five years of age and below. To achieve this objective, ADRA/Ghana has constructed MCH centers in each of the villages through the help of the local communities. ADRA provided the building materials and the community contributed their time and labor.
There are two village health workers, called Nutrition Agents in this project, in each of the MCH centers. They are selected by the village Health Committees and trained under the Government of Ghana's Primary Health Care scheme and ADRA/Ghana training programs.

Each center enrolls lactating mothers, pregnant women, and mothers with children up to five years of age. Specific groups and meeting days are assigned to each participant. On meeting days, participants are given lectures and demonstrations in child care, sanitation, nutrition, cookery, family planning, and back-yard gardening.

A growth surveillance project is undertaken for children within the target group. A malnourished child is placed on a nutrition intervention program. This aspect of the Matching Grant Program is being tied in with ADRA/Ghana's Title II Outreach Program in MCH. Growth charts are given to mothers to help monitor the children's growth. In the absence of adequate immunization facilities, arrangements are made for periodic immunization visits by health officers from the nearest health center.

The MCH centers offered some basic drugs such as Chloroquine for malaria, Paracetamol for fever and pain, eye ointment, vitamins, worm medicine, and oral rehydration salts. This service was terminated because of government regulation which did not allow unqualified nutrition agents to distribute the drugs.

To help improve the quality of health of mothers and children in particular and the villagers as a whole, the project emphasizes proper diet and sanitation. The MCH centers conduct cookery classes geared towards helping families obtain well balanced diets based on available foods. (3)

1.3 Relevant Policies

1.3.1 Donor Policies

ADRA/Ghana received 75% of its Matching Grant from the USAID and ADRA/International, and provided 25% match from local funding. The Matching Grant budget covered the direct project costs, training, development project supplies, and transportation.

ADRA/Ghana uses PL480 Title II commodities for the Maternal and Child Health Feeding Program. ADRA/International has prepared a handbook on Policies and Guidelines for the Use of Food Aid and it covers the USAID policies in Food for Peace Program and Maternal and Child Feeding Program. (4)

1.3.2 Government of Ghana's Development Policies

ADRA/Ghana has a commitment to use its resources to strengthen the overall development activities of the country. The government
of Ghana has a strategy to develop the North. (See Republic of Ghana, "Economic Recovery Plan 1984-1986," Vol. 1&2, Report prepared by the government of Ghana, October 1986.) ADRA/Ghana responded to the plan and entered into a greater involvement with the less developed areas of the northern region. (5)

2.0 The Project

2.1 Overview

2.1.1 Purpose and Objectives

The major concern that ADRA/Ghana perceived in the villages of Zangum, Gbimsi, Wungu and later Kparigu was the health status of the children five years of age and below. The nearest health facility is at Walewale which is an average of five kilometers from each of these villages. Walewale has a health center that has been providing treatment for many villages in the area. However, due to the lack of transportation, drugs, and personnel, there are no on-going health and nutrition education programs in any of the villages.

Malnutrition in children, particularly those in the age group of five years and under, is still a serious problem. The problem is attributed partly to the inadequate protein and caloric intake by the children. Inadequate weaning food, along with inadequate education regarding weaning food also contribute to the problem.

Through a maternal child health program, ADRA intended to provide needed nutritional intervention for malnourished children of five years and under and also provide health and nutrition education for the mothers of children in this target group.

The objective of the MCH program was to improve the nutritional status of selected malnourished children five years and below as well as selected women of child bearing ages and to provide nutrition and health education for both mothers of these children and the selected women.

The evaluation team went through the literature and could not find specific, measurable objectives for the Matching Grant MCH Program in the early documents. (6) However, from a more recent document, the Interim Progress Report of the Matching Grant Project, January 1988, there were a number of clearer objectives and a cluster of objectively verifiable indicators with which the evaluation team felt comfortable for evaluation purposes.

2.1.2 Strategy

Each village was instructed to plan a three year development project to run concurrently with the Matching Grant Program period. A village Development Committee was formed to coordinate all activities of the village. Its main function was to identify needs at the village level, and a priority list would be made
based on available resources, the time span, and the urgency of each item. (7)

For the nutrition rehabilitation services extended to malnourished children, and the growth surveillance services extended to nutritionally "at risk" children, the program was designed to care for 50 of the most severe cases of malnutrition in what was called an intern program, with 100 less severely malnourished children included in an extern program. On the average, each center has 150 mothers. The program provided feeding for 75 of these mothers who fit the following criteria: The mothers must be lactating, pregnant or single. Generally 25% of the extern group had all these three criteria.

