

UNIVERSITY OF CAPE COAST

REFLECTIONS ON THE OUTCOMES OF GHANA BAPTIST
CONVENTION'S RURAL PROJECTS: APPLICATION OF THE
INTEGRATIVE QUALITY OF LIFE THEORY

BY

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degree in Development Studies

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DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature:..... Date:.....

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Supervisors' Declaration

We hereby declare that the preparation and the presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

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ABSTRACT

The goal of all development is to help people attain high quality of life. People living in rural areas need more attention in the realisation of this goal because they are more disadvantaged. The socio-economic development approach, which is the major approach to development and driven by modernisation, overlooks other important factors of quality of life. From the literature, integrative quality of life (IQOL) theory addresses these challenges when adopted in project planning. The purpose of the study was to reflect on the outcomes of Ghana Baptist Convention's (GBC) rural projects applying the IQOL theory. A total of 271 beneficiaries including 32 key informants were randomly and purposively selected respectively for the study. The findings showed that income, health, education, fulfilment of basic needs, realisation of life potential, meaning in life, happiness, satisfaction with life and wellbeing were necessary and cherished components of quality of life. In all, GBC's interventions have been seen as positive by the beneficiaries. They also recommended that these interventions should be sustained. This study recommends that the measurement of development outcomes and indicators should shift from the economic growth approach to the holistic approach. Development interventions should seek to expand the scope beyond the economic to the other components of well-being and the churches such as GBC should lead the way.

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DEDICATION

To my family and parents for training me to be the kind of person I am today.

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LIST OF ACRONYMS

ADB	African Development Bank
BVTC	Baptist Vocational Training Centre
CBO	Community Based Organisation
CFBO	Christian Faith-Based Organisation
CHAG	Christian Health Association of Ghana
CHPS	Community-Based Health Planning and Services
COMQOL	Comprehensive Quality of Life
DCE	District Chief Executive
DFID	Department for International Development
EQOL	Existential Quality of Life
EU	European Union
FAO	Food and Agriculture Organisation
FBO	Faith-Based Organisation
GBC	Ghana Baptist Convention
GDI	Gender Development Index
GDP	Gross Domestic Product
GII	Gender Inequality Index
GLSS	Ghana Living Standard Survey
GNP	Gross National Product
GSGDA	Ghana Shared Growth and Development Agenda
HDI	Human Development Index
HPI	Human Poverty Index

ICT	Information and Communication Technology
IDI	In-depth Interview
IFAD	International Fund and Agriculture Development
IHDI	Inequality-adjusted Human Development Index
ILO	International Labour Organisation
IQOL	Integrative Quality of Life
ISIL	Islamic States and the Levant
KSCS	Kebkabiya Smallholders' Charitable Society
MCE	Municipal Chief Executive
MDG	Millennium Development Goals
MoFEP	Ministry of Finance and Economic Planning
MPI	Multi-dimensional Poverty Index
NDPC	National Development Planning Commission
NGO	Non-Governmental Organisation
NHIS	National Health Insurance Scheme
OECD	Overseas Economic Commission and Development
OQOL	Objective Quality of Life
PPP	Public-Private Partnership
PTA	Parent Teacher Association
ROLP	Realisation of Life Potential
SDA	Seventh-day Adventist Church
SQOL	Subjective Quality of Life
UK	United Kingdom

UNDP	United Nations Development Programme
UNESCO	United Nations Educational Scientific and Cultural Organisation
USA	United States of America
WCED	World Commission on Environment and Development
WHO	World Health Organisation
WHOQOL	World Health Organisation Quality of Life

CHAPTER ONE

INTRODUCTION

Background to the Study

Globally, it is the view of development thinkers and practitioners that the ultimate goal of development programmes and projects is to help people attain a holistic or an integrative quality of life (Contanza et al., 2007; Deneulin, 2011; Ioana, 2012; Lindholdt, Jes S., Ventegodt, S., & Henneberg, E. W., 2002; Liu, 1974; Ventegodt, S., Merrick, J., & Andersen, N., 2003; Ventegodt et al., 2010; 2005). In other words, the outcome of development interventions is to help beneficiaries attain an appreciable level of satisfaction in all domains of human life: economic, social, spiritual, psychological and political.

While this development goal is true for all people, it is also the case that rural people need more attention in its realisation (Dercon, 2008) for at least three reasons. Firstly, rural communities, compared to urban communities, are disadvantaged in accessing basic social interventions such as schools, roads, safe drinking water, and health facilities (Ghana Statistical Services [GSS], 2014). A rural area in this study is defined as a community with less than 5000 inhabitants (GSS, 2010). Ashley and Maxwell (2001) describe rural areas as places where human settlement and infrastructure occupy only small patches of the landscape dominated by fields and pastures, woods and forest or desert with shanty housing structures and poor social infrastructures.

Secondly, poverty is persistent in rural communities. As Kendie (2008) observes “poverty is rife amidst vast agricultural lands that cannot be utilised”

(p.58). Several views have been attributed to this challenge. One such view is that “succeeding governments would not pay serious attention to providing irrigation facilities”. In developing economies, statistical information show that rural people play a significant role in the production of the nation’s wealth in the agriculture sector. In some African countries, over 60% of the rural people are engaged in agriculture (African Development Bank, 2006). However, a share of the wealth and resource distribution from economic growth to the rural areas has been and still is a challenge for governments in developing countries (Dercon, 2008).

Finally, the population of rural people faced with poor quality of life is large and worrying (ADB, 2001; 2006; Cagliero, Cristiano, Pierangeli, & Tarangioli, 2011). Discussions on human development demonstrates that there are over 939 million people with poor quality of life in rural areas in the world with sub-Saharan Africa accounting for 204 million people (Ali, Gadir, & Thorbecke, 2003). What makes this figure worrying is that it includes vulnerable groups of people (women, children, and the physically and mentally challenged) (Agénor, Canuto, & Da Silva, 2010; Runger, 2006; World Health Organisation, [WHO], 2011).

Over the past four decades, efforts to improve quality of life in rural areas have received a lot of attention in development discourse (Ghana Living Standard Survey6 [GLSS6], 2013; Sen, 2002b; Streib, 2005; Ventegodt et al., 2003; Wagona, 2002). Translated into strategies, these efforts have been found in national development plans (Berger, 2003; Bukenya, 2003; United Nations Development Programme, [UNDP], 2009). They have been found also in

development programmes of donor agencies, non-governmental, community-based, and faith-based organisations (Wagona, 2002). In fact, integrated quality of life has become a regular topic in development discourse (Ondigi & Mugenda, 2011; Todaro & Smith, 2009; Constanza et al., 2007; Bukenya, 2003; Sen, 2000; 1990).

