SOUTHERN NEW HAMPSHIRE UNIVERSITY

AND

THE OPEN UNIVERSITY OF TANZANIA

MASTER OF SCIENCE IN COMMUNITY ECONOMIC EVELOPMENT

(2007)

REDUCING CHILD MALNUTRITION IN JONGOWE, NORTH 'A' DISTRICT, ZANZIBAR

MOHAMMED MAKAME MOHAMMED

SOUTHERN NEW HAMPSHIRE UNIVERSITY

AND

THE OPEN UNIVERSITY OF TANZANIA

MASTER OF SCIENCE IN COMMUNITY ECONOMIC DEVELOPMENT

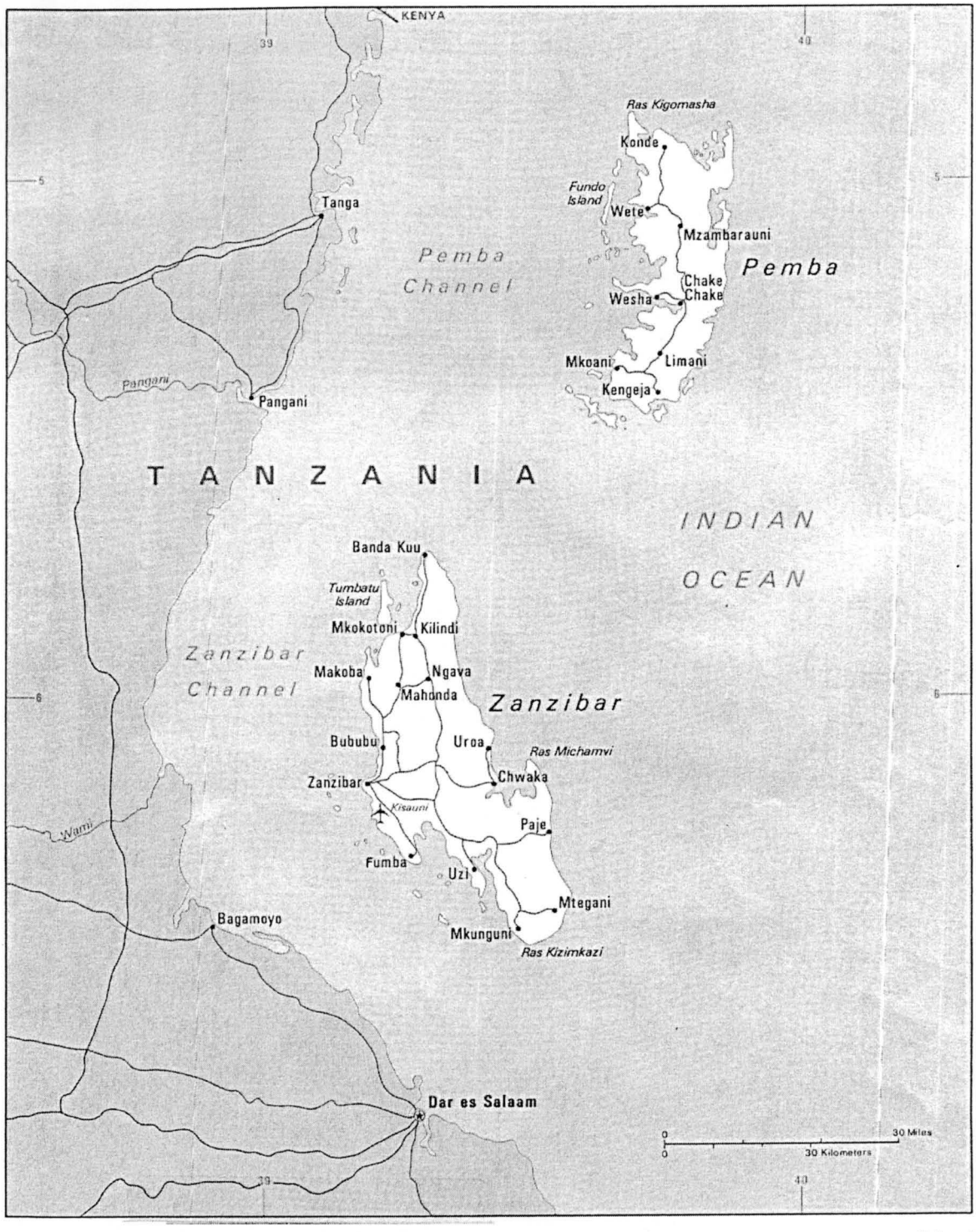
(2007)

REDUCING CHILD MALNUTRITION IN JONGOWE, NORTH 'A' DISTRICT, ZANZIBAR

"Submitted in partial fulfillment of requirements for the M.S. in Community Economic Development"

MOHAMMED MAKAME MOHAMMED

Zanzibar and Pemba



SUPERVISOR'S CERTIFICATION

The undersigned certifies that he has read and hereby recommends for the acceptance by the Southern New Hampshire University and Open University of Tanzania a project title "Reducing Child Malnutrition in Jongowe, North 'A' District, Zanzibar"

Name: Dr Sinda H Sinda

Signature: .....

Date: 01/10/2007

STATEMENT OF COPYRIGHT

DECLARATION.

I, **Mohammed Makame Mohammed** declare that this project report is my own original work, and that has not been submitted for the same or similar award to any other Institution.

Student's signature: .....

Date: 01/10/2007

DEDICATION

This work is dedicated to my beloved daughters Sauda, Hudhaima and the whole family.

ABSTRACT

This project proposal is about reducing child malnutrition in the Shehia of Jongowe in North A district, Zanzibar. Jongowe Development Fund (JDF) is a Community Based Organization (CBO) which hosts the implementation of this project. The main goal of this project is to improve the nutritional status of children of underfive years children in the Shehia. Specifically the project aims at reducing malnutrition of under fives years children, building capacities of community members to intervene on nutrition; and create awareness of the community on nutrition issue. Through participatory approach it was identified that malnutrition is a major health and social problem in this Shehia. Various methodologies were used to assess the needs which include interviews, discussion and meetings with different groups of people in the community.

Generally there are improvements in nutritional status of children in the Shehia and malnutrition has been reduced due to increased awareness of the community in malnutrition and its consequences. The result of the survey shows that there is reduction in severe malnutrition of children in the Shehia while moderate malnutrition has increased and well nourished children has dropped.

This is a three years project which intend to accomplish four major activities amongst which is the sensitization of the community, building the capacities of the CBOs and community, improving the community based information management system (CBIMS) and establish a coordination, monitoring and evaluation system (CMES). By the end of three years it is expected that the community will be able to intervene on nutritional problems and ultimately reducing the problem.

EXECUTIVE SUMMARY

Reducing child malnutrition in the Shehia of Jongowe is a project that is implemented to improve the nutritional status of underfive years children. Jongowe is among 32 Shehias in North 'A' district in Unguja North Region. Jongowe Development Fund (JDF) is a Community Based Organization (CBO) which hosts the implementation of this project. Various methodologies were used to assess the needs that include interviews, discussion and meetings with different groups of people in the community. The community of Jongowe through participatory approach identified malnutrition as a major health and social problem in the Shehia. The severe malnutrition rate of underfive years children was over 3.4% and 40.6% moderate. The main goal of this project is to improve this unacceptable condition and specifically reducing malnutrition of under fives by 10%; building capacities of community members to intervene on nutrition; and create awareness of the community on nutrition issues.

Some efforts that have been made during 1990s have helped to reduce the severe malnutrition rate from 9% to 3.4% but the rate is fluctuating. This is a three years project which intends to accomplish four major activities including the sensitization of the community, building the capacities of the CBOs and community, improving the community based information management system and establish a coordination, monitoring and evaluation system. By the end of two years it is expected that the community will be able to intervene on nutritional problems and ultimately reducing the problem. Different stakeholders will be involved in the implementation of the project including the District Commissioner's (DC) and District Council offices, UNICEF, Nutrition Unit of the Ministry of Health and Social Welfare and many others who have

the stake in the project. Stakeholders' participation is a crucial issue to consider in the implementation of this project.

This descriptive survey was undertaken in Jongowe village using a cross-sectional design where information was collected once at a single point. The methods used to collect data were interviews, observation and focus group discussion; while tools used were interview questions, checklist, questionnaires and documentary sources. Data was analyzed using a computer soft ware MS Excel and SPSS programme.

The research finding revealed that malnutrition in the Shehia is caused by food insecurity, inadequate nutrition education and poor child care system. Generally, there is an improvement in nutritional status. However, low capacities to deliver nutrition education to most extension workers slow down the efforts of improvement of nutrition status of children.

To address these challenges it is recommended to build capacities of the CBO and other stakeholders; and to comprehensively address the problem of food insecurity in the Shehia.

ACKNOWLEGEMENT

This project report is a result of assistance from many sources which in one way or another have contributed to the successful accomplishment of my assignment in Jongowe Development Fund. First and foremost, I would like to take this opportunity to express my sincere gratitude and appreciation to the leadership and members of Jongowe Development Fund, the Shehia authority and the entire Jongowe Community for allowing me to work with their organization and the hospitality shown by the community members during the study. I also express my sincere and utmost thanks to The Southern New Hampshire University and the Open University of Tanzania for granting me an admission to pursue this Master Degree course in Community Economic Development. I also would like to extend my sincere gratitude to those who have been involved in one way or another, in the successful accomplishment of this paper. Since it is impossible to mention all by their names, all those who participated in one way or another, I cannot forget their contribution and I appreciate.

First and foremost I would like to sincerely thanks Mr Haji A. Haji, Abbas M. Mohamed and Sheha M. Juma the JDF Executives and all members of JDF Executive Committee, for their willingness to work with and supported me in their project. I would also like to extend utmost thank to Mr. Michel Adjebodou, Mr. Felician Mutasa, Ms. Rukia Masasi, all lecturers and CED Tanzania staff who tirelessly facilitated the program successfully.

I would like to acknowledge Dr.Sinda H Sinda for his constructive contribution, consultation and good supervision from the beginning up to the end of this work without which could not stand at this stage.

I also extend by appreciation to Principal Secretary in the Ministry of Regional Administration Mr. Hassan H. Wambi and the Peace Corps Country Director Ms. Christine Djondo my employers for their kindness to accept my absence from work for the period of my study in different times while working in their organization. I also acknowledge the support given by senior staff of both the Ministry of regional Administration and the Peace Corps which helped in accomplishment of my studies.

I can't forget the contribution and support from my family, relatives and friends during the whole period of my study. My greatest debt is to my wife Riziki Daniel Yussuf and Miza Bakar Haji, my son Abdi-Nassir, my daughters Aisha, Rahma, Hafsa, Sauda and Hudhaima, my father Makame Mohammed and mother Mtumwa Khamis, brothers Mbarouk, Haji and sisters Mtoro, Jina, Fatma, Mariam and Asha and the whole family for their patience, tolerance, contribution and support during the whole period of studies. I appreciate the assistance and contribution provided by my colleagues during my studies. I can't forget the assistance provided by my fellow course participants during the whole period of the studies.

There are many others, not named who have assisted with information and comments. To list them all would be impossible and to list a few invidious. I ask them to accept my thanks offered generally to them.

TABLE OF CONTENTS

Page

CHAPTER TWO: PROBLEM IDENTIFICATION

CHAPTER THREE: LITERATURE REVIEW

CHAPTER FOUR: IMPLEMENTATION

CHAPTER FIVE: MONITORING, EVALUATION AND SUSTAINABILITY

LIST OF TABLES

Page

LIST OF FIGURES

Page

LIST OF PLATES

LIST OF PHOTOS

ABBREVIATIONS AND ACRONYMS.

JDF	Jongowe Development Fund
DHMT	District Health Management Team.
CSPD	Child Survival, Protection and Development.
GMP	Growth Monitoring and Promotion
VHD	Village Health Day
CORPS	Community Own Resource Persons
CBOs	Community Based Organizations
MCH	Maternal Child Health
MCHA	Maternal Child Health Aide
CBIMS	Community Based Information Management System.
U5	Underfive years Children
PHCC	Primary Health Care Centre
PHCU	Primary Health Care Unit
NID	National Immunization Day
MR	Mortality Rate
IMR	Infant Mortality Rate.
UMR	Under Five Mortality Rate
UNICEF	United Nations Children Fund
MORA	Ministry of Regional Administration
MOFEA	Ministry of Finance and Economic Affairs
MOHSW	Ministry of Health and Social Welfare.
UNICEF	United Nations Children Emergency Fund
NGORC	Non Governmental Organization Resource Centre
NGORC	Non Governmental Organization
GOZ	Government of Zanzibar
WHO	World Health Organization

LIST OF APPENDICES

DEFINITION OF KEY TERMS

Shehia:

It is the lowest administrative structure of Zanzibar Administrative system. The Zanzibar administrative structure at central and grass root levels looks like: - at the central level there is a Cabinet and Ministries, at Regional level there is Regional Commissioner's office and at District level there are District Commissioner's office and District Councils in the Rural District. In the Urban District there are District Commissioner, Municipal/Town Council, and while at Shehia level there are Shehia Council.

Sheha:

Is a village leader who is appointed by the Regional Commissioner on behalf of the government to oversee the government functions at the grass root level.

CHAPTER ONE: COMMUNITY NEEDS ASSESSMENT

This chapter dwells on Community Needs Assessment (CNA) which was conducted in Jongowe Shehia, with emphasis on the background information of the project, the Community and the CBO. The chapter also touches in brief the project history; Community context and description of the CBO, the essence and its involvement in the project in the Shehia. It also explains the methodology employed in data collection during the CNA and research findings and the discussion of the findings.

1.1 BACKGROUND INFORMATION

Jongowe Development Fund (JDF) was established in 2002 following the research conducted by NGO Resource Centre (NGORC) in 2002 in some selected Shehias of Zanzibar, including Jongowe Shehia. This local philanthropy research was aiming at identifying the local initiatives in funding development issues in indigenous society of Zanzibar. The NGORC is the Aga Khan Foundation project in Zanzibar, which is entrusted to build capacity of local NGOs and CBOs. It was observed from the study that the village lacks the Organization, Management and Coordination of resources in funding development activities in the village. Motivated group of youth who have been facilitating different development activities established this CBO and officially registered under the Society Act No 6 of 1995 and awarded certificate of registration No 290.

The CBO is working in Jongowe Shehia in Tumbatu Island, a sub district which is located about 30 kilometres from Zanzibar Municipal in North West of Unguja. Jongowe Development Fund (JDF) is the registered CBO established in 2002. The Head Quarters of the CBO is in Jongowe village which is located in North 'A' district Unguja North Region, Zanzibar. The Nutrition

project which is proposed and implemented intends to reduce the malnutrition problems prevailing in the village among children of underfive years.

The CBO's executive committee and the staff of the health centre have been working together and are responsible for managing the project in collaboration with other partners within and outside the village. The funding of the project is mainly from the district CSPD package which is potentially funded by UNICEF. The project is a continuous project that has started since 1990s. JDF has officially been involved in supporting the implementation in fiscal year 2005/2006 though it has been doing the activities since long time when the problem was first realized by the national campaign team. This is a three (3) years project therefore it is expected to end in 2008.

1.2 PROJECT HISTORY AND COMMUNITY CONTEXT

Reports from different sources have shown that Tumbatu is one of the areas with highest prevalence rate of malnutrition in North 'A' district. In 1990s the national campaign to assess the nutritional status revealed as high as 9% severe malnutrition, the highest in the district. The Zanzibar government has called upon all stakeholders to take action in addressing this problem in the district. With the support of UNICEF and the central government many Shehias were sensitized through District Development Committee (DDC). At that time the Child Survival, Protection and Development (CSPD) the programme aimed at facilitating health and nutrition issues, was introduced in Zanzibar in all district. In Tumbatu, Lisani Co-operative Society initiated a community initiative to intervene on the malnutrition by involving members of the community. The CBO organized a number of seminars and workshops which were funded by UNICEF. Jongowe Development Fund (JDF), a registered Community Based Organization

came into being and took over the initiative. The CBO has been collaborating with different partners who are concerned with the nutrition and other health related problems in this isolated island. The District CSPD which is a UNICEF funded program is the one that coordinates health and nutrition activities in the district. JDF has since that time been collaborating with District, CSPD and other partners in addressing the problem in the Shehia. The Jongowe Health Centre has been actively supporting the initiative of CBO and the District in addressing malnutrition by their daily routines in Maternal and Child Health (MCH) Clinic and Village Health days. In MCH Clinics and Village Health Days (VHD), health and nutrition education are provided to parents and guardians of children before undertaking a monthly or normal/routine monitoring of their children (GMP).