In the intern program, 50 mothers and their children met in groups of 25 every two weeks to receive instruction, medicine, and a ration of food for the next weeks. In the extern program, 100 mothers attended the program in monthly groups for the same activities but received a smaller ration of food. All together there were six groups in each center, about 25 mothers in each group. Groups A and B were usually designated as the intern groups and C, D, E, and F as the extern groups.

During each meeting, the children were weighed, and their weight-for-age data were recorded on the growth charts. A lecture on nutrition or health would be given to the mothers, followed by the giving out of food supplements. The mothers brought their own containers. Arrangement was made to call the meetings to coincide with the visitation times of the Health Team from a nearby government health center for immunization. A registration fee of 20 cedis (less than ten cents US) per child per month was collected.

The ration levels for the intern and extern groups are as follows: (units: Kilogram per month)

<table>
<thead>
<tr>
<th></th>
<th>Intern</th>
<th>Extern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soy-fortified Bulgur</td>
<td>2.1</td>
<td>1.05</td>
</tr>
<tr>
<td>Wheat Soy Milk</td>
<td>4.2</td>
<td>2.10</td>
</tr>
<tr>
<td>Vegetable Oil</td>
<td>0.4</td>
<td>0.40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6.7</strong></td>
<td><strong>3.55</strong></td>
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2.2 Process

2.2.1 Project Chronology

The Matching Grant Phase I began in July 1982, and ended in June 1985. There was no MCH program in the first phase of the grant.

The MCH Program started during the second phase of the Matching Grant. It was late November of 1985 when meetings were conducted in the villages of Zangum, Gbimsi, and Wungu, in some old buildings assigned by the local communities. The first batch of nutrition agents received a two week intensive training in November
1985. The second two week training was conducted in April 1986. The most recent training was a one month course in April 1987.

With the support of ADRA, the three village communities built their new MCH centers which were inaugurated on February 17, 1987.

The center in Wungu was burglarized on May 15, 1987. A carton of vegetable oil and six bags of wheat soy milk were missing. The case was settled in the court with no one convicted. The center has been closed since the burglary. ADRA turned to the village of Kparigu in June the same year for a new center. The community built and inaugurated the MCH building in October 1987.

The Matching Grant Phase II was supposed to end in June 1988. ADRA/Ghana has requested a no-cost extension to December 31, 1988, which was granted.

2.2.2 Monitoring and Reporting

The nutrition agents at the MCH center submit a monthly report on food stock and program activities to the MCH program coordinator in Accra. The program coordinator turns in quarterly reports to the country director who in turn sends quarterly reports to ADRA/International through the regional director of ADRA who is based in Abidjan.

Accurate and clear monitoring and reporting on food distribution could be traced back to September, 1986, in the files of Zangum and Gbimsi, and to October of 1987 in the file of Kparigu. Clear records of the amount of food at the beginning of the month, the amount of food received during the month, total available for distribution, amount of food distributed in the month, and amount of food remaining at the end of the month were on the report forms.

ADRA/International sent a technical advisor to Ghana in the beginning of 1988 to work with the MCH program coordinator to improve the monitoring and reporting system. Six forms were prepared. The three centers under the Matching Grant have been using the new forms since June of 1988. These report forms have greatly enhanced the monitoring and reporting system.

Reports were received in the ADRA/Ghana head office regularly. The data were analyzed by the program coordinator and her assistant. A feedback report was sent to each village center monthly.

2.2.3 Technical Support

The Matching Grant supported the regional program manager, who is an agriculturist overseeing the whole Matching Grant Project, and a program supervisor, who has ten years of elementary and middle school training. She received her three month primary health care
course under the Government Ministry of Health and the one month nutrition course given by ADRA.

The nutrition agents are chosen from the local village by the Health Committee. They receive high regards from the villagers. They were sent to Accra to receive a one month training in nutrition and health courses.

There are two MCH program staff in the ADRA/Ghana head office who give technical support to the program supervisor in the region. The country MCH program coordinator, who holds a degree from the University of Ghana in nutrition, and an assistant coordinator, who has secondary education and has received nutrition and health training by ADRA.

ADRA/Ghana received technical support from ADRA/International in programming, financial management, and evaluation.