However, improving quality of life of people in the rural areas has been elusive because of the different theoretical and conceptual emphases that have driven development thinking and practice since the 1950s (Cagliero, Cristiano, Pierangeli & Tarangioli, 2011). On one hand, in the 1950s, development emphasis was driven by classical traditional theories such as modernization theory, which focused on economic growth approach (Parson, 1951; Haque, 2004).

The thinking behind economic growth to development has been and is that effects of growth in terms of Gross Domestic Product and Gross National Product will trickle down from the developed to the developing countries and from urban to rural areas. The Trickle-down will create employment opportunities, improve income, and provide social services such as roads, schools, safe drinking water, and health facilities to improve quality of life of people in the rural areas since industries in the urban areas demand some supplies of raw materials from rural areas. Second, it is to change technology, norms, attitudes, and perceptions of some traditional societies toward modernity and secularisation and consequently improve people's quality of life.

The economic growth approach to improving quality of life has been supported by empirical evidence such as the studies conducted by Stevenson and

Justin (2008) and Clark and Senik (2010). In their study on economic growth and subjective well-being, Stevenson and Justin (2008) concluded that growth in GDP improves quality of life of people. The empirical work of Clark and Senik (2010) on economic growth and happiness also concluded that economic growth increases happiness in low-income countries. However, the development literature has shown that the trickle down effects of economic growth has not been effective in developing countries (Todaro & Smith, 2009; Sen, 2000; 1999). It had perceived human beings as means of production and it had failed also to measure other important economic measures such as household work by women. Subsequently, a shift in approach to development became necessary.

In the late 1960s, development emphasis shifted from economic growth to employment creation, a concept influenced by the International Labour Organisation [ILO], (ILO,1976). Eventually, this concept also left out employable as the disabled, old, and infirm in the improvement of quality of life (Boapeah, 2006; Henderson, 1995). Development focus then shifted from economic growth to income distribution or redistribution with growth (World Bank, 1974). The weaknesses in the implementation of this concept were that it neglected distribution of benefits to households and it left out non-material needs in measuring growth and quality of life.

In the early 1990s, development thinking refocused attention on the ILO's (1976) sponsored human centred approach to development (United Nations Development Programme, 1991; ILO, 1976). The thinking behind this approach is that the human being is both the means and the end of development. The

approach, therefore, chartered the course for development thinkers and practitioners to focus on people as the end of development and not only as means (Seers, 1969; Sen, 2000; 1999; Welzel, 2003). It provided and exposed the individual or group of people to their own worldviews and capabilities in order to address their quality of life needs (Potter, 2002). It demonstrated also that both non-monetary and monetary indices and indicators are necessary in the measurement of quality of life in both developed and developing countries.

The human-centred approach to development is driven by theories such as the human development theory (Welzel, 2002) and the hierarchy of human needs theory (Maslow, 1954). The human development theory puts forward the idea that economic growth, rising emancipative values, and good democratic practices combine to expand human choices toward improved quality of life. The hierarchy of needs theory simply postulates that human progress is contingent on addressing ordered needs (Maslow, 1974, 1954). The concepts in human-centered approach are many. Prominent among them are rural development (Zoomers, 2006), basic needs (Streeten, 1980), holistic development (Sen, 2000; 1999), quality of life (Ventogodt et al., 2003) and sustainable livelihoods (Chambers, 2005). These concepts have led to the use of additional indices for determining quality of life in development literature (Sen, 2000, 1999).

The literature on human development has shown that Sen's (2000;1999) work on human development led to a new focus on measuring quality of life using Human Development Index (HDI) and the Inequality-adjusted human development index (IHDI). These indices measure life expectancy, education and

income. In 2000, the UNDP sponsored the development of a new index, the Human Poverty Index/Multi-dimensional poverty (HPI/MPI), to measure quality of life in terms of longevity, education and decent standard of living (UNDP, 2000; 1990). The weaknesses in these indices were that they failed to address gender inequalities.

To address this quality of life trend, gender gap, the Gender Development Index (GDI) and the Gender Inequality Index (GII) were developed to measure gap in development progress between male and female (UNDP, 2014; 2001). The GDI and the GII use life expectancy, income and education as indicators for measurement (UNDP, 2014; 2001). It is to be noted that such continuous shift in development widened the scope of indicators for measuring quality of life. Indicators included human capability, political freedom and security, human rights, free press, participation, and rule of law (GLSS6, 2014; Organisation for Economic Co-operation and Development, 2013; Ventegodt et al., 2003).

Ideally, economic growth and human development indices are supposed to accelerate the attainment of holism in quality of life. However, development literature demonstrates that the economic growth approach has largely influenced the path towards improved quality of life in developing countries after World War II (Ghana Living Standard Survey 6, 2013; Matunhu, 2011). Despite growing literature on the necessity to include other non-monetary variables in the measurement of quality of life, socio-economic indicators (income, employment, education, and health) continue to be in uential and leading indicators (GLSS6, 2013; Van den Bergh, 2009).

In Ghana, attempts at improving the quality of life of the people by successive governments, and some non-governmental organisations (NGOs) through interventions have been driven by various strategic approaches since independence. Some of the strategic approaches were at the national level and these included the decentralisation and good governance strategy (Ahwoi, 2010), Ghana Shared Growth and Development Agenda (National Development Planning Commission, 2010) and the Millennium Development Goals (UNDP, 2010). Though, the MDG was not directly a rural development strategy, it served the same goal of improving the quality of life of people.

Strategies that were adopted at the regional level included Savannah Accelerated Development Programme (Ministry of Food and Agriculture, 2014), Increased Agriculture Production approach (Brown, 1986; ADB, 2005), Social Amenity approach (Brown, 1986; Asiedu, 2002), and the Accelerated Project Implementation approach (Brown, 1986; Botchie, 2000).

Strategic approaches adopted by many NGOs to improve quality of life, hitherto, are project-based. For the focus of this study, few are cited. Action Aid Ghana is involved in the provision of safe drinking water, education, and micro finance for vulnerable children, youths, and women in some rural areas in Ghana (Action Aid Ghana, 2010). World Vision International is involved in the provision of social services such as safe drinking water through digging of bore holes (World Vision Ghana, 2008). Plan Ghana is also involved in the improvement of quality of life through child education, provision of water, food, shelter, and psycho-social support to the vulnerable in society (Plan Ghana, 2013).