The district and the health centre reports (2005) have revealed a high prevalence of malnutrition among the under fives with total malnutrition of 44% and severe malnutrition of 3. 4%. The needs assessment conducted by the CBO also revealed the need to intervene the problem of malnutrition prevailing in the village.

1.2.1 Demographic Factors

The project is located in Jongowe village in the North A district. The project is within the priority plan of the district and region and in the main strategic plans of the poverty reduction of the country. It is in the context of improvement of social well-being of the society. The project is working with the community members at household level and its main target is the children of underfive years.

The Shehia has the population of 5,720 with 2,719 male and 3,011.female. The under five population is 1430 of which 744 are females and 686 are males (Shehia Report, 2005).The

village's main economic activity is fishing which contributes to over 90% of the total income of the village and other activities are farming and small business. There are also employed workers in village school and health centre. The contribution to the village income of these activities in exception of teachers and other employed workers is not reliable due to many factors. Environmental degradation in the fishing areas has contributed to the fall of fish catch in the village.

The village traditional way of fishing has caused shortage of fish in the shallow waters and reefs which made them to search for new fishing areas in other areas of Tanzania like Tanga, Dar es Salaam and others, where they take long period of time and leave their families suffer from basic needs such as food, health services etc. Feeding patterns have changed due to this behaviour of male parents which resulted into households' food insecurity.

1.2.2 Social Factors

Traditionally, the childcare was a collective responsibility of all members of the neighborhoods which has for many reasons changed to family responsibility. Economic situation has affected the care system because female parents who are left with children find very difficult to find ways and means of getting food and other basic needs for children and the family. This situation is for great extent contributing to the prevalence of malnutrition in the community.

The village leadership had once called for a meeting which was facilitated by the CBO to discuss the situation and look for immediate solutions for the problem. In 1990s before the CBO was officially registered the problem was discussed in the forum supported by UNICEF and came out with number of solutions which were implemented and the problem to certain extent

reduced. The CBO is using that experience and the participatory approaches that they think could help to solve the problem. Jongowe community is a closed community which has not yet interacted with other ethnic groups. This for them is one opportunity that makes them to be close to each other and make all people to be related to each other. The community is well organized, with their traditional leadership (Elders' Council) as well as government leadership (Shehia Council) work in hand to deal with their problems. The elders' council is the supreme and has the final decision. The Shehia leadership has to consult to the elders' council in all matters even those from central government before taking action.

Information in the Shehia is gathered in different ways considering the type of information. Main institutions which are gathering information are the Shehia office, School, health centre, CBOs, agricultural extension worker etc. Shehia office however is the major actor in information and uses these other institutions for accomplishing the task. The office has the Shehia registers for each sub-village which are used to collect different types of information. There is an organized system of information gathering and the Sheha uses effectively the existing facilities in gathering information. Both formal and informal structures are used to disseminate the information. Village meetings, notice boards of the school and health centre, 'upatu'- a local message dissemination media etc are always used to disseminate information.

1.3 DESCRIPTION OF THE ORGANIZATION

1.3.1 VISION

The vision of the Jongowe Development Fund is the "Poverty Free Society"

1.3.2 MISSION

The mission of the CBO is to improve the standard of living of Jongowe community through provision of socio-economic services and mobilizing community to participate in designing and implementing development programs and projects through self help initiatives.

1.3.3 GOAL OF THE ORGANIZATION

To assist, support and encourage community initiatives in poverty alleviation process through provision of socio-economic services, consultancy and technical support, networking with other CBOs, NGOs and development partners.

1.3.4 STRATEGIES

To design and implement Community Development Projects;

To mobilize resources for the implementation of socio-economic development projects; and

To support and promote the saving and credit scheme for Jongowe residents.

1.4 COMMUN ITY NEEDS ASSESSMENT

The Community Needs Assessment for the identified project was done through interviews discussions and meeting with different groups, CBO and the community members. The meetings which were held to discuss the problem with village leaders, health workers,

fishermen, youth and women groups and the CBO, together with the interviews conducted, came up with number of causes of malnutrition in the village. Among others, the major causes of malnutrition include, food insecurity, child care system-single parental care whereby male parents take long absence from the village for fishing trips and camps in other areas, and frequent illness especially malaria and poverty. The community thus suggested some measures to address the problem which aim at raising purchasing power of the people through initiating income generating projects such as fishing and other medium and small businesses.

1.4.1 RESEARCH METHODOLOGY

During Needs Assessment exercise data were collected in two phases. The first phase was the first entry in the community in understanding the community and identifying research topic. At this phase data were mostly collected at leadership and institutional levels and did not involve community members at household level. Various instruments were employed to collect both primary and secondary data such as interviews, focus group discussion, and documentary sources.

The second phase of the data collection was during the main survey of the project work which involved the whole community including households. Various instruments for data collection were used during this exercise such as interviews, questionnaires, observation and documentary sources.

This survey was about child malnutrition in Jongowe Shehia which had been identified as one of major health concern of the Shehia. As a means of data collection this survey had collected information in the Shehia concerning the malnutrition problem which is seen as a threat to the health of under five years children and to the community as a whole.

In addressing this problem, it was important that strategies and approaches be drawn and involve a variety of stakeholders at all levels, hence they were part and parcel of the solution of the problem. This survey therefore tried to reach representatives of all stakeholders in the Shehia in order to ensure that the interventions that are undertaken are not only addressing the problem, but also participatory.

This sub- chapter is highlighting the methodologies that were applied in collection of data and information on the situation of malnutrition in the Shehia. It also takes into consideration the environment to which this survey took place. It describes the major feature of the survey; identify the questions that structure the survey, select designs its characteristics and sampling.

SURVEY DESIGN AND SAMPLING

This section will discuss the survey design and sampling components i.e. characteristics, major features, objectives, research design and survey instruments.

CHARACTERISTICS, BENEFITS AND CONCERNS OF THE SURVEY DESIGN

In this survey, data was collected at one point in time that used a cross-sectional design in data collection. In each source, data collection was done only once at one point and was not be repeated which characterized this type of survey. The benefit of this type of survey is that it is simple to undertake and does not allow repletion on the respondents because each respondent was interviewed once in that particular point. Cohort design also used to study the particular cohort of under five years children to understand their nutritional status and the extent to which this cohort is being affected. Various instruments that were used to ensure that information needed from relevant sources were collected. These instruments that were used to collect both primary and secondary data include the following: -

- Mailed self- administered questionnaires were used to collect information from respondents in the Institutions of the Shehia which include health centre, primary and secondary schools, Community Based Organizations (CBOs) and Community Own Resource Persons (CORPs). This instrument was used to collect data in this particular group because they can read and understand the questions in the questionnaires easily than other groups of respondents in the Shehia.
- **In-person interviews** were used to collect information at household level, at clinic, Traditional Birth Attendants (TBAs) and from other members of the community. In-person interviews were administered to those who cannot easily understand the questionnaires, or because of the type of information required especially at household level.
- **Observation** of different places with various activities implemented in the project such as Health days, Maternal and Child Health (MCH) clinic, and Health and Nutrition campaigns were done. Different areas where the project operates were visited to observe various activities taking place. It was important to make observation and collect some information because not all information can be collected at the same way without observing.
- **Record review**: This was done to collect Secondary data from reading reports, publications, health and Shehia records and other relevant documentary sources. This too was used because some information have already been collected and kept in the report and or record forms. To review those documents help the researcher to collect enough information about particular issues.

MAJOR FEATURES OF THE SURVEY

Major features of this survey include the objectives, research design and the techniques that were employed, sampling, data collection, analysis and presentation.

OBJECTIVES OF THE SURVEY

The main objective of this survey was to collect data and information that would enable the researcher to assess the problem of malnutrition and the extent to which malnutrition in the Shehia is being intervened and suggest the appropriate and sustainable way to reduce the problem.

RESEARCH DESIGN

This study employed a cross-sectional design of sample survey method for data collection. Data were collected from different sources by using a cross- sectional survey design, where data was collected at a single point in time for all groups of the population in the Shehia. The method was selected because of the nature and purpose of the survey and several advantages that cross-sectional design have on the survey. Cross-sectional design describes things as they are so that the Shehia can plan according to what the survey reveals and they can change when needs arise. It also has the advantage of being easy to conduct as compared to other. Selection of this design has taken into consideration many issues including the proposal for the intervention to address the problem, consideration on time where as the respondents were accessed within the time limit. It is assumed that cross-sectional design has minimized the time for data collection.

SURVEY INSTRUMENT

Reliable and valid instrument for data collection were used so as to ensure the reliability and validity of the information. Various instruments were employed to collect both primary and secondary data such as interviews, questionnaires and focus group discussion.

- **Interviews** were conducted for collecting data from households and other groups such teachers, health workers and TBAs etc
- **Questionnaire:** Structured and unstructured interviews were used to collect information from the respondents at Shehia and household level. By using this tool information were collected from respondents in the Shehia. Structured and non- structured questionnaires, and open ended questions were prepared and administered at different groups in the Shehia in order to capture information at all level in the Shehia.

CONTENT OF THE SURVEY INSTRUMENTS

There were two types of questionnaires, one mailed questionnaire and other one was a guiding questions for in-person interviews. Mailed questionnaire had about 14 questions while the other one had 10 questions.

The questions in those questionnaires were focused to find out the information about the improvement of nutritional status and the reduction of malnutrition among under five year children. It also looked on the capacity building and sensitization issues in the Shehia. In the mailed questionnaire the types of questions were asking the personal information and then the basic aspect of nutritional improvements, achievements, then type of sensitization and capacity building programmes offered in the Shehia. The questionnaire for in-person interview also had the personal information of the respondent and the questions seeking to know the status of the

children in the households with regards to nutrition. It also asked the respondents accessibility to sensitization and capacity building programmes in the Shehia.

The response of the questions asked in both questionnaires varied from descriptive to Very high, High, Satisfactory and Not satisfactory. Questionnaire 1 had 14 questions described the status of malnutrition in the Shehia of which 5 questions surveyed on experience of respondents in the nutrition issues; 6 questions measured the improvements in nutrition status and the achievements in the interventions, and 3 questions surveyed the capacity of the respondents. Questionnaire 2 has 10 questions of which 5 questions surveyed the practice toward nutritional improvement and 5 measured the capacity of respondents in nutrition issues.

SURVEY METHOD AND DESIGN

This survey is a descriptive or observational in nature which is aiming at generating information on malnutrition which prevails in Jongowe Shehia. This observational design was selected in the sense that it is not meant for experimental or comparative purposes. The prevalence of malnutrition has impacted the community development in this Shehia; therefore the survey tried to describe the extent to which the problem has affected the Shehia and the way it can be intervened to solve the problems identified.

SAMPLE SIZE

This survey applied both probability and non-probability sampling procedures in selecting the respondents which were representative in the community.

- The probability (Simple Random) sampling was used to select respondents from the households where every member of the population had equal chance of being selected

and represented the population of both parents and guardians with under five years children and those who do not have. However the stratified random sampling was employed to select parents and guardians with under five years children so as to capture this age group in the survey which was the target group of the project.

- The non-probability (Purposive) Sampling was used to select respondents from special groups in the Shehia who could provide information in their areas. These include Shehia leadership, Health centre, Community Own Resource Persons (CORPs), Community Based Organizations (CBOs), Traditional Birth Attendants (TBAs) and special groups and people who were selected based on their positions in the Shehia.

  The sample was chosen using simple guessing in all sample units to select manageable sample. The survey targeted respondents from Shehia leadership, health personnel, community resource persons (CORPS) and community members (households) that are the ultimate beneficiaries. All segments of population were represented.

- A sample of 60 respondents was picked from the population in the Shehia. Number of respondents was selected in a representative manner so as to ensure reliability and validity of data collected. The selection of this sample has considered the time limit and resource constraint and manageability.

  A total of 48 respondents were reached which is about 80% of the sample.

- Potential Biases: In the selection of the sample some segments were given too much concern than others and not all segments of the population were represented. The most potential bias is that the survey selected only segments that are directly concerned with child nutrition, while those who do not have any relation were left.

CHOICE OF SAMPLE

Random sampling design was used to select the sample from the population of the target community. For this survey simple random sampling was used to select sample from households and purposive sampling to select a specified respondents such as Shehia leaders, health workers, CORPs, CBOs, and others. The Shehia has the population of 5720 with 2719 male and 3011 female. The under five population is 1430.

From this population, 60 respondents were selected from different groups in the Shehia who could provide information on malnutrition. About 3 respondents were selected from Shehia Council, 3 from Shehia Development Committee to make 6 respondents from the Shehia leadership and decision makers. About 16 household were selected randomly in main four Sub-Shehias: Kigunda, Vuga, Lisani and Kusini. The group of extension workers and staff include 2 health workers, 1 Maternal and Child Health Aide (MCHA), 2 Traditional Birth Attendants (TBAs) and 5 teachers. Representatives from special groups include 5 women, 5 fishermen, and 3 influential persons; while Community Based Organizations (CBOs) were represented by 3 representatives and Community Own Resources Persons (CORPs) were represented by 3 representatives. It was assumed that this sample was representative to all stakeholders in the Shehia.

Table 1: Distribution of Respondents

Sample	Sample Size
Shehia Council	3
Shehia D. Committee	3
House holds	20
Health Workers	3
MCHA	2
Government employee	2
TBAs	3
Influential persons	3
CORPS	3
C B Os	3
Rep of women group	5
Rep of fishermen	5
Teachers	5
Total	**60**

Source: Field Survey, 2006

ADMINISTRATION OF SURVEY

The survey was administered with the support of three CBOs members. The profile of the support staff was good with secondary education, good background and experience in community based programs. They have been involved in the implementation of the Child Survival protection and Development (CSPD) for many years in the community.

The orientation training on the survey administration was done for the survey administrators before data collection for 2 days to give them in a nutshell, the basic understanding of survey administration techniques.

They supported in the distribution and collection of questionnaires to respondents at their places and conduct the interviews in different areas of the Shehia. The whole exercise took one month.

PSYCHOMETRIC CHARACTERISTICS

This discusses the two types of psychometric characteristics- internal and external validity of survey.

INTERNAL AND EXTERNAL VALIDITY OF A SURVEY

For the purpose of ensuring both internal and external validity where by the results produced by this survey apply to the targeted population, and is free of nonrandom error and bias. Techniques and methods which were applied were carefully handled to avoid such error and bias. The selection of the sample was representative and considered all target population. The information that were generated from the survey were also relatively reliable. In order to have accurate information, tools employed in data collection such as questionnaires, interviews questions etc were tested before the actual surveys is undertaken to ensure the validity and

reliability of data. This was done by requesting different groups in the population to respond as pre- tests so as to correct redesign and reflect the language to give the meaning that is understood by the respondents. This was realized through ensuring that the definitions, which were used, are generated out of the grounded facts and established theories and experiences on the malnutrition issue.

(i) VALIDITY

In order to ensure that research instruments really give the intended information, tools were reviewed and edited by nutrition specialist with background and ample experience of nutrition issues at the Nutrition Unit. The specialist went through the instruments to find out areas of corrections and adjustments. After the reviewing process questionnaires were pre-tested before survey administration take place.

(ii) RELIABILITY

To ensure stability of data the questionnaire were pre-tested to some people in the office and in the CBO and to some members of the community before the final administration of the survey. The tools, especially the questionnaires were pre-tested by asking some people to fill them in, and then checked on the understanding of the questions. Minor changes were made to make the questions clearer to the respondents.

DATA PROCESSING, ANALYSIS AND PRESENTATION

This section will discuss the data processing, analysis and presentation and its limitations in the survey.

(i) DATA PROCESSING

The collected data were processed by using scientific methods which include computer software of SPSS and MS-EXCEL programme for coding, classification and tabulation, graphs, charts etc.

(ii) DATA ANALYSIS

A computer software MS- EXCEL and SPSS programme were used to analyze the collected data. Univariate analysis was used for the single variables that comprise computation of frequencies etc and bivariate analysis for the two variables which examine the relationships, correlation, and association of the survey findings.

(iii) REPORTING AND PRESENTATION

Data which were collected and analyzed were presented in the form of a report to the panel by the use of power point and full report will be submitted to the University as a document covering the entire item listed in the table of content.