2.2.4 Management

The program manager has good working relations with the local communities as well as the government level. The village Health Committees participated in selection of nutrition agents and other decision making processes.

The program supervisor made contact with the center nutrition agents and supported their work.

2.2.5 Accounting and Funding Patterns

ADRA/Ghana prepared the Matching Grant budget. It was prepared in the local currency. The locally approved budget was then sent to the ADRA/Regional office for consideration and approval. When the regional office approved the budget, it was sent to ADRA/International for consideration and approval.

The Matching Grant Projects budget has two distinct components, the country project budget and the headquarters' budget. The country project budget includes the direct project cost, training, development project support, transportation, evaluation and monitoring costs. The headquarters' budget includes the manpower resource development costs and the program management costs.

After the budget was approved, ADRA/International sent forms to ADRA/Ghana to schedule all withdrawals of money for its activities. These forms were sent through the ADRA/Regional office to the program manager at ADRA/I. He authorized the disbursement of the money. ADRA/I has a financial program officer who deals with and distributes all authorized money.

ADRA has its own accounting and auditing system. This system follows generally accepted auditing practices. All the records and documents for the Ghana project were kept in the ADRA/Ghana office, and copies of monthly or quarterly balances were sent to
2.3 Outcomes

2.3.1 Achievements

All three MCH centers are running a regular weight monitoring program with food supplements given to the malnourished children. The intern groups meet twice a month and the extern groups meet once every month. Two meeting days a week are held in the morning in all the centers.

According to the monthly reports, the three centers have been serving an average of 200 children and 200 mothers in the first six months of 1988.

During each meeting session, between the weighing and the rationing of food supplements, a series of nutrition and health lectures were given to the mothers. All the mothers who attended the MCH centers were keeping growth charts for their children.

The locally selected nutrition agents have been trained by ADRA and are effectively running the centers.

There is strong support given to the program by the communities. The village chiefs, elders, the village Health Committees, and the Government District Officers are supportive and the program has become part of the communities.

The MCH program in the three villages has been so well established that a number of the neighboring villages were asking for help. The Walewale District Secretary wrote a letter to ADRA/Ghana requesting ADRA to re-open the center in Wungu.

2.3.2 Impact

Before this evaluation, there was a baseline study done in January 1987. However, the survey was not done with enough references to the health behavior of the mothers and children to allow comparison in later studies. (8)

The recent survey done by the evaluation team in August, 1988, gave some indicators as to how the MCH program has had its impact upon the mothers and their children. (See Appendix E). Although there was no substantial data to support the inference, from the centers' monthly reports and the mothers' agreement, the most important impact of the MCH program was the improvement of the status of the malnourished children.

From the result of the survey, the mortality rate of the villages seemed to show a positive trend. It was particularly clear in Kparigu which indicated a reduction from 53 deaths/yr of children.
under five to 22 deaths/yr and later to 18/yr over the past three years.

With the extremely high illiteracy rate of the mothers in the villages, the nutrition and health education was slowly making its impact on the mothers. About 60% of the mothers knew how to interpret the growth chart. About 20% of the mothers knew how to tell the signs of a malnourished child. There were about 40% of the mothers who knew the composition of a nutritious balanced meal and how to prepare homemade ORS. Most of the mothers, about 98%, recognized the importance of immunization.

3.0 Discussion and Recommendations

3.1 Issues: Strengths and Limitations

3.1.1 Technical Issues

The nutrition agents in the MCH centers have their basic training in nutrition and health. Their performance during the evaluation interviews was satisfactory.

The program supervisor was giving supervision to the three village centers. However, she was restrained by the lack of transportation during the beginning and latter part of the project period.

The program supervisor seemed to be involved too heavily in the actual routine work of the center services. This became a constraint to the up-grading and better performance of the nutrition agents.

The regional program manager is from the northern region. He is an agriculturist and worked for the government agricultural department before he joined ADRA. He and his wife, the program supervisor, work very well as a team. However, because of the background of the program manager, the agriculture projects have been receiving more attention than the MCH program.

3.1.2 Management

There was good participation from the village communities. All three MCH centers were built by the local communities.

ADRA has been working closely with the local government, especially in agricultural projects. However, closer cooperation seems to be needed in the MCH program, particularly in the areas of immunization and dispensing of drugs. More communication and coordination with other NGO's would be helpful as well.
3.1.3 Monitoring and Reporting

Reports on food commodities were consistent and properly done. With the improvement on the reporting forms in programming, the overall reporting system was satisfactory.