Challenging Heights, in the Central Region, Ghana is also addressing child labour by providing education and micro finance to the children and parents concerned respectively in some rural areas in Ghana (Nkansa, 2011).

However, improving quality of life in Ghana by the government and other NGOs, and CBOs has followed the use of the traditional economic growth indices (Matunhu, 2011; GSGDA, 2010; NDPC, 2008; Mulwa, 2003; Aryeetey & Fosu, 2003). Although, based on economic growth indices, Ghana is said to be one of the eight fastest growing economies in the world with GDP per capita oscillating between 4% and 15% (GSS, 2013; Ministry of Food and Agriculture, 2011; Ministry of Finance and Economic Planning, 2011) and its economy has continued to benefit from strong economic growth leading to the achievement of a lower middle income status (GSS, 2013; United Nations, 2012), quality of life is still low in rural areas (GSS, 2013; 2010; MoFEP, 2013; GLSS6, 2013). In fact, the country continues to be ranked low in quality of life, 5.174 in 2005, and 4.78 in 2011 (UN, 2012). At least two reasons had been attributed to this phenomenon.

First, Ackah, Aryeetey, and Aryeetey (2009) has concluded that measurement of Ghana's level of development using indices such as production, employment, and income overlooks other important indices such as ecological degradation or congestion and their social costs (GLSS6, 2013; Ackah, Aryeetey, & Aryeetey, 2009). In addition, it has also been observed and argued in development discourse that such measurement approach overlooks important non-monetary quality of life factors such as freedom of speech and human rights,

happiness, well-being, self-worth and belief-systems (Gyekye, 1994; Sen, 1999; Henderson, 1995; Goulet, 1971).

The growing concern for development scholars and practitioners such as Gyekye (1994) and Nolan and Whelan (2010) to rethink the use of economic indicators in quality of life measurement cannot be over emphasised. Gyekye (1994) had concluded that the non-inclusion of subjective variables in measuring quality of life makes incomplete the determination of the overall outcome of the development of a country. Nolan and Whelan (2010) had concluded that non-monetary indices are necessary in the measurement of quality of life.

Given that economic growth indices alone do not capture and address the multidimensional nature of quality of life needs, a change for improved quality of life has become necessary in development discussions to fill the gap (Ventegodt et al., 2010; Constanza et al., 2007; Sen, 2000, 1999). As postulated by the theory of Change, a change occurs when an undesired condition of life (i) creates a motivation for change (ii) changes what needs to be changed and (iii) makes the change permanent (Schein cited in Wirth, 2004). Over the past three decades, development thinkers and practitioners have been rethinking ways in which a change or an alternate model measuring quality of life can be improved (Korten, 1990, Streeten, 1984, Sen, 1999; 2000; Constanza et al., 2007).

In the early 2000s the thinking to measure quality of life holistically emerged with the integrative quality of life theory (Ventegodt et al., 2003). The IQOL theory postulates that the quality of life of a person is a spectrum of objective, subjective, and existential domains of human experience (Ventegodt et

al., 2003). It defines the objective quality of life to mean one's good health, education, income, social relations and attainment of life goals. It also defines the subjective quality of life to mean one's well-being, satisfaction with life, meaning in life, and happiness. Finally, the theory explains existential quality of life in terms of an inner state life or spirituality of an individual.

It has been shown in quality of life literature that an improved objective, subjective, and existential quality of life is contingent on interventions (Welzel et al., 2003; Anderson, 2005; Constanza et al., 2007). According to Welzel et al. (2003), such interventions expand human choices to improve development (Welzel et al., 2003). Anderson (2005) had argued that such interventions produce outcomes that can be immediate, intermediate and long term while Constanza et al. (2007) had also argued that such outcomes are subjectively determined by those affected.

It is a fact that the government is responsible for the provision of development interventions to improve quality of life of its citizens since it holds in trust the resources of the country (Ghana Government, 1992). The literature on development and common knowledge show that since independence successive governments hitherto provide some interventions to communities with the aim to improve the quality of life of the people. However, it is also a well-known fact that the government alone has not been able to provide interventions to improve quality of life of its citizens. The national policy on public-private partnership introduced by the government in 2011 has brought on board some Non-Governmental Organisations who are contributing to the improvement of quality

of life through provision of some interventions (GSS, 2013; GLSS6, 2013; Duffour, 2011).

However, while government and some NGOs are noted for the provision of socio-economic interventions to improve quality of life, faith-based organisations (FBOs) are noted for their holistic approach to improving quality of life through provision of holistic interventions. Studies have shown that the Catholic Church is involved in development activities through the establishment of churches, schools, vocational training centres, health facilities, agro-processing projects, and hospitality projects, especially in the rural areas in the Ashanti, Northern, Upper West, Upper East and Central Regions (Salifu, 2011; Benstil, 1986).

Other studies show that the Methodist Church Ghana is involved in the religious and the socio-economic development of the people, including those living in some rural communities in Ghana. They are involved in the establishment of churches, provision of socio-economic services such as schools, hospitals, insurance, micro finance, and vocational training programmes (Methodist Church Ghana, 2009).

Blankson (2010) carried out studies on the development activities of the Seventh-day Adventist Church (SDA), Ghana and showed that it is involved in the spiritual and socio-economic growth of the people through the establishment of churches and socio-economic projects. Prominent among the socio-economic activities SDA is involved in are rural afforestation and forest conservation and some of these are the mangrove preservation in Sankor, Nsuekyir, and Warababa

in the Effutu municipality, Central Region, and in a tree planting programme in Ahwir Nkwanta in the Gomoa Central District.

According to Church of Christ Report (2012), the Church of Christ, Ghana is also involved in improving quality of life to people in some rural communities through establishing churches and providing socio-economic projects in some rural areas in Ghana. The development projects of the Church of Christ in Ghana include the establishment of Pan African University College at Asebu in the Gomoa Central District in the Central Region, and the provision of bore-holes in some rural communities such as Ojoogo in the Gushiegu district, Northern Region.

The Ghana Baptist Convention (GBC), which is the focus of this study, is one of the major religious denominations in Ghana involved in development activities in Ghana (Christian Council of Ghana, 2005; Ghana Baptist Convention, 2010; GBC, 2011; GBC, 2012). Its development initiatives are traced back to its history. According to Amo (2003), the GBC traces its roots to the Protestant Movement which occurred in Europe during the 17th century. Church history tells that the Protestant movement was born in Europe due to the desire of the people to change their undesirable life conditions (Cairns, 1991). According to Amo (2003), during the period of the Protestantism movement, the people behind the movement advocated for changes in their political, economic, social, and intellectual lives, as well as religious freedom and human dignity. Church historians, such as Baker (1959), indicate that the desire of the Proletariats to change their poor living conditions resulted in the formation of several ecclesial

movements including the Baptists in Holland, England and later in the United States of America.