The report was also presented to the Shehia and District levels where Shehia members and District officials got the opportunity to understand the situation pertaining to the problem that will help them in decision-making process for future actions. Both written and oral presentation methods were used to present the findings.

LIMITATIONS

During the study the researcher was limited by number of factors which to some extent hindered the data collection exercise. Most if the respondents were not reached in time due to some activities in the Shehia which were conflicting with the time scheduled for data collection, including economic, social, traditional and cultural events and festivals like wedding, 'maulid', farming (bush fallowing), which kept busy almost all people in the Shehia. Time and financial constraints had limited the researcher to effectively collect the information as was planned.

1.4 RESEARCH FINDINGS AND PRESENTATION

INTRODUCTION

The research findings and its analysis show how the implementation of the project can affect the life of the people in Jongowe Shehia, children and infants in particular. The presentation of findings has also been discussed in this chapter.

The main objective of this survey was to assess the improvements in nutrition status of the under five years children in Jongowe Shehia and assessed if the objective of the project has been achieved. The survey has tried to look if the malnutrition has been reduced due to awareness created on nutritional issue in the community. Also it assessed if there is capacity among community members to intervene on malnutrition through establishment of a mechanism of community own initiatives. The finding therefore is based in these objectives.

RESEARCH FINDINGS

The study revealed that about 92% of the 60-targeted respondents were reached, of which 48% were male and 52 % were female with the age range between 20 to 60 years. Most of the

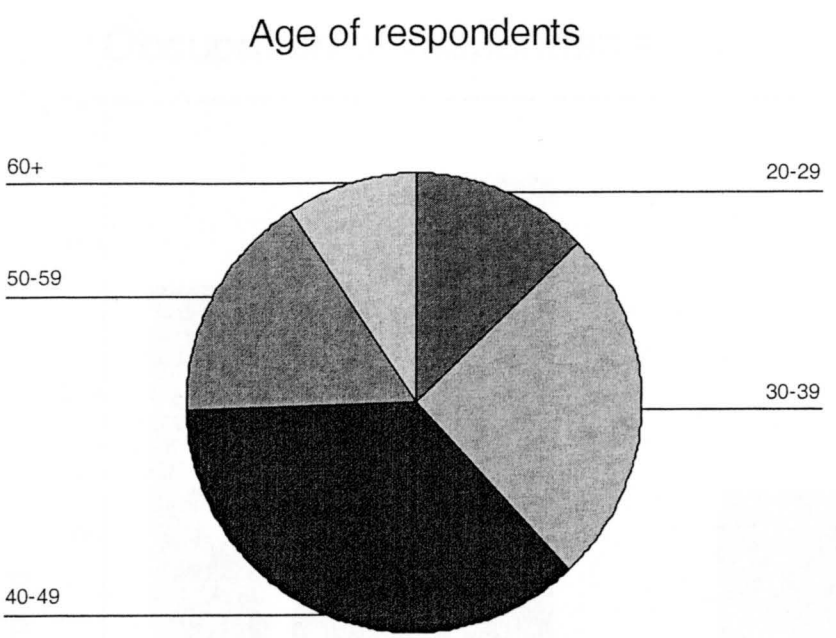
respondents were in the age group between 40 - 49 and 30 - 39 which account to 36 and 26 percent respectively. About 16 percent were in the age group of 50-59 and 13 percent were in the age group of 20-28 while those in age group of 60-69 are only 8 percent.

Table 2: Number of Respondents

Sample	**Sample Size**	**# of respondents**	**% Sample**
Shehia Council	3	3	6.20
Shehia D. Committee	3	2	4.20
House holds	20	16	33.30
Health Workers	3	2	4.20
MCHA	2	1	2.10
Government employee	2	1	2.10
TBAs	3	2	4.20
Influential persons	3	2	4.20
CORPS	3	2	4.20
C B Os	3	3	6.20
Rep of women group	5	5	10.40
Rep of fishermen	5	5	10.40
Teachers	5	4	8.30
Total	**60**	**48 (80%)**	**100**

Source: Field Survey, 2006

Plate 1 Age of Respondents



Occupation and Marital Status of the Respondents

Main occupation in the Shehia is fishing, farming, public/government and small business. The finding show that most of respondents are employed in government sector (33.3%), farming 27% and fishery sector (20.8%) while 10 10.4% housewives and 6.3% are not employed. This might not be a true picture due to nature of respondents accessed. The sample was randomly selected but also stratified to select a particular segment of a population, i.e. teachers, health workers, etc.

Most of the respondents were married (81%) and few are single (6%), divorced (4%) and widowed (8%). Divorce rate is seen to be some how high in the community due to culturally, ethically and religiously accepted and are practiced without restrictions.

Figure No. 1 Occupation of Respondents

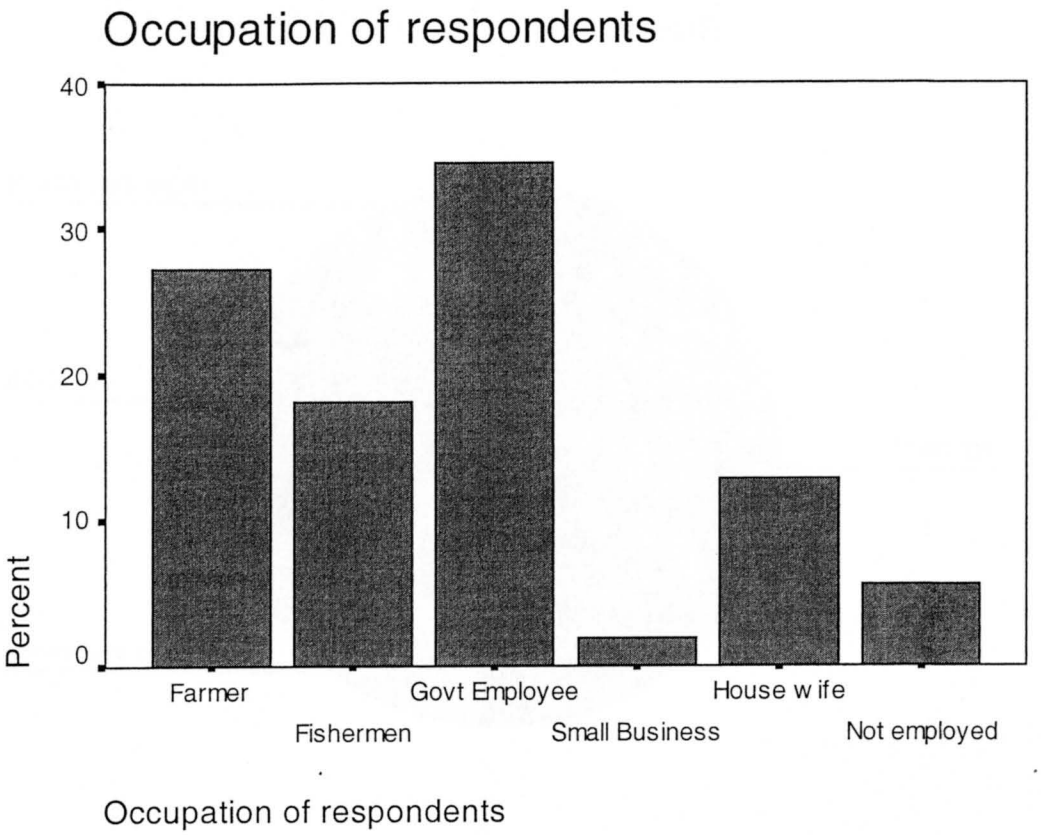
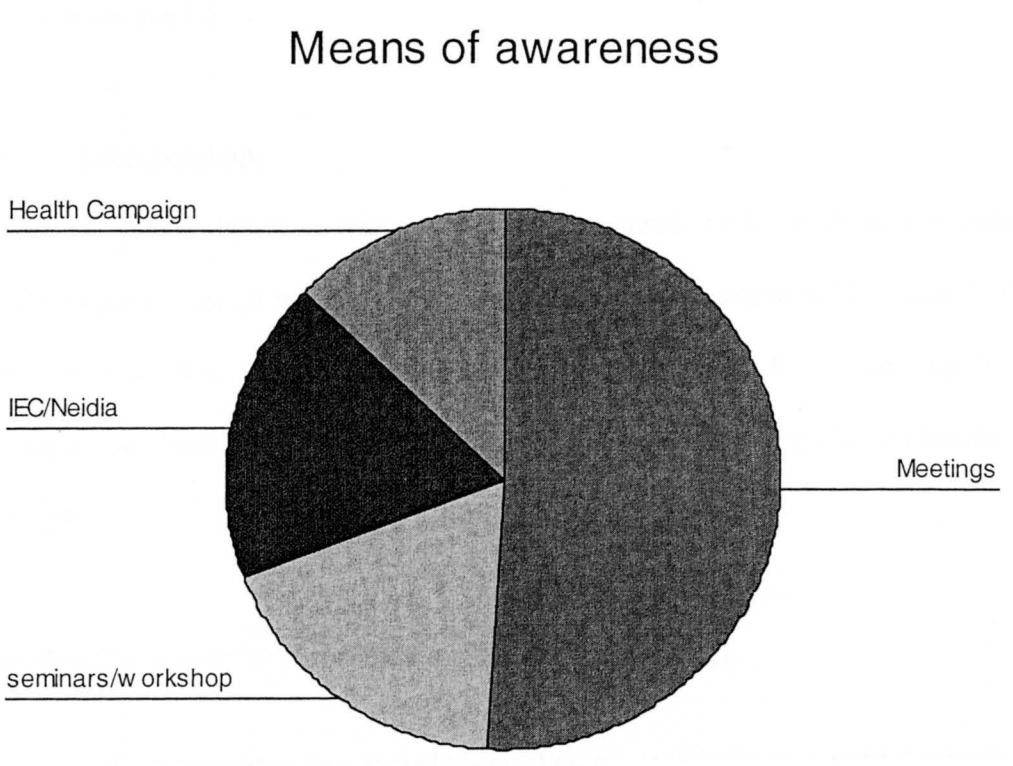


Plate 2 Means of Awareness



Awareness of respondents

Jongowe community is well sensitized on nutrition awareness which has been done by the CBO and other stakeholders such as health centre and the district commissioner's office. About 100% of the Shehia members are aware of nutrition and malnutrition. The awareness creation has been made through meetings, seminars, workshops, IEC/Media and health Education. Many people get awareness through meetings (41%), seminar/workshop (28%), IEC/Media (20.8%) and 10.4% through Health education. Awareness creation is one among the objective of the project. Jongowe Development Fund (JDF) therefore has been very successful in awareness creation by collaborating with other stakeholders including health centre. These sensitization activities are

being undertaken in the community hall and in the Village health centre which is seen in the photograph No 1and 2.

Capacity of Respondents

Capacity to deliver nutrition education is very minimal. 63% of all respondents have no capacity to participate in nutrition education and campaign, whereas 27% have high capacity while 10% have low capacity to deliver nutrition education. Means of nutrition capacity building in the Shehia are through training, workshop, and participating in Health Days and Campaign.

Figure No. 2 Capacity to Participate in Nutrition Campaign

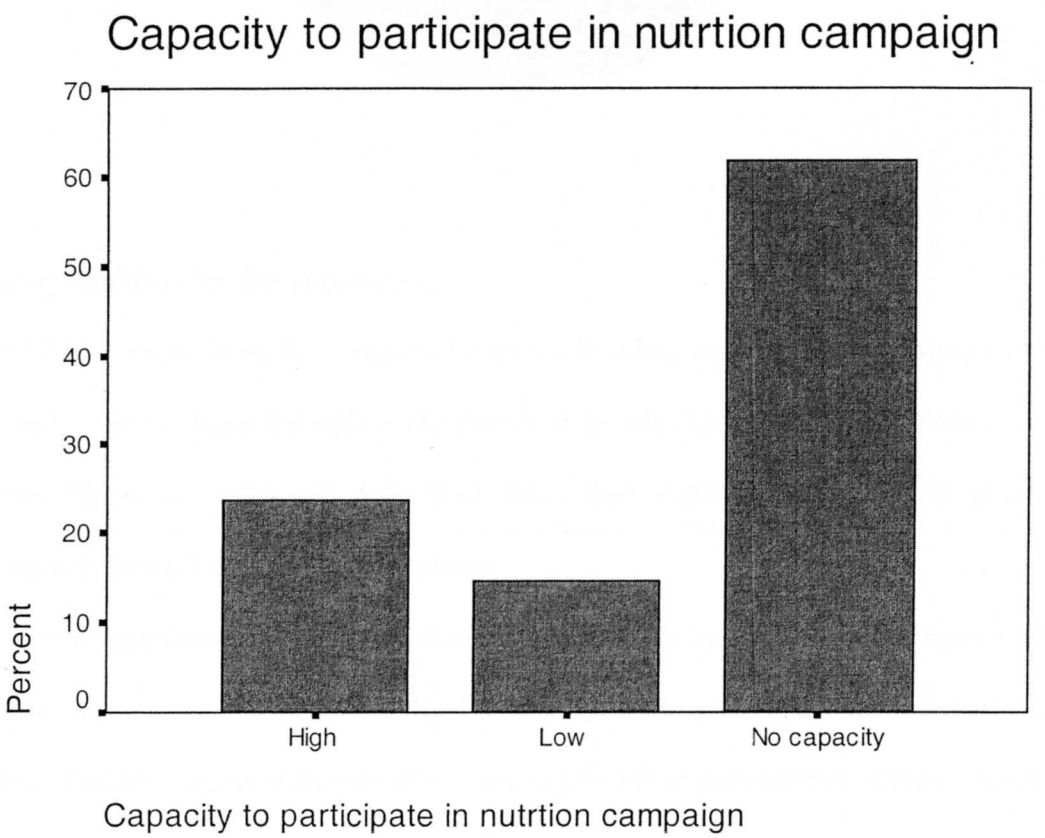
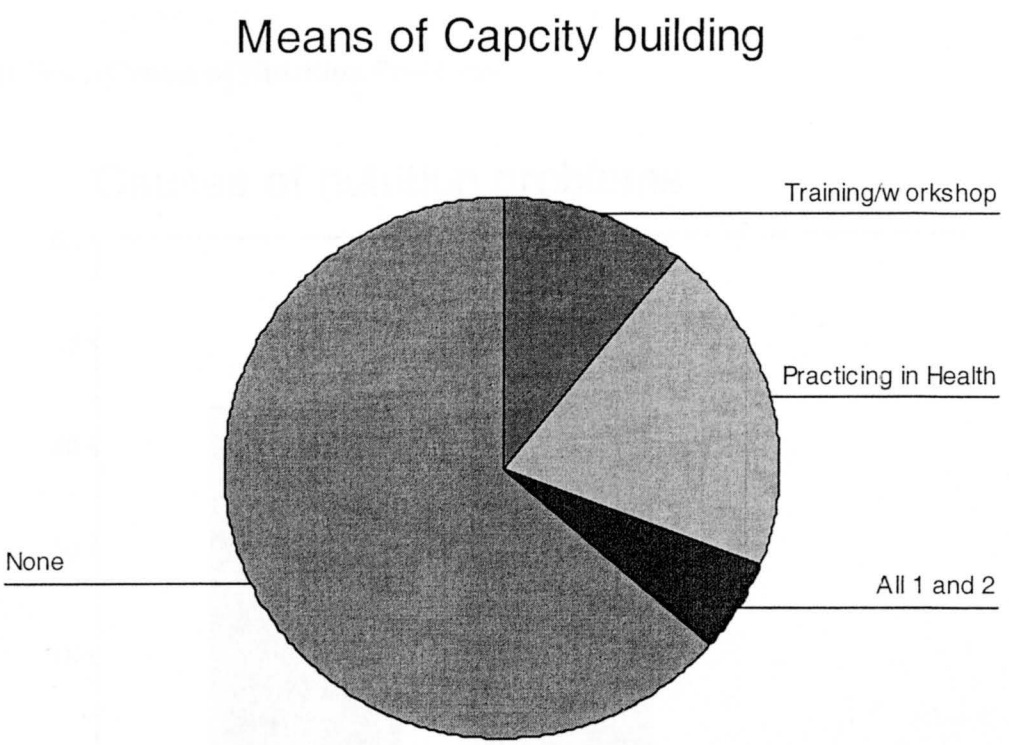