3.1.4 Sustainability

With the strong support of the local communities, the MCH centers will be able to continue their services. However, food supplements are still the main attraction for the high attendance rate of the mothers and children. ADRA is still paying an allowance to the hourly based part-time nutrition agents. The local communities are not in the position to be self-sufficient at this point.

3.2 Recommendations

3.2.1 Programming

Provision of immunization for the children in the villages is most urgent. We recommend that the ADRA regional manager and the MCH program supervisor take immediate action to work with the regional Ministry of Health Officer and the UNICEF officials to plan a schedule implementing the program as early as possible. The plan would include the fixing of the kerosene refrigerator, obtaining and storage of vaccines, the record cards or growth chart, transportation, and the personnel. ADRA's role, as indicated by the Ministry of Health Officer, would mainly be transporting the team to the villages.

With the past two and one-half years of experience with the MCH program in the Matching Grant Project, we recommend that ADRA consider expansion of the MCH centers into integrated primary health care centers with curative and preventive health care services. The need for medical care is strongly felt by the local communities. To begin with, arrangement should be made with the government to provide nurses to provide basic medical care in the centers.

In view of the high illiteracy rate, we recommend that more visual aids and demonstration programs should be introduced. ADRA/Ghana headquarters should allocate budget and personnel to produce teaching materials for all the centers.

In the nutrition and health education programs, we recommend that more learning incentives be introduced. This could consist of a very simple test and grading system for the learning mothers; a certificate for those who complete the course; or divide the mothers into groups and hold an inter-village quiz contest (with a prize) on the mothers' knowledge on nutrition and health. This recommendation is made in view of the rather poor performance of the mothers during the survey.
Recruitment program is recommended for the 19% of the mothers who have never attended the MCH centers according to the survey results.

The school health education is recommended.

A program on the provision of clean water is strongly recommended to prevent the most common problem of diarrhea in the villages. Open wells should be covered. Well dwelling projects should be correlated with the MCH program.

We recommend that the MCH program coordinator and supervisor make use of the results of the baseline survey done during this evaluation to plan their programs in order to measure outcome impact on the mothers and children in the future.

3.2.2 Management

A continuous up-grading training program for the program supervisor, as well as the nutrition agents, is the most urgent need in program management. The MCH coordinator should set a time table for the entire year to provide on-site training for the staff. Other types of training programs should be explored. For example, correspondence courses, to be turned in with the monthly reports.

A regional program coordinator is needed for the northern region. This coordinator will probably strengthen the program by bringing a degree in nutrition and/or nursing training to the project.

More communication and cooperation between ADRA and the Ministry of Health and other NGO's is recommended, especially in MCH program management. The regional program manager is doing well in agriculture.

Closer supervision is needed from the program supervisor on the centers' filing system.

We recommend ADRA/Ghana to review the policy on the allowance for the nutrition agents. All workers receive the same allowance even with different training received and working experience.

Consideration should be given to employ the nutrition agents full time if the MCH center should expand to give integrated primary health care services.

We recommend that the regional program manager to follow up on the matter of joining the Ministry of Health's Health Committee and the District Committee of the People National Development Council (PNDC) in health and community development.

3.2.3 Sustainability and Future Programming

ADRA/Ghana's role in the long run should help the local communi-
ties to be self-sufficient. As the centers expand their services, more revenue should be generated from the beneficiaries and the communities at large.

As recommended, closer cooperation with the Ministry of Health is important for the prospect of sustainability.

As proposed in the Multi-Year Operational Plan of 1989 to 1990, efforts will be made to institutionalize the education and growth monitoring components of the program to insure continuity even after the food commodity inputs have been withdrawn. This strategy is part of ADRA's phase-out plan. (9)

4.0 References


5. Ghana Specific Country Plan Food For Peace (FFP) Title II Program for Enhancement Grant, August 1986, p. 56.


Appendix A: Report on the meetings with the village chiefs of Gbimsi and Kparigu
Summary of the Meetings

1. On August 26, the evaluation team went to visit the Gbimsi village chief. We paid two visits to him, one in the morning around ten to ask for permission to begin our survey in the village, and the second visit was in the afternoon at 4:00 p.m. after we had completed the survey. The village chief expressed his appreciation to the contribution that ADRA has made to the village of Gbimsi. During our conversation, the chief made a request twice. He indicated the needs for basic curative health care and drugs in his village.