Amo (2003) chronicled also the Baptist work of human freedom and dignity from the United States of America (USA) and how it spread to Africa in the 19th century. He noted that the Southern Baptist Convention from the USA pioneered Baptist work of human freedom and dignity in Africa beginning from Nigeria particularly among the Yoruba community. According to him, the Yoruba Baptist Association, one of the earliest Baptist organisations in Africa, was established in 1935. It comprised all the established Baptist churches by the Yorubas in Nigeria as at that time. Many of the Yoruba Baptists were attracted by the rich minerals and agricultural activities in Ghana and so when they came to do business in Ghana, they brought along their religion and subsequently spread the Baptist philosophy across the country (Amo, 2003).

Amo (2003) indicated that beside the Yorubas' business and missionary efforts, there were other Ghanaians Christians who also started Baptist work in Cape Coast in the Central Region and Boamang in the Ashanti Region in 1935 and 1952 respectively. Subsequently, the Gold Coast Baptist Conference was formed in 1952. The name was later changed to the Ghana Baptist Conference in 1957 after Ghana gained independence and finally to Ghana Baptist Convention in 1964. Official records showed that the GBC is a legally registered faith based organisation since 1973 in accordance with the companies Code, Act 179 of 1963 (GBC, 1975). According to the Christian Council of Ghana (2010), the Ghana

Baptist Convention (GBC) is the third largest Christian denomination in Ghana with over 1400 churches in the country.

The philosophy of Ghana Baptist Convention, expressed in its preamble, is spiritual, social, intellectual, as well as physical, political and economic shalom (freedom) with God, one's self, others, and the environment (GBC, 2013). GBC's philosophy of spiritual shalom is explained to mean freedom from entanglement of Sin (defined in terms of an individual breaking God's Law and the breaking of relationships between him or herself and God, self, fellow humans, and the environment (GBC, 2013). The social shalom is also interpreted by the GBC constitution as stipulating gender respect since God created both sexes (GBC, 2013).

In addition to the spiritual and social shalom, the GBC also strongly believes in the promotion of intellectual progress (GBC, 2013). According to the GBC's revised constitution (GBC, 2013), the GBC's philosophy of intellectual progress is seen through its promotion of formal education at all levels (primary, secondary, and tertiary) by establishing primary, secondary and tertiary institutions throughout the country.

Apart from the promotion of intellectual progress, the promotion of good health and physical well-being is another objective of the GBC. According to its constitution (GBC, 2013), the GBC is to promote good health as motivated by several biblical examples (Matthew 8; Luke 4:18-19, 40, 52). According to its mission statement, GBC is to establish and operate health related facilities to ensure good health of people.

The GBC believes also in participation in national affairs. In this regard, members are encouraged to take up positions of leadership and governance in the government in order to influence decisions that promote well-being of the people (GBC, 2013a). According to its constitution, GBC is to promote economic justice because it believes it is a sacred obligation of the church to create job opportunities. In this regard GBC's constitution empowers its member churches to undertake economically viable projects, promote skill development, entrepreneurship, and employment creation for the people (GBC, 2013a).

The GBC, driven by its philosophy and guided by its strategic plan over a decade now, extends its development activities to rural communities because majority (67%) of its churches is said to be rural (GBC, 2012; GBC, 2004). GBC reports show that its interventions include establishment of churches in the country where moral and spiritual lives are fostered through religious teachings (GBC, 2012). It is involved in the provision of a number of social interventions such as schools, hospitals, safe drinking water and advocacy. It is also involved in the provision of micro enterprise projects for vulnerable women and men in rural communities and marine fishing and aqua farming equipment for fishermen along the coast of Ghana. In addition, it is involved in the provision of cash crops such as vegetable, cashew, coconut, palm nut, poultry farming and micro finance services (GBC, 2010).

Statement of the Problem

The attempt at improving quality of life needs since the 1950s has gone through shifts in focus driven by various socio-economic theories. The economic growth approach to quality of life improvement uses objective indicators such as goods and services, industrialization, and profit accumulation to determine the level of development. Studies have shown that using economic indicators do improve an aspect of quality of life needs but do not capture other indicators (UNDP, 2014; Nolan and Whelan, 2010; Ventegodt et al., 2003; 2005; Sen, 2000; 1999; Henderson, 1995).

The alternate attempt at improving quality of life using human development theories has also prompted many quality of life studies that focus on a dimension of quality of life: social, cultural, political and religious needs of people. Several empirical works, focusing on a dimension of QOL & using education, health, gender, governance, happiness, freedom & religiosity as indices have been done in both rural & urban communities in some developed & developing countries (Lindholt et al., 2003).

From the social perspectives, quality of life studies has been done, which included indicators such as human capabilities, education, self-worth and gender inequalities (Sen, 1999; Welzel et al., 2003; Poston, 2009). From the psychological perspective, quality of life studies has been done using happiness, sense of belongingness, as well as mental and emotional stability as indicators (Ventegodt et al., 2010; 2005; 2003; Lindholdt et al., 2003).

From the cultural perspective, sociologists and anthropologists have conducted quality of life studies that have included knowledge, belief, art, morals, law, and customs as indicators in the determination of quality of life (Gyekye, 1994; 1998; Constanza et al., 2007; Grulan & Myers, nd). Another strand of quality of life studies have been done from the political perspective and using right to selfhood, social justice, right to vote, freedom of speech, security, rule of law, et cetera as indicators (Welzel et al., 2003). Quality of life studies have also been conducted that have focused on ecological balance (UNDP, 2013). Such studies focused on the social and ecological dimension of quality of life. The social dimension used HDI indicators (life expectancy, education and income). The indicators used in the ecological dimension were land and water use since the idea behind land and water is to measure how much land and water a human population requires to produce the resources it consumes and to absorb its waste, using prevailing technology (UNDP, 2013).

Some quality life studies have also been conducted from a holistic perspective reflecting on outcomes of development using integrative quality of life theory (Ventegodt et al., 2010; 2005; 2003; Lindholdt et al., 2003). Such studies included, in addition to economic, social, political, and psychological dimensions of quality of life indicators, an existential dimension or a religious dimension of indicators. However, quality of life studies in rural areas that reflect on outcomes of development based on principles of integrative quality of life theory are not wide spread in Ghana in general and in rural communities in particular. Those that have been found focused on a dimension of quality of life

such as religion and health (Takyi, 2003), religion, marital status and education (Takyi & Addai, 2002), and religion and child survival (Gyimah, 2007).