Plate 3 Means of Capacity Building



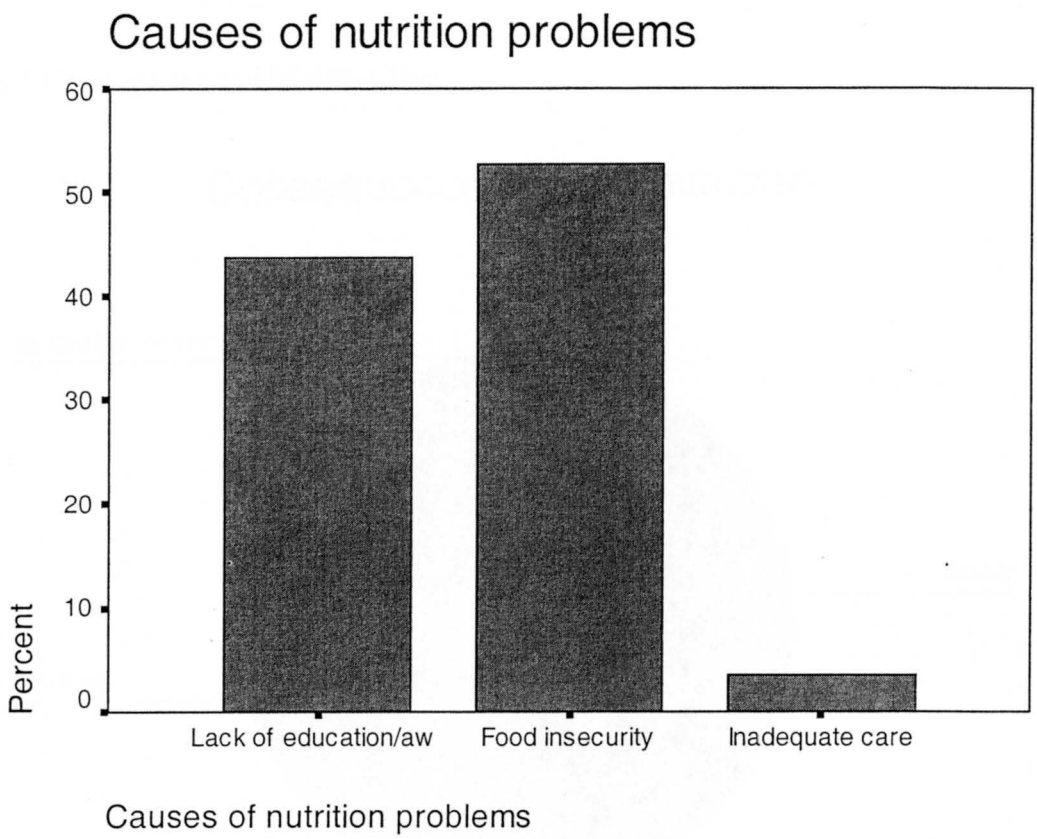
Capacity Building for Respondents

About 10% of respondents have received capacity building training and workshop while 19 % have built their capacity through participation in health days and other activities related to nutrition. There are other 6% who have built their capacity through both training and participating in health and nutrition activities.

Most of the respondents have shown that the malnutrition in the Shehia is caused by lack of education and awareness, household food insecurity, inadequate childcare and frequencies of infectious diseases. Food insecurity is the leading factor of malnutrition which account to 52 percent of the total respondents. This means that food insecurity is highly affecting the

nutritional status of children in the Shehia. The Shehia does not produces enough food thus depends food from main Unguja Island.

Figure No. 3 Causes of Nutrition Problems

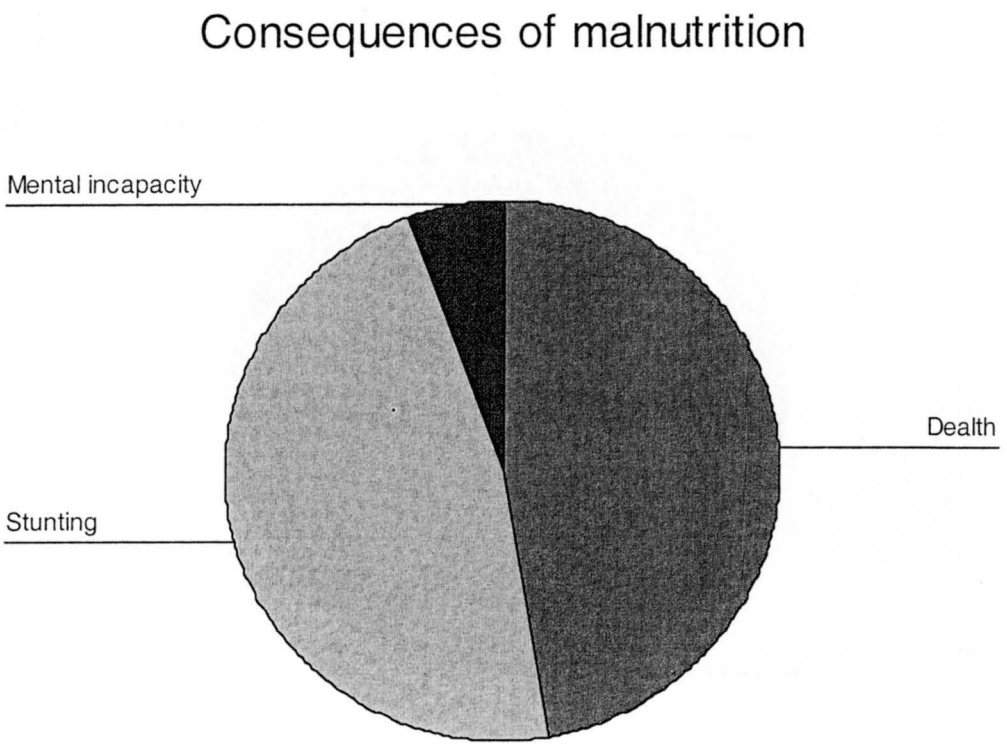


Causes of malnutrition in the Shehia

Lack of education and awareness on nutrition also are highly affecting the status of under five children. About 44 percent of people responded on lack of education awareness as the cause of malnutrition in the Shehia while the remaining said that malnutrition is caused by poor childcare system (4 percent). This indicates that community members recognize the identified factors as the main factors for malnutrition in the Shehia which need to be addressed.

Malnutrition has many consequences in the community which include deaths, stunting and mental incapacity of children. As many as 94 percent of the respondents mentioned death and stunting as the dominant consequences of malnutrition at equal rate of 47 percent, while 6 percent mentioned mental incapacity and disability as other consequence of malnutrition.

Plate 4 Consequences of Malnutrition

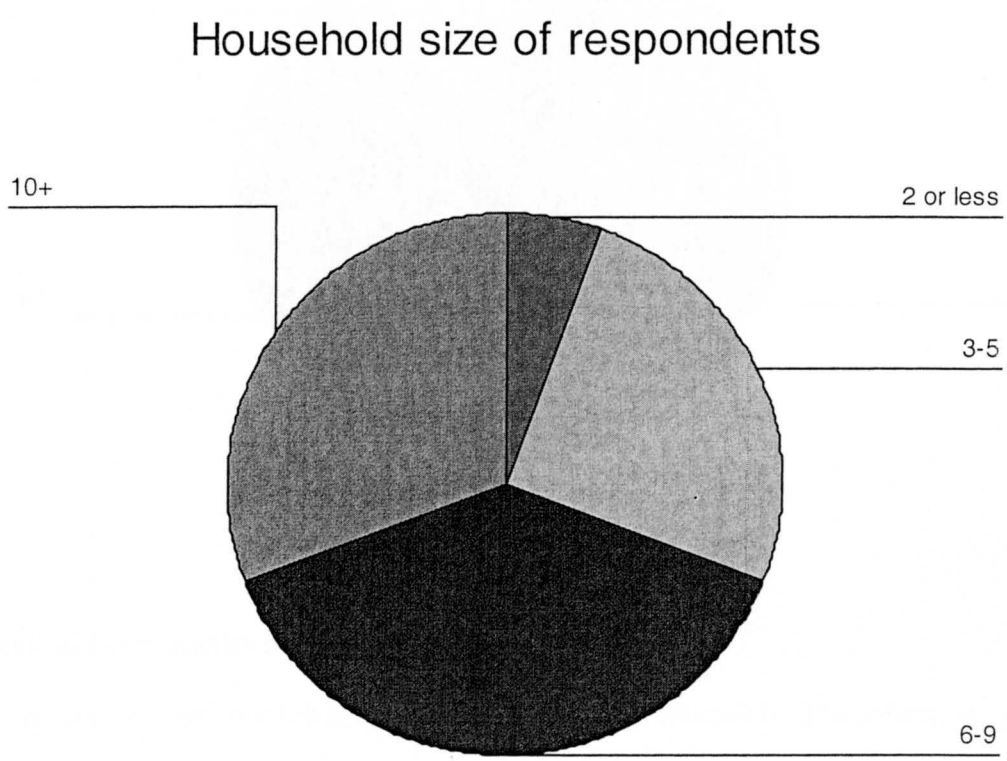


Factors influencing Child Care System

Household size and number of children in the household has been mentioned as factor influencing the care of children in the Shehia. The average household size in the Shehia is 6. About 69 percent of respondents have 6 and over children in their households, and 6 percent have below 2 children while 26 percent have 3 to 5 children and 30 percent have 10 and over

children. Socio economic factors to malnutrition was mentioned by some the respondents when asked to mention and comment on malnutrition in the village. The factors mentioned include education level and occupational status.

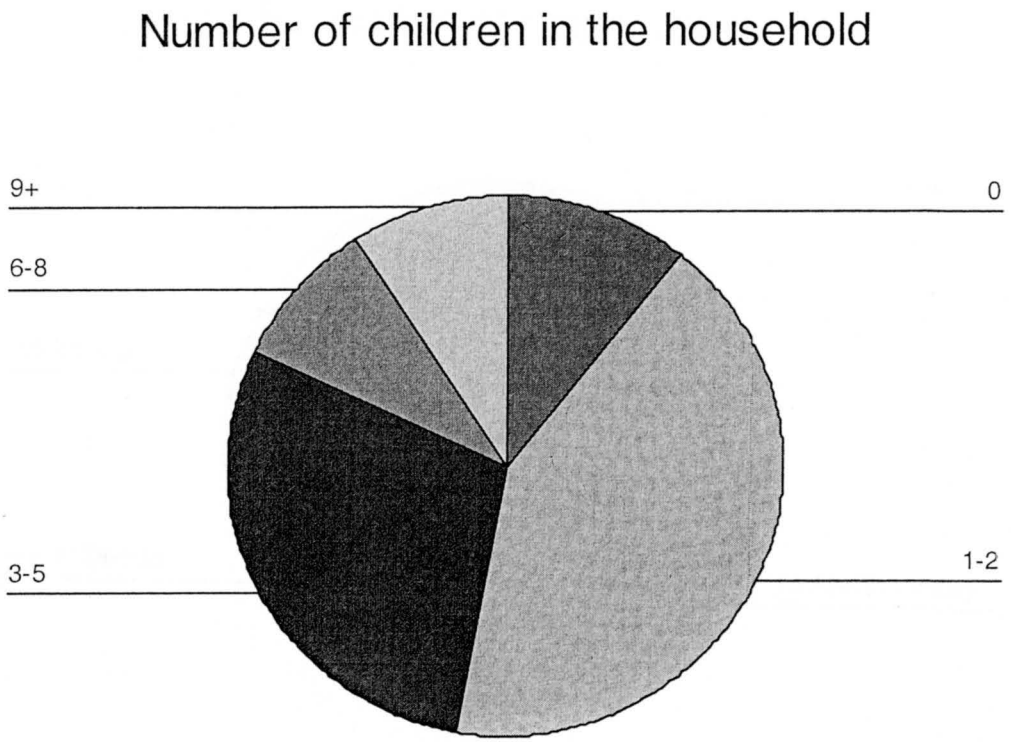
Plate 5 Household Size of Respondents



Number of Children in the Household

Most of households have children of fewer than five years of age which count to 89 percent of total population and as high as 42 percent have 1 to 2 children of underfive years, 29 percent have 3 to 5 children, while only 10 percent of the respondents do not have children of underfive years old.

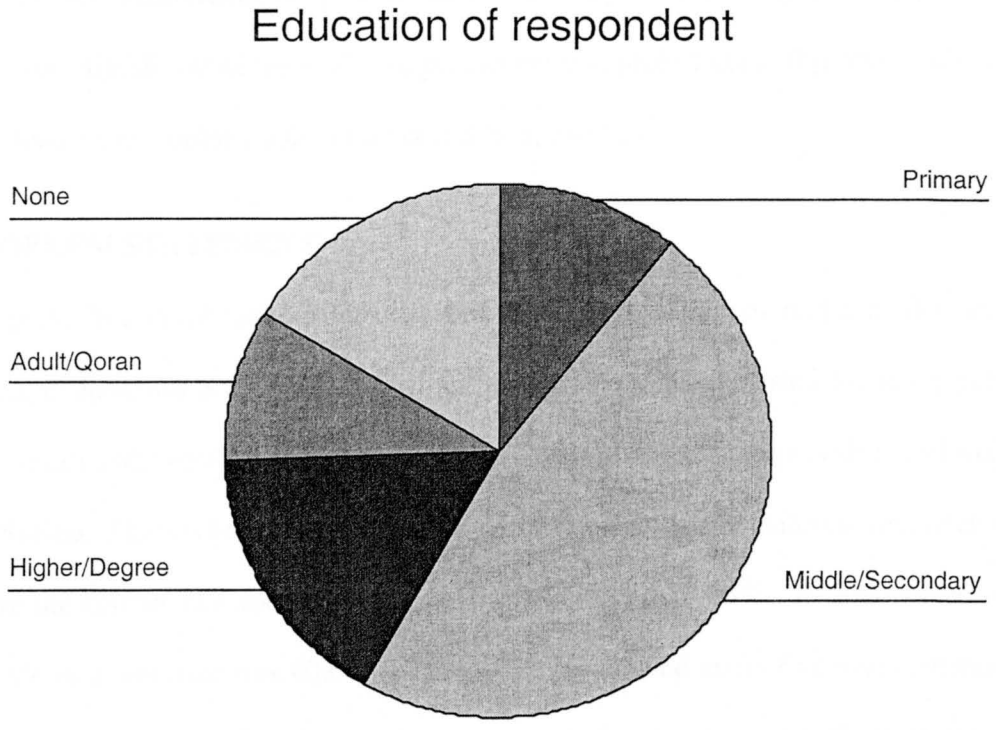
Plate 6 Number of Children in the Household



Education Level and its influence to Malnutrition

Most of the respondents have middle and secondary education. The education policy and system of Zanzibar put the emphasis of compulsory education to all up to middle and lower secondary (Form Two). The findings show many people (47 percent) in the Shehia completed compulsory education wile 16 percent acquire higher education at diplomas /degrees level while 10 percent dropped at primary level. About 9 percent have acquired informal (adult/qoran) education while 16 percent of the population has not attended any kind of formal or informal education. Most of the families with low education have been affected with the problem of malnutrition as compared to those with middle or higher level of education.

Plate 7 Education of Respondents



CHAPTER TWO: PROBLEM IDENTIFICATION

This chapter is discussing the problem identification process and highlighting problem statement, significant of the study, target community, project goal, objectives, research questions, stake holder's collaborators and its analysis.

2.1 PROBLEM STATEMENT

The prevailing child malnutrition has been identified as one of major health concern of the people in Jongowe Shehia. Child malnutrition problem has persisted for many years since the first health and nutrition campaign in 1990, which revealed high prevalence of malnutrition in the Shehia. The severe malnutrition rate of under five year's children was over 9% in 1990 above the district rate and the moderate was recorded over 55%. In 2004 severe malnutrition was 4% and moderate was 40.6% (NAD 2005). Infants and under five years are mostly affected by this problem whereby stunting features are obviously seen, as well as many children die. Many reasons have been mentioned by both community members and the nutrition specialists in connection to this high prevalence of malnutrition.

According to the reports from district and medical offices the feeding patterns and habits are claimed to have caused this persistence of malnutrition in the community. Diseases such as malaria, warms infestations and others are also mentioned as contributors to the problem. Community members have different views, from the male and female side. Female are complaining that long fishing trips outside the Shehia is contributing to the problem which result poor childcare by single parents(female parents). Fishermen in this Shehia take between three (3) and six (6) consecutive months in fishing camps out side their Shehia. Male are complaining of hardship in life led by economic system of the Shehia and the country in general

which is causing food insecurity and poverty in the Shehia. Many efforts have been taken to address the problem but some have not been sustainable such as established small-scale livestock and poultry keeping projects supported by Ministry of Women and Children through UNICEF in early 1990s. Sustainable solution to this problem is needed, which involve the community member like this one which has been identified in participatory manner.