2. On August 28, the evaluation team went to visit the Kparigu village chief. We again made two visits. One in the morning and the other in the afternoon around 10:00 a.m. and 5:00 p.m. respectively. The chief was well organized. He had prepared five instruction sheets with the names of the families that belong to the five sections of the village. He had arranged five local elders to lead our survey teams around the village. Our survey teams followed the instruction sheets with great ease in completing our survey of 243 mothers. The chief shared his burden concerning the welfare of the village with the members of the evaluation team. He is an agriculturist. He expressed the need for expanded agricultural projects and primary health care, and especially the need for drug dispensing. He also made a special appeal for a young cripple, asking ADRA to support him to start a self-supporting poultry farming business.

Main Findings

1. It is very important to solicit the cooperation of the community leaders, like the village chief, in rural community health development.

2. The survey in Kparigu was much easier than Gbimsi because of the support and good leadership of the village chief.

3. Both the village chiefs made the same request for some basic drugs for their people.

4. The environmental sanitation in Kparigu seemed better than that of Gbimsi. The Kparigu village chief is active in community development.
Appendix B: Report on the evaluation of the two MCH centers at Gbimsi and Kparigu
Summary of Direct Observation of the two MCH Centers

1. The evaluation team visited the Gbimisi MCH center on August 26 at 11:00 a.m. The center is well located in the village with easy accessibility. The center is clean and well kept. The building was erected by the community. It is a simple building with two small rooms and an open space with roofing for lecturing. The two nutrition agents were giving a talk to about 34 mothers with their children when the team arrived. The talk was on breastfeeding. The mothers were attentive and responded to the questions asked by one of the nutrition agents. After the talk, one mother was asked to present the talk on breastfeeding to the other mothers. Two evaluation team members later interviewed one of the nutrition agents. The visit lasted for about one and a half hours.

2. The evaluation team visited the MCH center in Kparigu on August 28 around 11:00 a.m. The center can be located easily. It has a room for food storage and a larger sheltered open space for lecturing.

We saw two carpenters working on a solar dryer wooden bed for the agriculture project at the center. The team reviewed the records and reports of the center, inspected the food commodities in stock, checked the visual aid materials, and later interviewed the two nutrition agents of the center. The visit went for about an hour.

Main Findings

1. Both the centers in the two villages are located for easy access.

2. The center in Kparigu needs better upkeep. The store room needs fumigation.

3. The food commodity tally report forms and the monthly MCH activity report forms are up-to-date and complete in both centers. However, there is a need for files to keep the forms in good order.

4. The centers are receiving feedback from the head office regarding their reports.

5. There are no visual aids for immunization, the causes of diarrhea, and the administration and preparation of ORS.

6. The center at Kparigu needs more wooden benches for the mothers to use during health talks.
Appendix C: Report on the meetings with the Nutrition Agents
Summary of Meetings

The evaluation team had three different meetings with the nutrition agents from the MCH centers of Gbimsí, Kparigu, and Zangum. Two members of the evaluation team, Nick and James, did the interviews. Each interview took about 40 minutes. All the nutrition agents have adequate English to communicate and they were able to answer all the questions we asked. The three interviews were conducted one on August 26, and two on August 28. The two nutrition agents were questioned at the same time. They took turns in answering the questions.

Main Findings

1. The nutrition agents vary in training received. Among the six we interviewed, four had received one month training from ADRA in Accra, one took a three month primary health worker course given by the government besides the ADRA course, one had one week intensive course held in the region by ADRA. With the different level of training received, all received the same allowances.

2. According to the nutrition agents, the main health problems in the villages are diarrhea, malaria, and measles.

3. The suggested main cause of diarrhea in the villages of Kparigu and Zangum was contaminated water sources, especially the ground level uncovered wells.

4. All the nutrition agents expressed the need of resuming the dispensing of basic drugs which the villages once had.

5. The immunization program provided by the government in the three villages was very inconsistent. The last service in Kparigu was done in September, 1987. Children have to be referred to Walewale health center for immunization.

6. The nutrition agents expressed their need of continuous education, particularly in the areas of first aid, and antenatal care.