The Ghana Baptist convention has been involved in the provision of rural interventions aimed at improving quality of life of people in rural communities in Ghana from a holistic perspective. However, literature providing reflections on the outcomes of Ghana Baptist Conventions' rural interventions based on the principles of integrative quality of life theory is limited.

Objectives of the Study

The general objective was to reflect on outcomes of the rural interventions of the Ghana Baptist Convention based on the principles of Integrative Quality of life. The specific objectives of the study were to

1. Examine the rural interventions of the Ghana Baptist Convention.
2. Assess the effects of Ghana Baptist Convention's rural interventions on the objective quality of life needs of the beneficiaries.
3. Assess the effects of Ghana Baptist Convention's rural interventions on the existential quality of life needs of the beneficiaries.
4. Assess the effects of Ghana Baptist Convention's rural interventions on the subjective quality of life needs of the beneficiaries.
5. Recommend policy options and practices to improve integrative quality of life in specific rural communities.

Research Questions

1. What are the rural interventions of the Ghana Baptist Convention?
2. How are the outcomes of Ghana Baptist Convention's rural interventions addressing the objective quality of life needs of its beneficiaries?
3. How are the outcomes of Ghana Baptist Convention's rural interventions addressing the subjective quality of life needs of its beneficiaries?
4. How are the outcomes of Ghana Baptist Convention's rural interventions addressing the existential quality of life needs of its beneficiaries?

Significance of the Study

The goal to help people achieve an integrated quality of life is the desire of development thinkers and practitioners alike. The continuous use of socio-economic indicators and the over-look of some important non-economic indicators that go into addressing the total needs of a person persist. Integrating all aspects of human life in the measurement of quality of life remains highly demanding and innovative, for the type of information it requires, the relationships it needs to address, and the recommendations it is expected to deliver on policy issues. Largely, it also depends on the people, the kind of interventions needed and the outcomes it brings and for the sustenance of positive changes for future generations.

The study, further, is to provide an understanding of the fact that integrated quality of life is essential and it determines individual, community and national progress and stability. Since quality of life is multidimensional, the study

is to provide standard for people in the study area in measuring quality of life. Moreover, for most people in the rural areas in Ghana, physical, social, economic, political and spiritual issues are still paramount in the determination of their quality of life. This means that to fail to address these aspects of human needs mostly results in incomplete development of the individual and consequently unrealistic in the measurement of development outcome. There is, therefore, the need to conduct research into reflecting the outcomes of GBC's rural projects on the principles of the integrative quality of life theory so as to assess whether the quality of life of the people accessing the GBC's rural project measure up to the principles. This study fits very well in that context

The study is expected to contribute to knowledge that answers questions regarding all aspects of life and other natural phenomena (Sarantakos, 2005). It is expected to add to the limited knowledge on integrated quality of life from the rural perspective in Ghana. Most of the studies relating to this topic have focused on developed countries especially America (Bukonya, 2003), Denmark (Lindholdt et al., 2003) and few developing countries especially Kenya (Ondigi & Mugenda, 2011), Romania (Ioana, 2012) and Peru (Graham, 2008). It will add a voice to the concern being raised in development discussions about the need to include indicators such as wellbeing, satisfaction with life, meaning in life, spirituality, and realisation of life potential in the measurement of development outcomes.

Finally, the study is expected to build on existing studies that emphasise the relevance of socio-demographic, economic, social, religious, political, psychological variables in examining residents' attitudes towards integrated

quality of life in both developed and developing countries. The study is expected to reinforce the views of development thinkers and practitioners that socio-demographic, economic, social, religious, political, psychological characteristics are important variables when investigating factors of integrated quality of life.

Organisation of the Study

The thesis is divided into seven (9) chapters. Chapter One consists of the introduction: it focuses mainly on the background to the study, statement of the problem, objectives, research questions, significance of the study and the organisation of the study. Chapter Two discusses theories and concepts related to the study. It discusses integrative quality of life, hierarchy of needs, human development and change theories. The concepts focus on rural development and holism in development. Chapter Three discusses empirical cases related to the study and presents the conceptual framework guiding the study.

Chapter Four looks at the methodological issues involving research philosophy, study area, study population, unit of analysis, sampling procedures, data sources, pre-testing of research instruments, ethical consideration, fieldwork and community entry protocol, data preparation and analysis, field experiences and challenges and ethical consideration.

Chapter Five presents findings and analysis based on the objective one of the study. It examines GBC rural interventions. Chapter Six presents outcomes of GBC's rural interventions on the objective quality of life that address objective two of the study, Chapter Seven presents outcomes of GBC's rural interventions

on the subjective quality of life that address objective three of the study, Chapter Eight presents outcomes of GBC's rural interventions on the existential quality of life that address objective four of the study and Chapter Nine presents the summary of the findings of the study, conclusions and recommendations.

Chapter Summary

The chapter presented overview of the study. It gave the background to the study, presented the statement of the problem, the objectives of the study, and the research questions. Furthermore, it stated the significance of the study and finally presented the organisation of the study in chapters. The next chapter dealt with the review of related literature on the theoretical perspectives and conceptual issues, empirical studies and conceptual framework.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

Introduction

This chapter deals with the theoretical framework of the study and it reviews the following theories: Hierarchy of needs theory, human development theory, change theory and integrative quality of life theory (which is the main theory the entire study is focused on). This is followed by review of the concepts of rural development and holism in development.

Theoretical Framework

The theoretical perspective of the study was built around Hierarchy of needs theory, Change theory, human development theory and integrative quality of life theory. These are theories were expected to facilitate the construction of a framework that defines what constitute integrative quality of life.

Hierarchy of needs theory

Maslow's hierarchy of needs is a theory in psychology, proposed by Abraham Maslow in his 1943 paper *A Theory of Human Motivation*. Maslow subsequently extended the idea to include his observations of humans' innate curiosity. His theories parallel many other theories of human developmental psychology, all of which focus on describing the stages of growth in humans. Maslow's (1943; 1954; 1970) theory suggests that human needs can be classified in seven broad categories. These are physiological needs (food, health, physical contentment et cetera) safety needs (security, freedom et cetera), and

belongingness (love, friendship et cetera). The rest are esteem (achievement, self-esteem, prestige et cetera), self-actualisation (growth, self-fulfilment et cetera), knowledge/understanding (satisfying curiosity, expanding one's knowledge) and aesthetic needs (need for order, perfection).