The nutritional situation of the Shehia from 1998 is summarized in Table1.

Table 3: Nutritional status of children in Jongowe Shehia from 1998 - 2004

Years	Registered	Attended	Green	%	Gray	%	Red	%
1998	443	437	172	39.35	228	52	36	8.2
1999	502	480	194	40.4	257	53.5	29	6
2000	546	478	201	41.3	255	53.34	22	4.6
2001	590	510	236	46.3	254	49.8	20	3.9
2002	598	515	244	47.4	251	48.7	20	3.9
2003	615	560	310	55.4	229	40.9	21	3.8
2004	635	552	309	55.97	224	40.6	19	3.4

Source: Jongowe PHCU, 2005

Infants and under five years are mostly affected by this problem whereby their growth is stunting and even causing deaths of children.

The meeting held to discuss the problem with village leaders, health workers and the CBO and the interviews came up with number of reasons for the prevalence of the malnutrition in the village. Among the major causes of malnutrition include, inadequate food security, child care

system-single parental care whereby male parents takes long absence in the village for fishing trips in other areas, frequent illness especially malaria and poverty.

The malnutrition in the village is a social problem, which affect almost half of the population that is why the JDF is concerned. If the problem is not taken in to action to solve it will become more terrible and affect the entire village.

2.2 SIGNIFICANCE OF THE STUDY

The results and findings of this study will help the policy and decision makers, planners and other stakeholders to understand the implementation status and the performance of the project. It will also help to understand factors that contribute to malnutrition in the Shehia and utilize the information in policy formulation, decision-making and planning strategies to improve the child survival, protection and development issues.

At national level the study findings will help the ministries responsible for the coordination of nutrition and in particular the CSPD programme and Nutrition Unit of the Ministry of Health and Social Welfare to plan strategies that will improve the health and nutrition. At district level the findings will help decision makers to plan, strategize and take actions on the recommendations provided by the researcher on how to improve the implementation of the programs. Community and other stakeholders will use the findings to take appropriate measures and actions to improve the nutritional status of the children.

2.3 TARGET COMMUNITY

Shehia of Jongowe particularly under fives children who are suffering from malnutrition are the target community. Jongowe Community has for long time being actively participating in socio-economic activities that touch their lives.

2.4 PROJECT GOAL

The main goal of this project is to have improved nutrition status of the under five years children in Jongowe.

2.5 PROJECT OBJECTIVES

- To reduce malnutrition by 10% from the prevailing rate by 2008.
- To build capacity of community to intervene on nutrition through establishment of a mechanism of community own initiatives.
- Create awareness to the community on nutritional issue in the community.

2.6 RESEARCH QUESTIONS

The survey was guided by the following research questions:

- Has the nutrition status of the under five children have improved?
- To what extent malnutrition is being reduced within the community?
- Is there any capacity building mechanism in place to assist community interventions?
- What is the awareness level on nutrition issues within the community?

2.7 RESOURCES AND STAKEHOLDER ANALYSIS

Resources in all forms are limited in the Shehia especially financial and material. Human resource is available both skilled, semi- killed and unskilled. In the Shehia there are number of skills like trained teachers, health workers, agriculture extension, masonry, fishermen, carpenters etc. There are also other many skills which are not in the Shehia but can be used because they are natives from the Shehia which include planning, administration, agriculture, health, education, environment etc. This kind of human capacities can be used by the CBO. Physical resources available in the Shehia include housing, land, fishing vessels and other gears, boats etc. Among the institutional capacity the Shehia has is the transport facilities (local and motor boats) which ferry people from the Shehia and the Unguja main island.

2.8 POTENTIAL COLLABORATORS

The district commissioner's office with the support of UNICEF is running the Child Survival and Protection Programme (CSPD) in the Shehia which has the similar objectives and target group. The similarities in these two is that the target group is the children of under five years, there is a component of nutrition in the CSPD but in general perspective. The CSPD is mostly focus on the administration of health days at community level and creation of awareness of community members on nutritional issues but what next after is not being done by the programme, it is the community responsibility. JDF is acting on behalf of the community on dealing with the next step which the CSPD has established.

2.8.1 STAKEHOLDERS

The main stakeholders of this project are the District Commissioner's office, District Council, UNICEF, Jongowe Environmental Management Association (JEMA), Health Centre, Nutrition Unit of the Ministry of Health and Social Welfare, Shehia Council, Elders' Council, and CBOs/NGOs.

2.8.2 PROJECT STAKEHOLDERS ANALYSIS

STAKEHOLDER	PARTICIPATION	EVALUATION	IMPACT OF PARTICIPATION	RATE	PLAN
CBO Leaders	Participate in problem design, planning for monitoring and evaluation	High	Positive impact led to writing problem statement	High	Plan to involve them actively through out the project period
CBO members	Participate in Need assessment and defining the community problem. Participate in planning of the	High	Positive impact, Identify list of needs and prioritize major problem for action	High	Encourage providing self help and support the project.

	project.				
District officers	Facilitate the planning process in the community	High	Positive impact, community people were highly encouraged and they are willing to participate in the project.	High	Share responsibilities with Ngo leaders to mobilize and raise awareness of the community
Nutrition Unit	Consult and advice on identified problem	High	Positive impact	High	To collaborate in designing technical issues
Community members	Assist in the identification of need and information about major problems	Medium	Positive impact	Medium	To involve them at all stages of project

Health Centre	Participate in identifying and provided information about the situation	High	Positive impact	High	To cooperate and involve them at all stage of the project
UNICEF	Consult them as the major partner for children issues	Medium	Positive impact	Mediu m	To consult and encourage to support the project
NGO leaders	Participate in problem design, planning for monitoring and evaluation	High	Positive impact led to writing problem statement	High	Plan to involve them actively through out the project period

2.9 SPECIAL CONSIDERATIONS

Jongowe is among the community with high prevalence of malnutrition in the district. The 1990 national nutrition campaign revealed that the total malnutrition rate was more than 50% while severe was 9% beyond the district rate of 7% (GOZ, 1993). This had raised the concern of Government at district and national level whereby a special programme to support the most hard hit areas in Unguja and Pemba to be initiated. The income generating activities were established in communities such as livestock keeping, shallow water fishing, glossaries etc. The programme was not participatory in the sense that the communities were not involved in the need assessment and identifying type of projects. All the projects initiated in the Shehia are no longer in operation. This might be due to many factors including management, organization; planning and technical capacity etc.This project was designed to address the problem of malnutrition considering the past experience so that it would be avoided.

2.10 ASSUMPTIONS

It was assumed that the project goal and objectives would be well achieved if the implementation would be fully accomplished within the time frame and the community participation in the implementation would be realized. The commitment of the CBO members in designing and implementation would also determine the performance of the project. The project achievement was highly expected since it was concurrent with the mission of the CBO.

2.11 MY ROLE IN THE PROJECT

I had been taking an active role in advising and participating in the CBO activities as a technical advisor. In the organization chart of the CBO I'm placed at the executive level to the Executive Director whom I reported to and as his immediate advisor. I had also been taking the role of sharing knowledge and skills of Community Economic Development to the CBO and the community in general.

2.12 EXPECTATIONS IN THE CED CONTEXT

- **Professional achievements:** I took this as a potential learning opportunity that had raised my knowledge and skills during the whole period of my contract in the CBO.

- **Participatory Development**: My expectation during this period was to acquire participatory experience of working with CBOs in the implementation of their work plans at which environment they are working. I had learned many things including their experience in Community Based development activities. I had also shared my experience that helped to improve their activities.

- **Practical Application of CED principles.** This had been a best opportunity to practice and apply the principles of CED in the CBO. I utilized this opportunity effectively for the benefit of parties, the CBO and myself.

CHPTER THREE: LITERATURE REVIEW

This chapter reviews various literatures of different writers, scholars and practitioners on nutrition issues. The review will focus theoretically, empirically and policy analysis that addresses the problem of malnutrition.

3.1 THEORETICAL LITERATURE REVIEW

Many people have different views on the theoretical side of the problem of malnutrition. Some of them have explicitly suggested that the concept and definition is ambiguous. David Seckler (2000)[1] has pointed out that the concept of malnutrition cannot be comprehended except in terms of the economic theory of optimality. "In order to understand what I mean by this statement it is first necessary to understand that malnutrition is an extremely ambiguous word". The Random House Dictionary, for example, defines malnutrition as "lack of proper nutrition". Since proper nutrition is not defined, one must simply assume that it is "lack of malnutrition." As Ford (1964) observes: The term "malnutrition" has been in use for a very long time and appears to be self-explanatory but even the briefest perusal of the vast literature on nutrition raises grave doubt about that. There is no way of knowing if the word has the same significance in all parts of the world or if its interpretation lies, like beauty, in the eyes of the beholder, anything less scientific than this chaotic inexactitude would be difficult to imagine. The problem is that there are two quite different criteria of "proper nutrition" and "malnutrition." Under one criterion proper nutrition is defined as sufficient intake of nutrients to reach the full genetic growth potential of the individual defined by various anthropometrics and nutritional standards. Malnutrition then becomes abnormally "low size" and/or inadequate food

[1] http://www.unu.edu/unupress/unupbooks/80478e/ÿÿ478E0l.htm

consumption. Under the second criterion, malnutrition is defined in terms of certain clinical signs of nutritional inadequacy and/or indices of functional impairment, such as the inability to work productively. Proper nutrition then presumably becomes the absence of these clinical-functional signs of malnutrition. The problem is that most of the people who are not properly nourished under the first criterion are also not malnourished under the second criterion! There exists a considerable gray area, consisting of perhaps as much as 80 per cent or more of the conventionally estimated world of malnutrition, which are neither properly nourished nor malnourished. They are simply "small but healthy" people who have attained an optimum size with respect to their environment.

Cheryl et.al (2001) defined malnutrition as faulty or inadequate nutritional status; undernourishment characterized by insufficient dietary intake, poor appetite, muscle wasting and weight loss. Malnutrition can start before birth and can persist throughout life. Many babies are born with low birth weight and micronutrient deficiencies. Poor feeding practices during the first two years of life have immediate and often long-term negative consequences on growth and development. Nutritional stress during adolescence and the reproductive years affects the health of women and, consequently, the next generation (USAID, 1999).

Malnutrition is considered as one among health problem affecting many under five years children, which is associated with growth of child. Growth is a biological process of childhood. Growth denotes increase in size which may be due to increase in the number of cells or the enlargement of each individual cells or the enlargement of each individual cell. Growth monitoring card is used to indicate the growth of a child. A child is considered malnourished if the growth chart in the growth-monitoring card is below 60% standard weight for age (Ebrahim,

1982). Malnutrition can be assessed into different ways. According to Ministry of Health Zanzibar (1992) the growth of a child can be measured monthly and should be regularly done to monitor the growth properly so as to identify those with good and poor nutrition (malnourished).

It is not surprising that medical and nutritional scientists interpret variations in human growth as the result of variations in health and nutrition. But as Tanner (1978) argues, recent advances in genetics, endocrinology, and other fields involved in the study of growth are creating a fundamentally different view of the process of growth. Tanner recommends that the study of growth should become a field of its own, the field of "auxology," in which health and nutrition contribute a part, but only a part, of the explanation of a far more complex and even sophisticated growth process than has hitherto been contemplated.

The prevailing theory of growth and nutrition may be described as the deprivation theory. Under this theory, it is assumed that every individual is born with a given, genetically determined, potential growth curve. If the individual is healthy and well nourished, he will grow along this curve. Per contra, growth significantly below this curve indicates poor health and/or malnutrition. Of course some people are normally small, and it is difficult to determine if any small individual is abnormally small or not. But in large populations a skew of the distribution curve of size toward the small is regarded as evidence of poor health and malnutrition in that population.

In contrast to this view, there is an alternative perspective which may be called the "Homeostatic Theory of Growth." This theory is based on a substantially different genetic interpretation in which the single potential growth curve of the older view is replaced by the

concept of a broad array of potential growth curves in several anthropometrical dimensions - in a word, with the concept of a potential growth space. Within the bounds of this potential growth space the growing child may be rather indifferently mapped through various paths of size and shape in response to nutritional and other sources of information from the environment (David Seckler, 2000)[2].

The principal instrument of control in the homeostatic process is control over the rate of growth of the child. If nutrient constraints are encountered at a given rate of growth, the rate is slowed to bring nutrient demand into equilibrium with nutrient supply. By thus regulating the speed of internal, physiological "clocks," short-term equilibrium is established and the ultimate size and shape of the adult may be moulded to its environment.

Anthropometrics measurement is commonly used for monitoring weight of children where by nutritional status of children can be detected as follows (King, 1984):

- Weight for age: measures for relative change of weight with age.
- Height for age: used to assess stunting.
- Weight for Height: used to identify the very thin or wasted children.
- Middle upper Arm Circumference (MUAC) used to identify thin and wasted children - a cut point of 12.5cm is used to classify undernourished child.

[2] http://www.unu.edu/unupress/unupbooks/80478e/80478E0l.htm

Table 4: Anthropometrics measurements reference weight for age.

Months	Year	A health child's weight in kg.
Birth		3.5
4		6.3
6		7.5
8		8.9
10		9.3
12	1	10.0
18	1 ½	11.3
24	2	12.5
36	3	14.5
48	4	16.5
60	5	18.5

Source: King, (1984).

Malnutrition has two constituents – the protein energy malnutrition and micronutrients deficiencies. Muller (2005) noted that malnutrition, with its 2 constituents of protein-energy malnutrition (PEM) and micronutrient deficiencies, continues to be a major health burden in developing countries. It is globally the most important risk factor for illness and death, with hundreds of millions of pregnant women and young children particularly affected.

Lisa et al (2000) concur with this and noted that 'malnutrition causes a great deal of human suffering, and it is a violation of a child's human rights. It is associated with more than half of all deaths of children worldwide. People who survive a malnourished childhood are less physically and intellectually productive and suffer from more chronic illness and disability. The costs to society are enormous'. Taras (2005) also wrote on the effect of malnutrition on child education by saying that "children with iron deficiencies sufficient to cause anemia are at a

disadvantage academically. Their cognitive performance seems to improve with iron therapy". On the other hand Malnutrition is perceived as no longer a health problem rather a social problem which needs.

By using the TFNC/UNICEF[3] conceptual framework of the determinants of malnutrition, it is possible to be addressed multisectorally. It distinguishes three major levels of problems and causes related to malnutrition.

Table 5: Analysis of Different Problems and Causes Related to Nutritional Status

Level of problem	**General causes**
a) Immediate causes	i. Inadequate food intake
	ii. Infectious Diseases
b) Underlying causes	i. Inadequate Household Food Security
	ii. Inadequate Caring Capacity and women's control of resources
	iii. Inadequate provision of essential services like health, education, water and sanitation and housing.
c) Basic causes	i. Economic
	ii. Ecological
	iii. Political/Policies
	iv. Culture and beliefs
	v. Institutionnel

Source : TFNC/UNICEF, 2005

[3] www.unsystem.org/scn/archives/tanzania/ch08.htm

Both the level of the problem and the causes are interrelated. It is, therefore, important to stress especially at the level of underlying causes of food, care and essential services that while all three are necessary conditions for good nutrition, none is sufficient on its own. Poverty is the main basic cause of malnutrition worsened in some instances by negative cultural practices despite a favorable political commitment. Thus poor economic situation combined with climatic (floods, drought); environmental problems like deforestation and low production technology all conspire to cause poor food production. The immediate causes and problems are related to low frequency of feeding; low energy density of consumed food staples; and diseases particularly malaria, diarrhea, intestinal worms and respiratory infections. In recent years, AIDS is becoming an increasingly important cause of both child and adult mortality and malnutrition. Intervention measures are constrained by low capacity in service delivery[4].

Lisa et al (2000) suggested that "eradicating malnutrition remains a tremendous public policy challenge. Which types of interventions will have the greatest impact in reducing child malnutrition is a question which needs to be answered by the practitioners, scholars, planners and policy makers". According to Young (2004) Public nutrition is a broad-based, problem-solving approach to addressing malnutrition in complex emergencies that combines analysis of nutritional risk and vulnerability with action-oriented strategies, including policies, programmes, and capacity development. Nutrition vulnerability in Tanzania has been classified accordingly by TFNC[5] as it is shown in the table below with its magnitude.