7. The nutrition agents believed that the food supplements had improved the status of the malnourished children.

8. The nutrition agents received supervision from the district program supervisor. The ones from Zangum said the supervisor visited them every week.
Appendix D: Report on the meeting with the Ministry of Health Officer
Summary of the meeting

Three members of the evaluation team, Nick, Irene and James, led by the Regional Program Manager, met with the Walewale district Ministry of Health Officer, Mr. Issahaku Adam, at his residence near his office, at 15:00 on August 28. We had a very profitable discussion with the Officer. He appreciated the projects run by ADRA and supports ADRA. We asked many questions concerning the relation between ADRA and the Ministry of Health, suggestions for future development and improvement, and cooperation among the PVO's in the region. The discussion lasted one hour.

Main Findings

1. The Ministry of Health would like more participation in the training programs for the nutrition agents with ADRA. It can provide training in basic drug dispensing and intensive training for the primary health worker.

2. The Ministry of Health in the region has enough personnel to carry out immunization for the villages, but the main problems are transportation and cold chain facilities for the vaccines. The kerosine refrigerator in the MOH needs spare parts and wicks.

3. The Ministry of Health in the region can provide the village MCH centers with the basic drugs if the nutrition agents have received training to dispense them.

4. The UNICEF can provide vaccines for immunization and can work with the MOH and ADRA if transportation and cold storage can be arranged.

5. The Ministry of Health has a District Health Management Team in charge of the government health program in the area. It is possible that ADRA and other PVO's would be invited in the future to attend its meetings as cooperative members of the team to enhance better cooperation between the MOH and PVO's, and among the PVO's themselves.

6. The Catholic Agriculture Project has started a small scale immunization program in some of the villages.

7. The Ministry of Health Officer expressed the need for school health education in the district. There are no visual aids for health education, the curriculum does not include health education, and teachers are not trained in the field.

8. The Ministry of Health recognized that there were real impacts the ADRA MCH programs have had upon the mothers and children. The growth monitoring and nutrition education programs were effective.
Appendix E: Report and date analysis on the survey conducted in Gbimsi and Kparigu
1. Background for the study

Since ADRA implemented its MCH program in the Walewale district in 1985, some impact is expected on the mothers and children through food supplements, nutrition, and health education.

2. Description of the study's purpose

There were two main purposes of the study. One was to obtain baseline information from the villages ADRA is serving. Another was to look for trends showing the extent of the villages' health problems and the effectiveness of the MCH program intervention.

3. The methodology

The informal survey of Rapid, Low-Cost data collection method was used. This survey is characterized by three features: first, it focuses on a few variables; second, sample size is generally small; third, the informal survey does not use strict probability sampling. The informal survey can be combined with other Rapid, Low-cost data collecting methods to yield additional qualitative data. The survey does not use a rigorous probability sampling process, so respondents may not accurately represent the population. At best, the data collected indicates trends and the extent of a problem or the effectiveness of intervention.

The questionnaire was prepared by the evaluation team. It was discussed with the six national surveyors who had secondary or college education and knew the local dialect. A role playing session with two surveyors acting as surveyor and a mother going through the questionnaire in the local dialect was performed.

4. A summary of the findings

<table>
<thead>
<tr>
<th></th>
<th>Gbimsi</th>
<th>Kparigu</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total of mothers interviewed</td>
<td>187</td>
<td>237</td>
</tr>
<tr>
<td>Average people in a household</td>
<td>23</td>
<td>27</td>
</tr>
<tr>
<td>Husbands leave household more than one month per year</td>
<td>14%</td>
<td>28%</td>
</tr>
<tr>
<td>Average number of children</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Children under age five</td>
<td>49%</td>
<td>55%</td>
</tr>
<tr>
<td>Average number of under five</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Number of children who died in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1988</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>1987</td>
<td>33</td>
<td>22</td>
</tr>
<tr>
<td>1986</td>
<td>23</td>
<td>53</td>
</tr>
</tbody>
</table>
Number of children under five had the following sicknesses in the last year:

<table>
<thead>
<tr>
<th>Sickness</th>
<th>First Group</th>
<th>Second Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diarrhea</td>
<td>138(46%)</td>
<td>179(45%)</td>
</tr>
<tr>
<td>Measles</td>
<td>77(26%)</td>
<td>61(16%)</td>
</tr>
<tr>
<td>Yellow Fever</td>
<td>52(17%)</td>
<td>88(22%)</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>21(7%)</td>
<td>51(13%)</td>
</tr>
<tr>
<td>Severe malnutrition</td>
<td>17(6%)</td>
<td>24(6%)</td>
</tr>
</tbody>
</table>

Illiterate mothers:

- 97% in the first group
- 95% in the second group

Mothers or children who received food:

- 69% in the first group
- 66% in the second group

Mothers or children who never attended the MCH:

- 19% in the first group
- 18% in the second group

Mothers who keep a growth chart in comparison with % of lactating mothers:

- 52% in the first group
- 75% in the second group

Average number of marks above the bottom line of growth chart:

- 2.7 in the first group
- 3.8 in the second group

Average number of marks below the bottom line of growth chart:

- 2.5 in both groups

Mothers who understood the meaning of the bottom line:

- 57% in the first group
- 68% in the second group

Mothers who knew the signs of malnutrition:

- 20% in the first group
- 19% in the second group

Mothers who knew the composition of a nutritious balanced meal:

- 40% in the first group
- 30% in the second group

The average length of breastfeeding:

- 2.4 yr in both groups

The average age to start weaning a child:

- 6 mo in both groups

The most common food for weaning:

- T.Z.
- Rice

Mothers who treated their child with ORS:

- 43% in the first group
- 33% in the second group

Mothers who knew how to prepare homemade ORS:

- 40% in the first group
- 35% in the second group
Mothers who knew the causes of diarrhea 24% 16%
Mothers who knew the importance of immunization 96% 99%
Mothers who claimed their child has had immunization 64% 77%
Children without immunization records 77% 76%
Mothers who said they like the MCH services 98% 92%
Mothers who were pregnant 8% 11%
Mothers who were lactating 77% 82%
The average age of mothers 29.5 28
The eldest among mothers 45 50
The youngest among mothers 15 15

5. Conclusions

With the sample size of 187 mothers in Gbimsi and 237 mothers in Kparigu, the data collected in the survey give reasonable baseline information concerning the two villages.

The data collected from the two villages which are about 30 kilometers apart from each other but are within the same region of northern Ghana show close similarity.

The mother illiteracy rate is very high in the villages. This might be the main cause of the unsatisfactory performances in the testing of their understanding of some of the nutrition and health knowledge which was taught in the MCH center.

The MCH service coverage of all mothers is 81% and 82% in the two villages. This can be improved.

There a correlation between the percentage of children immunized and the prevalence of measles in the villages appears. In Gbimsi, according to mothers' reports, 64% of the children were immunized and 26% of the children under five have had measles. In Kparigu, according to reports of the mothers 77% of the children were immunized and 16% of the children under five have had measles.

Half of the children in both villages were under the age of five, and their main problem was diarrhea.
There were 77% and 82% of lactating mothers in the two villages, however, only 52% and 75% of all mothers interviewed were keeping a growth chart for their child in Gbimsi and Kparigu respectively.
Appendix F: Report on the meeting with the People National Development Council (PNDC) Government District Officers
Summary of the meeting

The evaluation team met with two of the government local district officers on August 29 at 9:00 a.m. The District Secretary of the PNDC, Mr. Dokurigy Nantomah, seemed to know our program manager very well. Our discussion lasted about 45 minutes. We discussed some of the problems in the surrounding villages. We talked about the ADRA programs in the region as a whole and what improvement could be made in the future.

Main Findings

1. There is good communication between ADRA and the local district officials.

2. Clean water is a major problem in the surrounding villages. According to the officers, there is only one village among the 36 surrounding villages that has clean water supply.

3. There is no school health program running in the district schools.

4. ADRA MCH program in the northern region is well appreciated and services should also be considered for the surrounding villages.

5. ADRA staff might be invited to participate in the District Committee to give input in the areas of health and community development.
Appendix G: Report on the meeting with the Matching Grant MCH District Program Supervisor and Program Manager
Summary of the meeting

The evaluation team held its last meeting in the north with the Matching Grant ADRA MCH district program supervisor and program manager on August 29 at 9:30 a.m. The team discussed the job assignments of the program supervisor. She described her routine work in supervising the nutrition agents of the three villages. The team then closed the meeting by sharing some of the findings and recommendations with the program manager during the five day evaluation in the north.

Main Findings

1. The MCH program supervisor received her three month training in primary health worker course given by the government and the ADRA one month intensive training in Accra. There is need for her continued education for increased effectiveness as program supervisor.

2. The main difficulty in supervising the MCH program in the three villages is transportation. The program supervisor used to have a motorcycle, but it was put damaged during an accident and she has to rely on the program manager for transportation.

3. The main concern of the program supervisor is to facilitate the government immunization program to meet the need of the villages.