Maslow (1970;1954;1943) argues that the most basic level of needs must be met before the individual will strongly desire (or focus motivation upon) the secondary or higher level needs. He explains that if these needs are not provided, the human body simply cannot continue to function. Therefore, he concludes that in the levels of the first five basic needs, the person does not feel the second need until the demands of the first have been satisfied or the third until the second has been satisfied, and so on. Max-Neef, Elizalde, and Hopenhayn (1991) have also argued in line with Maslow that fundamental and contingent on human survival and progress is the assumption that basic human needs such as food, clothing, safe drinking water, and health are made accessible to human beings.

According to Maslow (1970), there are two groups of human needs in the pyramid: deficiency needs and growth needs. The deficiency needs are those in the first four levels of needs in the hierarchy. The growth needs are in the last three levels of needs in the hierarchy. He argues that within the deficiency needs, each lower need must be met before moving to the next higher level. Once each of these needs has been satisfied, if at some future time a deficiency is detected, the individual will act to remove the deficiency. According to Maslow, an individual is ready to act upon the growth needs if and only if the deficiency needs are met. Huitt (2007) concludes that provision of these basic physiological needs such as

air, safe drinking water, and food are necessary metabolic requirements for survival and development in all living beings.

Critique of Hierarchy of Needs Theory

Some scholars have criticised Maslow's theory in terms of its generalisability of the needs ranking (Wahba & Bridwell, 1976), ethnocentric nature of the theory (Hofstede, 1984), and its individualistic tendencies (Cianci & Gambrel, 2003; Kenrick, Griskevicius, Neuberg, & Schallar, 2010). It has also been criticised for its lack of empirical evidence to support his hierarchy. Despite these criticisms, the theory has received wide popularity and acceptance, and it has often been the most cited theory among theories of human motivation (Wahba & Bridwell, 1976; Soper, Milford & Rosenthal, 1995; Huitt, 2007). Maslow's (1970) Hierarchy of needs could help this study in the identification, definition, and scope of human needs that call for a change in human progress.

Theory of Change

The theory of change was developed by Lewin (1947), a German social psychologist, who developed interest in human aspect of change. His interest in groups led to a research focusing on factors that influence people to change. His research led to a theory of change, which postulates a three-staged process of change namely; unfreezing, transition, and refreezing. In re-appraising Lewin's (1947) theory of change, Schein (cited in Wirth, 2004) provided a more comprehensive model of change defined in terms of the individual (i) becoming

motivated to change (ii) changing what needs to be changed and (iii) making the change permanent.

The principles underlying the theory of change are both internal and external. Internally, Wirth (2004) points out that, from within a person emanates a level of dissatisfaction of a situational condition because a specific need or goal in life is not addressed. He concludes that such a condition of life is sufficient enough to desire change. Boyatzis (2006) pointed out a two-way process that can bring such change of a dissatisfying condition. First, change occurs when a person discovers his/her real self in the present dissatisfied condition. Second, change occurs when the individual begins to discover his/her ideal self (what he/she wants to be in life).

Externally, Constanza et al. (2007) argues that change occurs by inducement of some outside interventions. Constanza et al. (2007) call them opportunities. The paper cites social, economic, human, natural capitals as external interventions that serve as opportunities in inducing change for the dissatisfying condition of life of a person. Ondigi & Mugenda (2011) have also concluded that social, political, economic, and religious interventions induce change since human experiences embraces all the above areas of needs.

Socially, one expects improvement in emotional, marital and other relationships, and educational level (Ventegodt et al., 2003; 2005). Politically, one expects freedom toward selfhood, respect, and self-worth (Ahwoi, 2010; Wisdom, 2001). Economically, one expects improvement in income statuses (Stevenson & Justin, 2008). Religiously, one expects change in moral virtues

expressed in equalities, justice, love, acceptance and joy (Ventegodt et al., 2003; Contanza et al., 2007; Tomalin, 2007).

The theory of change also postulates goal-orientation. Anderson (2005) opines that such a goal can be positive or negative, immediate, intermediate or long term. He argues that a positive change occurs when an intervention addresses a specific need to the satisfaction of the person. It is negative when such intervention addresses a specific need of person unsatisfactorily. However, change can be neutral as well, especially when an intervention does not affect the unsatisfied situation that is expected to change.

The rate of change is affected by contextual circumstances. Constanza et al. (2007) and Bolender (2008) argued that the outcomes of change are confronted with a variety of situational conditions such as values, norms, beliefs and ideas that influence the selection of the outcomes and the interventions (means). Constanza et al. (2007) concluded that such situational conditions are affected by the subjective and time-varying weights (level of importance, level of satisfaction, level of knowledge) that the individual or group give to the interventions in achieving such goal relative to others.

Critique of Change Theory

The theory of change has been criticised by development theorists. Sewell Jnr. (1992) criticises the theory of change for its lack of definition of social structure. Connell and Kubisch (1998) had argued that the theory of change seems to portray that outcomes are easily measurable when in fact it had been proven

that some variables in the change process are more difficult to measure. Variables such as love and peace are difficult to measure objectively. Measures of community attributes such as social capital, shared values, and strong networks are more elusive, as are institutional change indicators of service integration, responsiveness to community needs, and systems reform.

In spite of these criticisms, the theory of change is necessary in this study because it will facilitate in the explanation of the level of outcomes of GBC's rural interventions in terms of how immediate, intermediate, and long term changes in the lives of beneficiaries. Application of the principles of the theory of change will also facilitate this study in showing the link between interventions and the desired change that is required. It will facilitate the process of formulation of policies in the selection of appropriate interventions.

Human Development Theory

Welzel, Inglehart, Klingemann's (2003) human development theory postulates that socio-economic growth, rising emancipative values, and effective democratic practices work together to enhance expansion of human choices. They argue that provision and access to socio-economic factors including income, health and education increase impact on quality of life of individual, families, communities or nations. The theory advocates rising emancipative values of the individual or group of people direct their subjective orientations towards choices that promote improvement in quality of life. This means that when growing individual resources widen the scope of possible human activities, strives for self-

realization, autonomy and emancipation finds greater leverage, strengthens people's desire to have free choice and control over their lives.