[4] www.unsystem.org/scn/archives/tanzania/ch08.htm.

[5] www.unsystem.org/scn/archives/tanzania/ch08.htm

Table 6: The Magnitude of the Nutritionally Vulnerable Groups in Tanzania

Description of the vulnerable group		Estimated number of people involved
A.	**Poverty prone groups**	
1.	Rural households with holdings too small to provide sufficient subsistence	700,000
2.	Rural households estimated to earn income below the absolute poverty line	2,000,000
3.	Rural minimum wage earners working on the state farms and estates	150,000
4.	Urban low-income workers, mostly engaged in informal sector activities	600,000
5.	Food growers living in "drought/flood prone pockets" that face "transitory" food insecurity (40% of population)	10,000,000
B.	**Biologically vulnerable groups**	
1.	Pregnant women	1,500,000
2.	Toddlers from six months to three years who are passing through the weaning period	4,000,000
C.	**Geographically vulnerable groups**	
1.	Every person living in iodine deficient areas (40 percent of the population)	10,000,000

Source: World Bank (1988) and TFNC report No.1322, 2005

There are rural and urban variations on the magnitude of malnutrition in Tanzania. Because of the generally low socioeconomic development of the rural areas, all forms of malnutrition are consistently higher in the rural than in the urban areas. The 1991/92 DHS data confirm these earlier observations (table 2). The rural-urban differentiation of the rates of malnutrition hides the observation that in the peri-urban areas and urban slums, the rates are similar to those in the rural areas. It is of particular concern to point out that Zanzibar which is mostly urban has higher malnutrition rates than even rural Tanzania mainland. The DHS data confirm earlier observations that while there is a general trend of an improvement in the nutrition situation in the mainland, the general trend for Zanzibar is one of deterioration. The trend for IMR and U5MR for Zanzibar is one of general decline, contrary to previous estimates which had indicated some increase. However, the inter-censual decline is very small; only of 0.3 per annum compared to 1.9 for mainland. In addressing the malnutrition problem, Shagvi (1999) suggested that 'It is necessary to follow a series of steps to systematically introduce an effective nutrition program in district health services. The steps are assessment of program gaps and identification of partners; capacity-building and health systems strengthening; implementation of a coordinated set of activities in health facilities, via community organizations and workers, and using communication channels; and periodic review and redesign.

3.2 EMPIRICAL LITERATURE REVIEW

In most areas where nutrition programmes have been undertaken the result has been very positive. The WHO (1998) report shows that the impact of programmes on child malnutrition has been modest, even in those programmes considered to have been successful. In Tamil Nadu in India the original integrated nutritional project (TINT) initiated in 1980 reported an annual

reduction in malnutrition of 1.5%. In Iringa Tanzania the severe malnutrition levels (< 60% WFA) dropped from 5%–2 % in four year of programme implementation from 1984 – 1987, in the same period the under weight (< 89% WFA) dropped from 46% - 38%. In the expansion of the original Iringa Project to other Districts of Tanzania between 1985 to 1997 drops in severe malnutrition of between 40% and 90% were achieved (WHO 1998). The Zanzibar 1992 village health days (VHD) have reported the improvement of nutrition status from 37% moderate and 5% severe to the current status of 25.8% moderate and 7% severe respectively in 2000 (Government of Tanzania/UNICEF 2002).

The empirical review in this project will base on the implementation of the programme of Child Survival, Protection and Development (CSPD) in the North A district which has the similar objective of reducing malnutrition, where a tremendous achievement have been made on reducing severe malnutrition among under five years children, between 1990 and 2005.

The main targets for the reduction of child malnutrition were focusing on severe and moderate malnutrition. The targets were set at national wide and each district and Shehia to domesticate accordingly. The first target that is in line with malnutrition is the "Reduction of severe malnutrition to 2% in Unguja and 3% in Pemba."

This target was reached in 2005 in North 'A' district. The quarterly report (January/March 2005) shows that out of 4,619 under 5 years children registered in 6 Shehias, 72% attended in VHD where by only 2% were severely malnourished. In 15 years of CSPD implementation, a tremendous reduction of severe malnutrition has been noted. In 1990 severe malnutrition in the district was 9% while in October - December 2003 was 2.6% and Jan - March 2004 was 3% (North A district report 2005). This indicates that greater efforts have been put in the reduction

of malnutrition in the district. Severe malnutrition has reduced by 7% i.e. from 9% to 2% (Weight for Age). The percentage of children of underfive years with under 60% standard weight for age (WA) in red zone of growth monitoring card has been reduced.

The second target of "Reduction of moderate malnutrition by half (to 17% in Unguja and 19% in Pemba)". The percentage of children of U5 years with 60% to 80% standard WA in gray zone of growth monitoring card reduced. The 2005 report showed that the moderate malnutrition have been reduced to almost by half from 59% in 1990 to 25% by March 2005, in 2003 and 2004 the rate was 33% (North A district 2005). Percentage of well-nourished children (100% WA) has been improved to 74% in 2005 (March 2005) as compared to 37.5% in 1990, 64% in 2003 and 63% in 2004 (North A district 2005).

Table 7 represent some of the empirical data which show the distribution of nutritional information of under five years children in North 'A' District where the Jongowe Shehia is one Shehia of the District. The information indicates the variation of the magnitude of the problem in different areas in the district as a base for policy decisions.

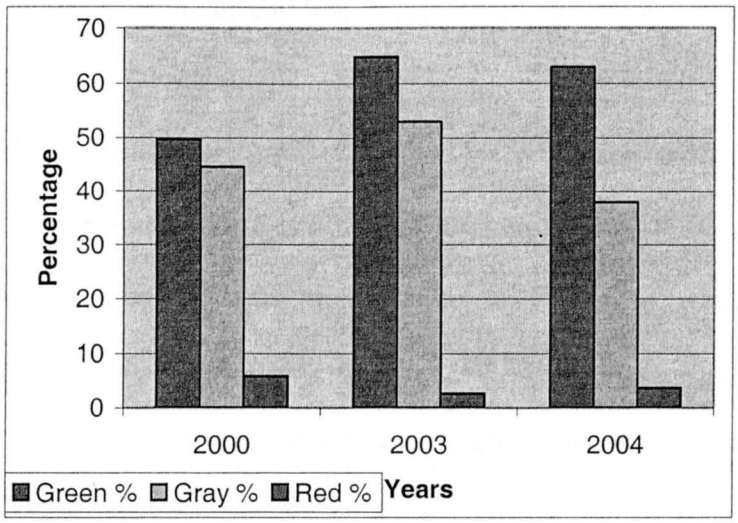
Table 7: Nutritional status by Shehia (Jan March 2005)

Shehia	Registered. Children	Attendance		Nutritional status					
		Total	**%**	**Green**	**%**	**Grey**	**%**	**Red**	**%**
Gomani	998	947	95	581	61	340	36	26	3
Kigunda	330	313	95	208	66	100	32	5	2
Nungwi	1081	590	55	499	76	134	23	7	1
Kijini	510	428	84	342	80	81	19	5	1
Matemwe	1350	639	47	545	85	83	13	11	2
P/Mchangani	350	195	56	146	75	46	24	3	1
TOTAL	**4,619**	**3,112**	**72**	**2,321**	**74**	**784**	**25**	**57**	**2**

Source: North A district, 2005

The Figure 1 is representing annual variations of nutritional status in the District. Nutritional status in the district has shown improvements as indicated in tables 1 and in figures 1. Number of children in green has increased and those in red reduced. Children with below 60 % WA have reduced and with 60 % to 80% WA has increased as well as that of 100% weight for age.

Figure 4: Nutritional Status of U5 years children in North A district



Source: North A District, 2005

3.3 POLICY REVIEW

The United Nation Assembly adopted the convention on the Rights of the Child in 1989 and in 1990 the Organization of African Unity (OAU) now African Union (AU) adopted the African Charter on the Rights and Welfare of the Child. According to the Article 5 of the Convention, the rights of survival and development is among the basic right of the children which has specifically elaborated in Article 24 by ensuring an appropriate pre-natal and post-natal health. Article 5 of the OAU states the right of survival, protection and development of child (UNICEF Tanzania office 2003).

The Government of the United Republic of Tanzania ratified the convention on the Right of the Children in 1991, while the Zanzibar government domesticated it on 3rd September 1991 in the House of Representatives, Wete Pemba. In September 2000, at the United Nations Millennium Summit, world leaders agreed to a set of time bound and measurable goals and target which is the Millennium Development Goals (MDGs) In implementing Goal 4 of reducing child

Mortality, The United Nations in its Millennium Development Goal (MDG) has set target of reducing deaths of children at risk of dying before five years by two third to be achieved by 2015 (UNDP 2000).

The Zanzibar policy for child survival, protection and development (CSPD) has outlined the malnutrition problem is affecting rural areas more than urban. It further identified poverty as basic causes of malnutrition of children in Zanzibar, which limits children's right to physical, mental and psychological development. This situation is inhibiting the Zanzibar government capability to provide prevention, protection; education, health, and welfare services for children. One among the challenge for the government and the community of Zanzibar is to identify and analyze the causes and consequences of poverty. The strategic policy statement for children is to ensure that their welfare is improved physically, mentally, economically and socially by formulating strategies to raise their nutritional status and community awareness on child nutrition (GOZ 2001). This policy statement together with international convention on CSPD such as Convention on the Rights of the Child (CRC) has given the government, Non Governmental Organization NGOs and Community Based Organization (CBOs) opportunity to plan and implement programmes and projects for the welfare of children.

This project is an attempt of the JDF to implement this policy as one of stakeholder. The policy implications of this conventions and analysis can be addressed in terms of theoretical, empirical as well as policy framework globally and locally. Global policy implication can be addressed in terms of three distinctions "Worlds of Nutrition." World 1 consists of "properly nourished" people as defined by received anthropometrics and nutritional standards. World 2 consist of people who are not properly nourished but who are also not functionally impaired. The

available evidence indicates that these small but healthy people have been able to adapt their size - and, therefore, their consumption requirements - to less than standard levels without suffering adverse effects. World 3 consist of people who have been pushed below the threshold of adaptation. These people are small, undernourished even for their size, and functionally impaired.

Roughly speaking, world 2 corresponds to MMM people comprising 80 to 90 per cent of all people not of world 1, with the balance of world 3 people either at the severe level of malnutrition, or in clear and present danger of severe malnutrition From a policy point of view the crucially important distinction between worlds 2 and 3 is that needy people in world 2 can, while those in world 3 cannot, work if given the opportunity. I believe that food-for-work programmes (FFWP) should be the principal instrument of policy for world 2. These programmes should be integrated with clinical programmes that provide nutritional and medical care and job training to world 3 people so that they can be enrolled in FFWP when they are in condition to work.

The great advantage of FFWP is that they provide both an effective means of excluding less needy people from the income benefits of food aid and a permanent improvement in the economic environment in which these people must live. Since people must do hard manual work in FFWP only the most needy will enroll. Since FFWP creates permanent community assets in the form of roads, schools, hospitals, drinking water, irrigation, and the like, they lay a basis for sustaining the improvements created by food aid. FFWP also provides a mechanism for eventually liquidating the clinical programmes necessary for world 3 people. In my opinion, all other programmes, such as school lunch programmes and supplemental feeding programmes

for at-risk groups, should be used only as a last resort when there is good reason to believe that the FFWP-based programme is inadequate.

CHAPTER FOUR: IMPLEMENTATION

This chapter will discuss and analyze the implementation of the project which include the implementation plan and present the framework and matrix which show the activities/output/ outcome, implementation schedule, analysis and discussion of the findings with charts and figure illustrating the research findings.

4.1 IMPLEMENTATION PLAN

The implementation of this project started in the fiscal year 2005/2006 with the assistance from district commissioner's office by CSPD program. It is expected to have a life span of three (3) years. Main activities of the project are:

1. Sensitization of different groups such as women, youth, fishermen, teachers, key informants (Sheikhs, TBAs, Influential persons) and CBOs;
2. Building capacity of Community Committees (CC), CBOs, Health Workers (HW) and CORPs on Assessment, Analysis and Action (Triple A cycle);
3. Improving the Community Based Information Management System (CBIMS); and
4. Coordination, Monitoring and Evaluation

The implementation plan is presented into two levels:

1. Planning and implementation which comprises two categories
    - Activity /Output / Outcome,
    - The project-planning schedule,

4. 2 ACTIVITY /OUTPUT/ OUTCOME – FRAME WORK

ACTIVITIES	TASK	EXPECTED OUTPUT	EXPECTED OUTCOME	INDICATOR
Sensitization of community on CSPD and Nutrition problems	- Conducting meetings with groups,CBOs and key informants -Conducting seminars of groups reps and key informants	Meetings conducted Seminar conducted	Community sensitized and children's problems are recognized.	Number of meetings conducted Number of seminars conducted Number of participants attended
Capacity building on Triple A cycle	-Training of CBOs, HW, CORPs -Study visit to learn best practices from other Shehias	Training conducted Visit conducted	Trainees capacitated and apply triple A to solve their problems	Number of groups and people trained Number of visits conducted
Improving CBIMS	-Training of CBOs, HW, Corps, teachers -Provide tools and equipments for	Training conducted Tools and equipments provided	Trainees capacitated Number and type of tools and equipments provided.	Number of groups and people trained

	VHD,and Shehia registers -Supervise Village Health Days activities	-HVD supervised	VHD activities improved. Efficient data collection, processing and utilization	Number of VHD conducted Types of information recorded
Establish Coordination, Monitoring and Evaluation mechanism	Monthly and or quarterly meetings with stakeholders Participatory Monitoring and Evaluation of the project	Meeting conducted Participatory M&E established	Coordination and Monitoring System improved,	Number of meetings conducted Number of people participated in the

This project-planning **framework** summarizes the steps in the planning the project implementation trend which include activity and the task in each activity. It also shows the output and outcomes of the activity with their indicators that indicates the performance of the activities in the implementation plan. The planned activities for this project include the sensitization of CSPD and nutrition, capacity building, improving CBIMS and Monitoring & Evaluation.

4.3 PROJECT ACTION PLANNING

This project was designed based on the project planning cycle technique that involved different stakeholders in the Shehia. It went through the common steps in project planning with participatory approach from the identification stage, planning, and implementation to Monitoring and Evaluation. The summary below show the Action plan of the project indicating of activities is presented in the matrix bellow.

4.4 ACTION PLAN MATRIX

ACTIVITIES	TASK	RESPONSIBLE	TIME FRFAME	BUDGET(TS)
Sensitization of community on CSPD and Nutrition problems	-Conducting meeting with groups,CBOs and key informants -Conducting seminar of groups reps and key informants	Secretary Secretary	Feb- March 06 March 06	73,000.00 330,000.00
Capacity building on Triple A cycle	-Training of CBOs, CC, HW, CORPs -Study visit to learn best practices from other Shehias	Executive Director	April –June 06	2,265,000.00 463,000.00
Improving CBIMS	-Training of CBOs, CC, HW, CORPs, teachers -Provide tools and equipments for VHD,and Shehia registers -Supervise Village Health Days activities	Executive Director	July-Sept 06 July–Sept 06 Sept 06 – Dec 07	2,265,000.00 500,000.00 675,000.000
Establish Coordination, Monitoring and Evaluation mechanism	-Monthly and or quarterly meetings with stakeholders -Participatory Monitoring and Evaluation of the project -Final Evaluation	Secretary	Feb 06- Dec 07 Feb 06- Dec07 Dec 07-Jan 08	400,000.00 1,000,000.00 1,800,000.00

The Action Plan framework show activities of the project and the tasks of each activities with the responsibilities for each of the activities planned in the project so as to make close follow up the implementation. The Action Plan also show the time frame in which the activities to be covered with the estimated budget for each activity that covers the cost of each activity and task in the project life. These was planned so that it helps in tracking the project implementation and make the Monitoring and evaluation of the project done according to the project design.

4.5 IMPLEMENTATION PLAN FRAMEWORK

ACTIVITIES	TIME FRAME 2005/2006											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Sensitization of community												
Capacity building on Triple A cycle												
Improving CBIMS												
Coordination, Monitoring and Evaluation												

ACTIVITIES	TIME FRAME 2006/2007											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Sensitization of community												
Capacity building on Triple A cycle												
Improving CBIMS												
Coordination, Monitoring and Evaluation												

ACTIVITIES	TIME FRAME 2007/2008											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Sensitization of community												
Capacity building on Triple A cycle												
Improving CBIMS												
Coordination, Monitoring and Evaluation												

The implementation plan show the timing of each activity, the period when each activity was and will be done. This p is a three plan stared its implantation in 2005/2006 fiscal year and is expected to phase out in 2007/2008n fiscal year. It can be extended in another period to be determined by the stakeholders in the community which include JDF, District Commissioner's office, The Community and others. There are four main activities in the project that were planned including sensitization of community which took place in the period of first seven months of January to July 2005. Capacity building on Triple 'A' cycle i.e. Assessment Analysis Action on health and nutrition took place in April to July 2005 and April to June 2006 and in 2007. Other activities for Improving Community based management System (CBIMS) where the Village Health Days (VHD) are being conducted at dispensary and at Sub-Shehias in quarterly bases throughout the year, together with monitoring of the project implementation. Evaluation of the project was done once and is expected to be done again after the completion of the project.

Monitoring, Evaluation and Sustainability (M, E&S) chapter discuses these three aspects of the project in the project planning cycle. Monitoring part dwells with the purpose of the monitoring and its key principles, monitoring plan, indicators, methodology used in data collection in monitoring and its findings. The evaluation sub-chapter deals more on the purpose of evaluation, types and methodology used in data collection during the evaluation exercise and its findings; while sustainability sub-chapter explains the major aspects of sustainability in the context of this project.

5.1 1MONITORING

5.1.1 PURPOSE OF MONITORING

Monitoring of the program or project is to monitor the development of a program/project as a whole, and of its components:

- In relation to changes in the context and circumstances of their implementation;
- In regard to goals, time lines, and any unforeseen circumstances that may occur;
- To implement a rapid problem identification system as well as a system for internal communications to the various stakeholders;
- To facilitate evaluation procedures during and after activities, through the definition of specific indicators.

The monitoring aspect of the project is emphasizing on development of monitoring system within the CBO which will involve three levels- Project level, Management and Organization level. We emphasized the essential role of monitoring at all stages of the project implementation. This monitoring system is still in its early stages of development. Efforts have been made to coordinate the various systems of data collection, analysis and dissemination. These efforts include the

creation of monitoring officer within the CBO responsible for networking and bring together the various data producers and users to discuss how the current system could be improved to better meet the project and users' needs. Efforts also include the development of indicator databases designed to track wide variety of project monitoring input of result.

5.1.2 COMPONENTS OF MONITORING

This monitoring system will focus on the key principles for project to be successful:

- Community ownership: The participatory process for defining and designing the monitoring system should be led and owned by community stakeholders. This ensures that the monitoring system is appropriate for the community project's individual needs, and will enhance its impact on policy decisions and advocacy.
- Accountability: A strong monitoring system enhances stakeholder accountability by providing evidence that can be used to evaluate project and guide debate for measuring the success of the project.
- Coherence and efficiency: Different stakeholders of the project implement various activities in different areas of the Shehia and they develop their own monitoring system whether formal or informal system of monitoring that reduces duplication of efforts and enhances the coherence and scope of data, and link with national efforts.
- Prioritization: Our inclusive monitoring system allows stakeholders the opportunity to define common priorities and allocate project efforts and resources accordingly.

5.1.3 MONITORING PLAN

Categories of Information	What to Monitor	What record to keep	Who collect data	Who use data	Results/Remarks
Work plan Activities	Implement ation of the project activities	Meetings,Trainings, VHD reports	Project Team, HWs, CORPs	Stakeholders	The plan implementation is going on well
Resources	Utilization	Income/expenditure /supplies	Treasurer/Cashier/Store keeper	Stakeholders	Better utilization of resources has facilitated the output/outcome of the project
GMP	Child growth	Child weight	MCHA	Stakeholders	Child weights/growth monitoring reports is showing improvements

This monitoring matrix summarizes the key aspects in monitoring and what the monitoring team was doing in the implementation of the project. With the support of monitoring indicators the monitoring team had been collected different information pertaining to project implementation based on project components or planned activities. The information gathered were focused on activities or work plans, resources and growth monitoring of underfive children which was categorized as the focus of the project performance that would also help in the evaluation process. In each of these categories, there were number of questions or issues the team wanted to know these were: what to monitor, what records to keep, who collect information/data, who are the users

of information/data and recommendation in each category. This matrix helped the team to have an insight before the exercise and made it successfully.

5.1.4 MONITORING INDICATORS

In the course of project implementation the project management with the project implementation team developed indicators that were used to measure the project performance, effectiveness, efficiency and impact of the project. In monitoring the project at various stages, the linkages between inputs, outputs, outcomes and impacts became clearer, and we could identify whether policy change and resource became clearer, and resource reallocation would be in order. Some important indicators considered were intermediate and final indicators: input, output and outcome/impact indicators.

5.1.5 INDICATORS

- Attendance of children in clinic , health days,
- Child weight and height for age,
- Weight at birth (under weight or normal),
- Types of mechanism in place,
- Number of community members participating in the program,
- Household food pattern,
- Number of Health days conducted,
- Number of meetings conducted,
- Number of seminars and workshop conducted,
- Percentage increase in nutritional status, and

- Mortality and morbidity.

5.1.6 METHODOLOGY AND DATA COLLECTION

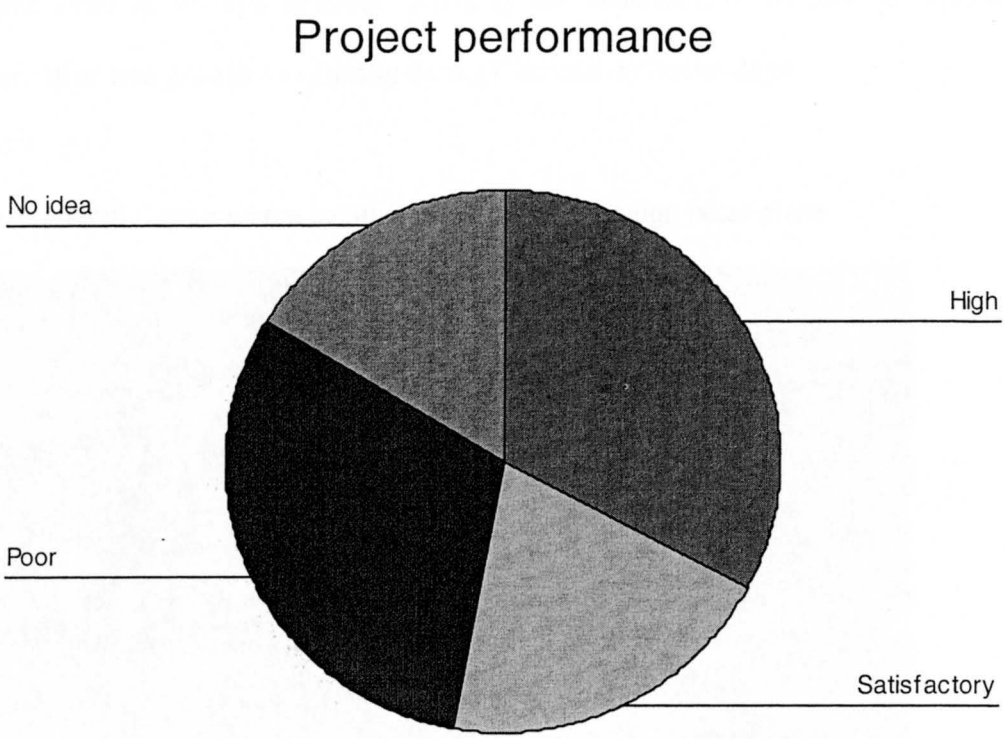
Monitoring of the project is a continuous process which assess the performance of the project implementation or to monitor the development of a program/project as a whole, and of its components. The methodology used to assess the performance of this was survey and the tools used included the following:

- Interviews were conducted for collecting data from project implementers such teachers, health workers and CBO members.
- Questionnaires: Structured and unstructured questionnaire were used to collection data in he community and institutions implementing the project.
- Observation: This involved the observation of different places with various activities implemented in the project such as Health days, MCH clinic, Health and Nutrition campaigns etc as shown in the clips. Different areas where these project activities are operated were visited to observe various activities, discuss with beneficiaries and implementers. Data were collected using group meetings, interviews, checklists, open-ended stories, and others.
- Documentary sources: Project status reports, implementation report were used to collect project progress and its performance.

5.1.7 FINDINGS

The findings have revealed that there was a progress of the project .Most of the respondents appreciated the program performance whereby 33% ranked high performance of the project while 31% ranked low performance. About 21 % of respondent have said that the project performance is satisfactory and 14% have no idea of the project performance.

Plate No 8



Project Performance

One of the issues that were discussed during the survey was the project performance. The finding has shown that people' perception on the project is performing well whereby more than 54% of

people have recommended that there are changes due to the implementation of health and nutrition activities.

The progress and performance of the project was assessed in different ways including observation. The photos below show the implementation in various areas of the project in the Shehia. They indicate the different activities such as nutrition campaigns at the health center, health days where different child health and nutrition activities are undertaken. The pictures also indicate child immunization and growth monitoring during Community health days.

Photo 1: Health Centre where health and nutrition campaign takes place

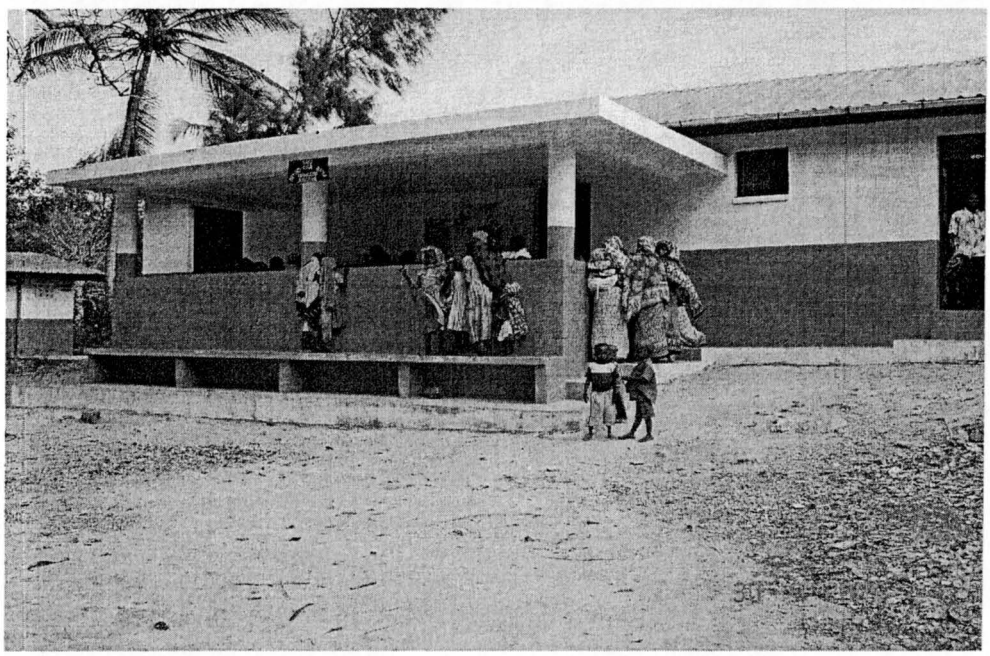


Photo 2: One of Health day in the Shehia Health Centre

Photo 3: Child Immunization against diseases

Plate 4: Child Immunization against diseases

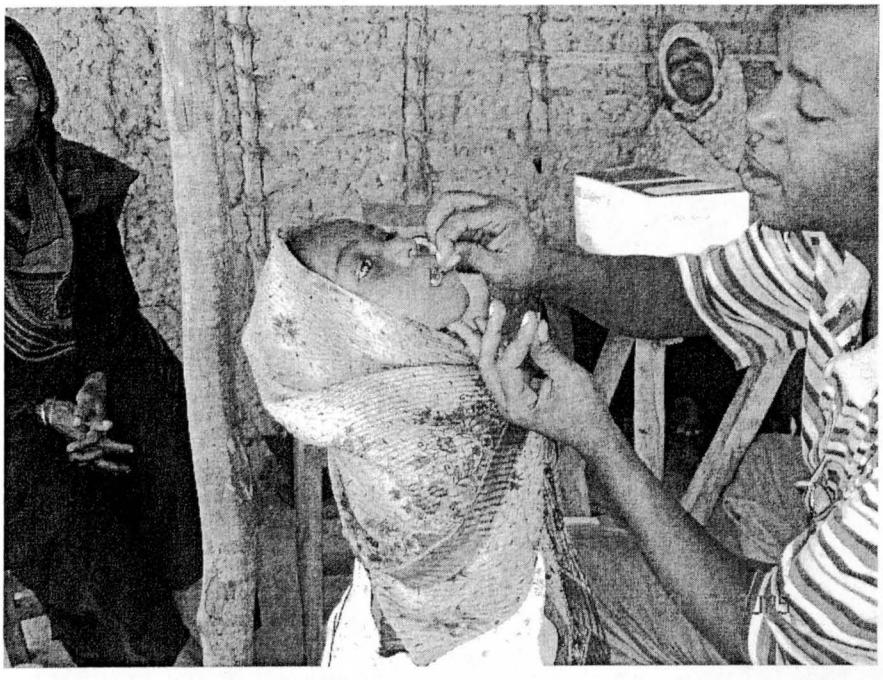
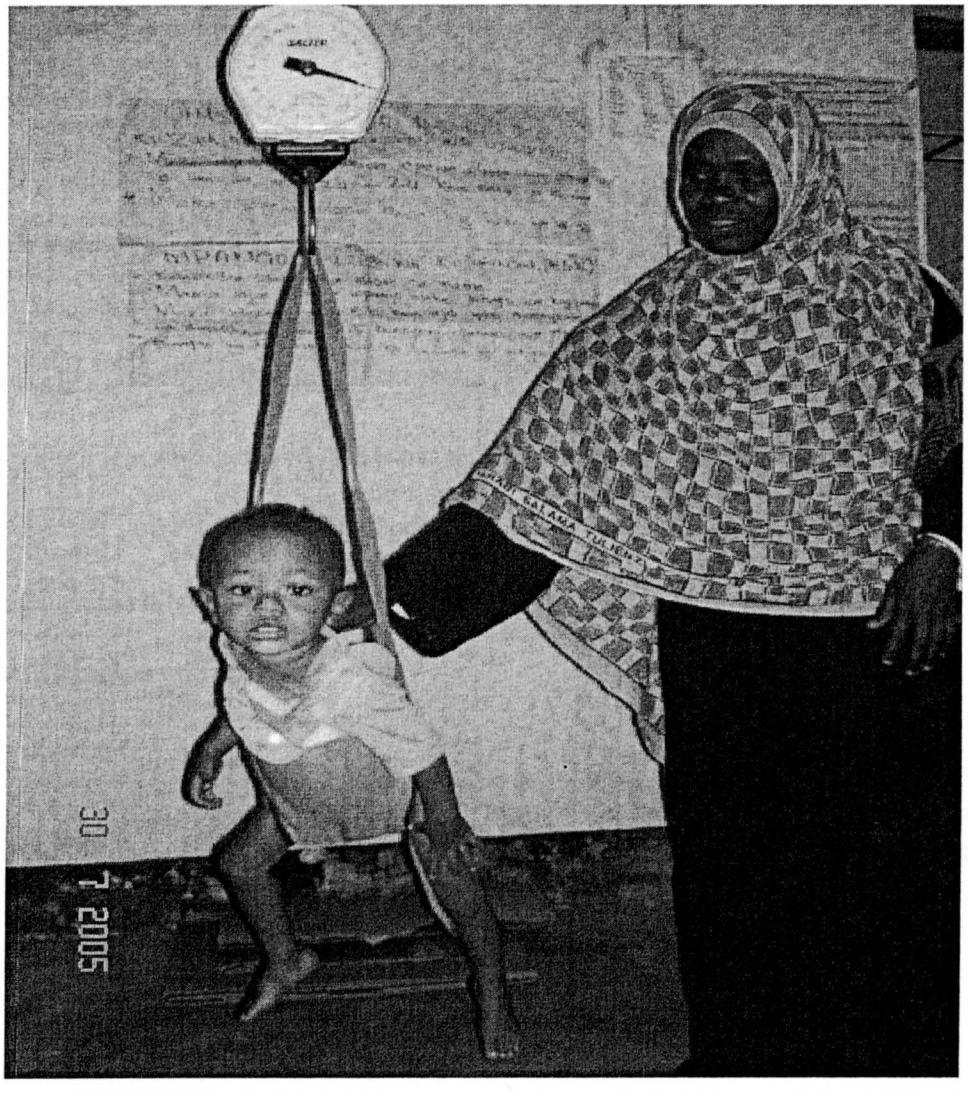


Plate 5 Child Growth Monitoring for Nutritional status



5.2 EVALUATION

The project evaluation was planned to be conducted during and after the project implementation (mid-term and terminal evaluation) by the evaluation team formed by the CBO leadership. Evaluation was participatory so that all stakeholders understand the project status and the monitoring results will be used to serve an evaluation functions. The exercise is expected to improve the project design and planning, and can set the stage for evaluation activities throughout the project cycle. Evaluation exercise ensure that the project is addressing the relevant development problem and that it has a clearly defined purpose, as these two attributes are important for enhancing project performance and facilitating the project evaluation activities. It is emphasized that, during the project design stage, some of the more vital aspects put into consideration are:

- Establishing a clear understanding of the development problem;
- Building into the project design lessons from previous similar operations; and
- Setting the stage within the project design for effective evaluation both during the monitoring and ex-post stages.