The Human development theory also postulates good democratic principles including freedom of choice, participation in decision-making process and governance. Landman (2007) points out that the idea of governance, based on some degree of popular sovereignty and collective decision-making, remains largely uncontested. He argues for inclusion of collectivism in decision making that affect human life. Democratic principles have been defined in various ways. For instance, Sen (2003) argues that freedom with responsible choices, respect, and dignity for the individual promotes human progress. Punyaratabandhu (2004) argues for good governance and Ahwoi (2010) defines it as popular participation.

Democratic principles are related to human choice because they institutionalize legal rights that guarantee people's choices in private and public activities. However, it is important that these rights are not only formally guaranteed, but work effectively in practice. Effective democratization, in this sense, is any extension of people's effective rights in choices, autonomy, and emancipation (Ahwoi, 2010; Donnelly, 2000). According to Ahwoi (2010), these are basic right for the individual person. Donnelly (2000) had explained that any social or cultural norm that challenges freedom of speech, freedom of choice, and respect for humans has the potential to affect negatively an aspect of quality of life. The human development theory has been applied in some studies. Few of them are discussed.

Critique of Human Development Theory

The human development theory advocates socio-economic growth, emancipative values and democracy for the expansion of human choice (Welzel et al., 2003). However, the human development theory has been criticised for not defining the common denominator of socio-economic growth, rising emancipative values and democracy (Centre for Democratic Studies, 2002). It is also criticised for being silent on human religiosity since it is a component of human experience (King & Baxter, 2005). However, the application of the theory in this study is necessary in the sense that together with Maslow's hierarchy of needs theory and Change theory, they are expected to explain clearer the principles of the integrated quality of life theory, which is the main theory in this study.

Integrative Quality of Life Theory

Historically, three factors led to the emergence of IQOL theory. These are (i) the crime rate in the midst of wealth in the United States of America in the 1960s (Day & Jankey, 1996), (ii) the shift of the entire philosophy that had undergirded the industrial revolution and the emergence of human needs theories in the 1970s (Liu, 1974; Henderson, 1995; Bach & Rioux, 1996), and (iii) the emergence of health care and human development crisis in Europe in the 2000s (Lindholdt et al., 2003). The above factors drew attention to various understanding of what constitute quality of life.

Quality of life has been defined in various ways. Skevington, Lotfy and O'Connell (2004) define quality of life as an individual's perception of his/her

position in life in the context of the culture and value systems in which he/she lives and in relation to his/her goals, expectations, standard and concerns. They argue that the concept is affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relation to salient features of their environment. Constanza et al. (2007), on the other hand, perceived quality of life as the extent to which subjective quality of life of an individual is achieved by the opportunities (interventions) offered to meet the needs of the individual. They define human needs to include dimensions of social, economic, political, religious and psychological. In other words, they perceive quality of life as integrative.

The integrative quality of life theory (IQOL) postulates that life in its fullness is observed across an "objective-existential-subjective" spectrum of human experience. According to the theory, the individual is compared to a green apple with red patches and a hidden nucleus and combines this picture with the picture of humanity as an onion that has a number of layers (quality of life factors) between the surface and the nucleus. The IQOL theory, therefore, postulates holism in quality of life expressed in the objective, subjective and existential domains of the individual's life.

Objective Domain of Quality of Life

According to Ventegodt et al. (2010; 2005; 2003), the objective domain of quality of life of a person comprises objective factors (defined in terms of income, health, social contacts) fulfilment of needs, realisation of life potential, and

biological balance. They argue that the objective aspects of the quality of life are related to the external factors of life and are fairly easy to establish. They further argued that these factors are closely associated with the culture in which, a person live and that these factors determine how one's life is perceived from the outside world. The literature has also shown that education, employment, and housing are necessary objective indicators in the determination of quality of life (Stevenson & Wolfers, 2008; Welzel et al., 2003). For the purpose of this study, the objective indicators to be reviewed are limited to income, health and education because definition and measurement of factors such as realisation of life potential, social contact, and fulfilment of needs are subjective, contextual and based on people's perceptions.

Income

According to (Ventegodt et al., 2003), income is one of the objective factors that determines a person's status in a society or the culture in which he/she lives. Income is the cash flow or cash equivalent received from work, capital or land. According to the Ghana Living Standard Survey Report (2008), there are three main sources of household income in Ghana. These are income from agricultural activities (35%), wage income from employment (29%), income from self-employment (25%) and remittances (less than 10% of household income). Remittances constitute less than 10 per cent of household income. Average annual household income in Ghana is about GH¢1,217.00 whilst the average per capita income is almost GH¢400. There are regional differences with Greater Accra region recording the highest of GH¢544.00 whilst Upper West and Upper East

regions had less than GH¢130.00. Urban localities had higher per capita income than rural localities.

According to GLSS6 (2014), income level at the rural communities is still below national standard of GHC 1000.00. The reports showed that rural communities as compared to urban communities continue to face challenges in accessing socio-economic services that should enhance their choices toward improvement in quality of life. Studies show that income improves quality of life (Stevenson & Justin, 2008; Ondigi & Mugenda, 2011).

However, other studies also have also shown that income alone cannot determine one's quality of life (GLSS6, 2013; Nolan and Whelan, 2010; Easterlein & Angelescu, 2009). Non-monetary indicators are now being used in a variety of ways in European countries and at EU level in the belief that they can bring out what it means to live a low quality of life. However, as Nolan and Whelan (2010) observed there is no consensus about how best to employ these non-monetary variables, and the underlying rationale(s) may often be implicit rather than explicit. However, the volume of research employing material and non-material deprivation indicators and the interest in it in policy circles is certainly growing. However, whereas income is a necessary determinant of quality of life, health is also another necessary determinant.

Health

According to Ventegodt et al. (2003), health is necessary factor in the determination of quality of life. The World Health Organisation (1997) defines health as a state complete physical, mental and social wellbeing not merely

absence of disease. It is clear from WHO's (1997) definition that poor health status affects human strength to work, social contact, and contentment in life. Inclusion Ghana (2013) has also concluded that it breeds national poverty. Inclusion Ghana (2013) had concluded in a study that the success of any country in the fight to reduce poverty is contingent on the health status of its population. Poor health status also results in lower expectancy. According to the GSS (2013) report, persons living in rural areas continue to have poorer health and a lower life expectancy due to a higher prevalence of health needs and unmet health needs than the rest of the general population. This means that provision of and access to health facilities is necessary for quality of life improvement.