The evaluation involved the project team and other members of the Shehia to assess the project results in relation to the problem of malnutrition and how the community has benefited due to the implementation of the project. They will also measure the impact of the project after its termination. The evaluation has been considering two main important types of evaluation – formative and summative evaluation.

Formative evaluation focused to assess the organizational context in terms of delivery of the programs in the areas of personnel, procedures, and input for implementation of the project.

Summative evaluations examined the effects or outcomes of some object, describes what happened subsequent to delivery of the project, determining the overall impact of the causal factor the immediate target outcome.

5.2.1 METHODOLOGY

- The project evaluation exercise was intended to improve the project design and planning, and set the stage for re-planning activities throughout the project cycle. The project evaluation was planned to be undertaken into different stages in assessing the output, outcome and impact of the project. The methodology used to assess the intermediate project results was through survey and observation methods which involved the interviews of parents and observation of child weights in growth monitoring cards in their homes and at MCH clinic during and after growth monitoring sessions. Documentary sources were also used to gather information from monthly and quarterly reports on nutritional status and child health.

5.2.2 TOOLS USED IN DATA COLLECTION

- Interviews were conducted for collecting data from different stakeholders and beneficiaries.
- Questionnaires: Structured and unstructured questionnaire were used to collection data in he community and other stakeholders.

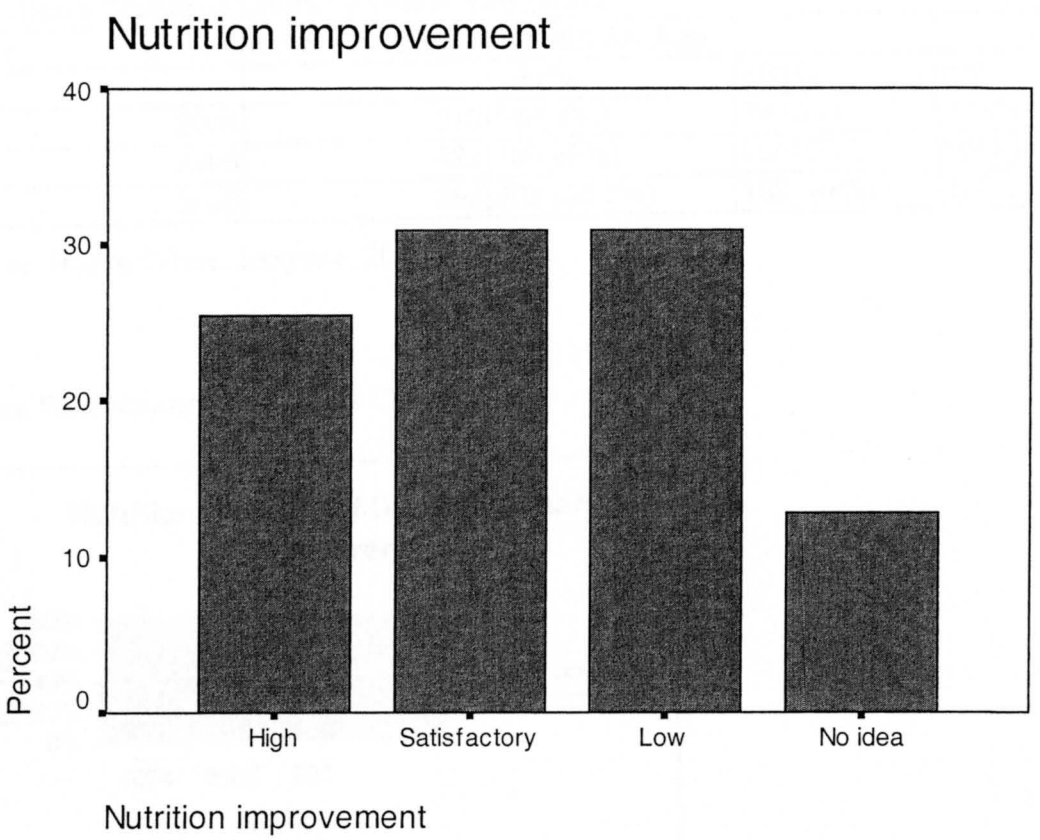
5.2.3 FINDINGS

Generally the evaluation revealed that the project implementation is conformity to goals and objectives of the project. In part of formative evaluation the organization is delivering the services that reach the targeted beneficiaries at satisfactory level.

As compared to the objectives of the project the findings show that there is some improvement in nutritional status of children within the first year of the implementation. Summative evaluation focused on output/outcome of the project. The record from both sources shows that there is an improvement though it is fluctuating. Whereas the severe malnutrition of children has been reduced, the number of children in moderate malnutrition has increased and well-nourished children have dropped as shown in the table and charts bellow.

This indicates that the outcome of the project is positive since the focus is on reduction on malnutrition. However efforts now should focus on both reduction of malnutrition and improvement of nutritional status.

Figure No 5 Nutrition Improvement



On the nutrition improvement of the under five years children, many responded that there is an improvement as compared to the last 10 years. About 27 % responded high improvement and 31% responded satisfactory, while about 31 % show that they feel nutrition improvement is low and 10 % have no idea on nutrition improvements.

Table No 8 Nutritional Status of U5 Years Children

Nutritiona Status of Children Under five years				
Year	No of Children	Weight for Age		
		>80%	<80%	<60
2004	213	142(66.)	74 (34.)	3 (3.4%)
2005	222	138(62%)	79(35%)	5(2%)
2006	385	202 (52.5%)	182 (47%)	1(0.5%)

Source: Health Centre, Jongowe, 2005

Figure Well Nourished U5 Years Children

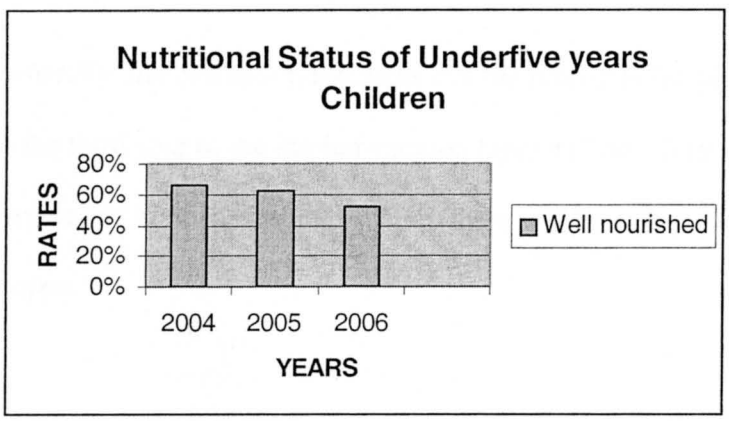


Figure 7 Moderately Nourished U5 Years Children

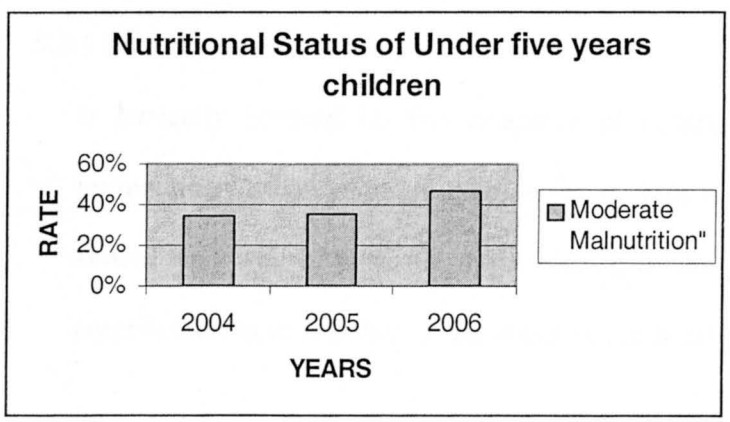
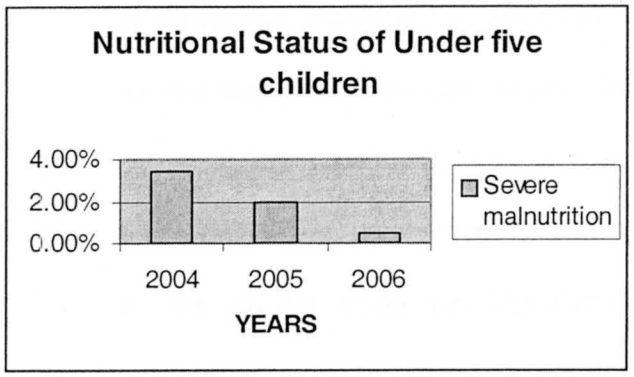


Figure 8 Severely Malnourished U5 Years Children



Generally, the evaluation indicates that the project is ferrying well with the set goal and objectives. In the third year of the implementation there will be a final evaluation to assess the outcome of the Project and after the implementation there will be a post ante evaluation to assess the impact of the project.

5.3 SUSTAINABILITY

The question of sustainability of this project is based on financial, political and social aspects.

5.3.1 Financial sustainability

Is basically focused on the assurance of continuity of the project funding after the termination of the existing funding sources. This means that the CBO and the community should find way of ensuring the financing of the projecting from own sources or local contribution from whether local initiatives or local government contribution.

.5.3.2 Political sustainability

It ensure that the project is supported by the political and community leaders so that the project activities are continue to provides services and benefits to the targeted beneficiaries. Sustainability in political aspect in this project also focuses on participation of community and stakeholders. Involvement of both stakeholders and community members in all stages of the project cycle i.e. identification, planning, implementation, monitoring and evaluation, ensures how sustainable the project is, after the phasing out of the project. Community and stakeholders contribution in the planning and implementation of the project is a good indication of the project sustainability. Jongowe community and all the stakeholders are involved in the project at all stages and are contributing in the implementation process due to awareness created by the CBO- JDF.

5.3.3 Social Sustainability

This ensure the beneficiaries continue to access to all social services provided by the project after phasing out. Village health days, Clinical and community child monitoring, immunization and other services should continue in the health centre as well as in the community.

Social sustainability also means that the project is accepted and supported by all members of the community now and after the passing out of the project.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

This is the conclusion and recommendations chapter that conclude and gives the main summary of the project by highlighting the problems and the research findings in the nutshell. The chapter also shows the implications of the research findings and finally suggests the recommendations for addressing the identified issues from the research findings.

6.1 SUMMARY AND CONCLUSION

This project is aiming at reducing malnutrition that is now endemic in the Shehia. Many causes have been identified, of which lack of capacity on nutrition self-intervention on the problem. Some efforts have been done to address the problem particularly on creating awareness and building capacitates of the community on self-intervention, though the findings has revealed that the capacities towards malnutrition intervention is very low but awareness is very high which is an indication of opportunity for positive impact. Stakeholders' involvement is another opportunity that might be used bridge the missing link in intervening on this problem. It was earlier perceived that nutrition as health problem whereby health sector was only concerned and left out other sectors, but through the involvement of the CBOs and other stakeholders the problem is addressed multisectorally. Participation of community at large is a crucial issue to consider in the implementation of this project.

Research finding shows that there is improvements in nutritional status of children in the Shehia even though the data collected from different sources show that there is slight differences. These differences might have been caused by lack of consistency and uniformity in the data collection mechanism in the Shehia.

Generally malnutrition has been reduced despite the fluctuation in different period and those slight differences in data collected by various sources all show some improvements. Respondents show that there is some improvement in physical appearance of children and as compared to the past records. This might be because of the increased awareness of the community in malnutrition and its consequences. As per objectives and research questions, the result of the survey shows that there is some improvement in nutritional status of children. The record from both sources show that there is an improvement in severe malnutrition of children in the Shehia while moderate malnutrition has increased and well nourished children has dropped. These sources are Shehia registers, Health center, Health days and House hold surveys (the child clinic cards).

6.2 IMPLICATIONS

The results of this survey show that the status of children is improving slightly. While severe malnutrition has reduced, the moderate malnutrition has increased and well nourished has reduced, which imply that number of children in danger zone are reducing while those in safe zone are also reducing. The efforts of following up severely affected children are very high while forgetting to sustain the success recorded in the past. This indicate that malnutrition can be improved if efforts are taken by the community themselves, and by involving them from the beginning of the program initiatives. Participatory planning approach in community-based initiatives is very crucial so as to record good achievement of any project. Community members can be very potential partners in development if they are fully sensitized and their awareness is adequately created and have enough knowledge of their status.

6.3 RECOMMENDATIONS

In the areas where this kind of project have been implemented, there have been a remarkable improvement of nutritional status and ultimately the reduction in the mortality rate of both infants and the under fives children. This is worthy for the project to be implemented fully in this Shehia where malnutrition abounds. Efforts to build capacity of CBO members and all other stakeholders working with the project is imperative so as to effectively address the problem of malnutrition.

Based on the analysis of the findings of this survey, it is generally recommended that Jongowe Development Fund (JDF), the CBO in the Shehia and the Shehia Council should involve other partners to work together in the implementation of the project in order to sustain the achievements and develop a comprehensive plan for the implementation this project.

A comprehensive program to address food insecurity and poverty should be planned as it is the major and has been the priority of community in addressing malnutrition. The CBO, Shehia authority and the District office should find out ways to raise the income of the community to address the problem of household food insecurity. Fishery sector as a back born and main economic base of the people should be earmarked. Agriculture as a second and supportive sector should also be improved to sustain food security. The techniques and innovations that would be compatible to the arid and coral rag areas should be utilized to improve agriculture in the Shehia and the island.

Mechanism to monitor child nutrition that is consistent and sustainable should be established by Community with close collaboration with JDF and involving other stakeholders in all stages in planning, implementation, monitoring and evaluation.

BIBLIOGRAPHY

David Seckler (2000) Malnutrition: an intellectual odyssey: Ford Foundation, New Delhi, India, and Colorado State University, Boulder, Colorado, United States

Ebrahim, GJ (1982) Child Health and Changing Environment, Macmillan Press Ltd, London

Garner, P (1999) Is Routine Growth Monitoring effective? A system review of trials, Liverpool School of Tropical Medicine, UK

Gebre-Medhin, M (1992) Nutrition in Primary Health Care, Wageningen, the Netherlands

Government of Tanzania and UNICEF (2003) Programme of Cooperation 2002-2006

Government of Zanzibar (1998) Speech of the Minister of Planning and Investment on the implementation of CSPD and the State of Women and Children, Day of African Child -16/06/1998

Government of Zanzibar/UNICEF (1993) Annual Review Report, Zanzibar Joint Nutrition Support Programme, Zanzibar

Government of Zanzibar (2003), Annual Review Report, Child Survival Protection and Development, Ministry of Finance and Economic Affairs, Zanzibar.

http//www.worldbank.org/hdnet/hddocs.nsf/

http//www.unsystem.org/scn/archives/tanzania/ch08.htm

http//http://www.ifpri.org/divs/fcnd/dp/papers/fcndp98.pdf

http://www.unu.edu/unupress/unupbooks/80478e/80478E0l.htm

Maurice K (1984) Nutrition in Developing Countries, Oxford University Press, Nairobi

NGORC (2002) Philanthropy report on indigenous initiatives to development in Zanzibar

North "A" District (2005) District Annual Report 2005

Shehia Registers, Jongowe Shehia (2000 and 2005)

United Republic of Tanzania and UNICEF (2003) Zanzibar Programme, Plan of Operation for 2002-2006

UNICEF Country Office, Tanzania (2000) CHILDREN'S RIGHTS

UNICEF (1998) The State of World Children: Focus on Nutrition