However, accessing health facilities in the rural areas is a challenge (GSS, 2013). According to GSS (2013) reports, despite provision of CHPS and introduction of the National Health Insurance Scheme (NHIS) by the government of Ghana and other development agencies, accessibility, affordability and quality health care in rural areas remains a challenge. The GLSS6 (2013) reports conclude that the period 2005/06 to 2012/13 had witnessed increased rates of access to a range of health services including consultation with doctors and visits to health facilities. Nevertheless, disparities remain between urban and rural areas.

Studies continue to show that good health enhances economic growth towards national development and the improvement of quality of life in both the developed and developing countries (Lowry & Xue, 2009; Bukenya, 2003). Aside from health and income as necessary components of integrated quality of life,

education has also been proven to be a necessary component of integrated quality of life.

Education

Education has been described as one of the key quality of life factors (OECD, 2014). Education, in this study, is limited to formal type where people are taught how to write, read, and understand simple sentences. The literature indicates that education enhances quality of life (Ranis, 2004). In Ghana, according to Ghana Statistical Services (2013), a person was considered literate if he or she could write a simple statement with understanding. About 71.5 percent of the Ghanaian population aged 15 years and above were literates with the remaining 28.5 being non-literates in 2010. Studies have shown that despite several attempts at providing educational facilities and quality education in the country and more especially in rural communities, the rural-urban ratio is still bias toward urban education (Ghana Statistical Services, 2014; GSS, 2013; Ghana Country Analysis, 2010; Akyeampong, Djangmah, Oduro, Seidu & Hunt, 2007; Ranis, 2004; Hannum & Buchmann's (2004). However, OECD (2014) has concluded that education alone does not tell the whole story of a person's quality of life. According OECD (2014), economists have recognised this limit themselves and have endeavoured to develop various other mechanisms for taking into account non-market but subjective factors that determine quality of life.

Subjective Domain of Quality of Life

According to Ventegodt et al. (2003), the subjective domain of quality of life connotes the psychological or behavioural state of a person, which is, sometimes in an attempt to address it, given visible expressions. The domain is defined to include well-being, satisfaction with life, happiness, meaning in life. The fulfilment of needs and realisation of life potential factors, where included in the objective domain of quality of life have been added to this domain because as indicated earlier, they are subjective in nature (Ventegodt et al., 2003). These factors are discussed briefly one after the other.

Wellbeing

The wellbeing of a person is defined as a state of relative stability in life, which expresses itself in adventure, excitement, curiosity, fantasy, and playfulness (Ventegodt et al., 2003). Michaelson et al. (2009) perceives wellbeing as a dynamic process that gives people a sense of how their lives are going through the interaction between their circumstances, activities, and access to physical and psychological resources. Constanza et al. (2007) also define wellbeing of a person as a pre-conditional subjective human need, which is enhanced by access to resources and influenced by the culture of the person or group of persons.

Forgeard, Jayawickreme, and Seligman (2011) argue that wellbeing is both an objective and a subjective construct measured by the use of objective and subjective indicators. They argue that wellbeing is objective because it manifests itself in factors like health, employment and income. It is subjective because it

manifests itself in factors like happiness and sadness. Constanza et al. (2007) had argued that the wellbeing of a person is culturally determined. In other words, it is the individual in his/her culture who best can explain his/her state of 'well-being' after gaining an appreciable level of satisfaction in the fulfilment of his/her basic needs. This means wellbeing of a person implies a fulfilled state of that person's life after being subjectively satisfied with the fulfilment of a person's needs. As explained in the Maslow's hierarchy theory, this means that after fulfilling other needs, the move to fulfil other needs such as adventure, curiosity, fantasy, and playfulness becomes evident.

Satisfaction with life

The second factor in the subjective quality of life domain is satisfaction with life and it is defined as a cognitive entity dealing with one's mental contentment in life. Satisfaction with life connotes the narrowing of a gap between what one hopes for to fill in an unsatisfied condition of life and the realisation of that hope or desire in the fulfilment (Ventegodt et al., 2005; Lindholdt et al., 2003). This means that one is said to be satisfied with life if the desire to address a particular need (such as health) is narrowed by the means (accessibility, affordability and quality health care) to address it.

Lindholdt et al. (2003) explain that there is always something that people are dissatisfied or disgruntled with in life and in such a state of life either the individual with his or her mental state tries to correct the situation or gives up on it. Lindholdt et al. (2003) point out that one's satisfaction with life can either be constructive or destructive. They argue that a constructive satisfaction with life

demonstrates itself in the desire to preserve life and environment but a destructive satisfaction with life shows itself in the wish to waste and destroy life or destroy environment. They conclude that both approaches generate the same satisfaction with life for the individual. According to Ioana (2012), a person who has lived a difficult life due to unemployment, poor sex life, chronic illness, or poverty, always seems to be satisfied with his or her life because of gradual adaptation through resignation or fate. This means that a person's satisfaction with life is enhanced through appropriate interventions. As Constanza et al. (2007) points out, the individual does not give up when they are presented with resources to address the undesired state of life.

Happiness

Happiness, according to Ventegodt et al. (2003), is associated with non-rational dimensions of life, such as love, environmental care, and spiritual security. They argue that it is an experience that emanates deep within the individual and is expressed outwardly through rational and non-rational elements of life. Hills and Argyle (2002) had also argued that happiness is affected by events and circumstances. They pointed out that some people derive their happiness through having access to basic social services, successful execution of a rational life plan or successful closure of a gap between what one would like to do and what one has done. They opined that happiness is expressed as a result of one's state of good health or when one feels particularly pleased with the way he/she is in life. They also argue that happiness shows when people are intensely

interested in maintaining social contact with other people, and they have very warm feelings towards almost everyone.

Happiness, according to Hills and Argyle (2002), is aroused in people when they find most things amusing, have enough time to rest from their labour and struggle, are optimistic about the future, and are always committed and involved. Hills and Argyle (2002) argued further that happiness is aroused when people feel that life is very rewarding, generally good, feeling that the world as a good place to live in, laughing a lot and often experiencing joy and elation. They concluded that happiness is expressed through having fun with other people, and having particularly happy memories of the past.

Susniene and Jurkauskas (2009) also concluded that happiness depends on a person's meaningful life philosophy and balanced state of mind, financial security, social background, religiosity, and sense of belongingness in a society. Quality of life studies by Ondigi and Mugenda (2011) had also concluded that happiness in developing countries is, largely, invoked by the provision of services such as safe drinking water, financial, educational, health, power, and road infrastructures.

Empirical evidence shows that there are conflicting conclusions on the correlation between happiness and quality of life. Some studies show that 'happiness' relates significantly to quality of life (Veenhoven, 1996; Stevenson & Wolfers, 2008). However, Easterlein and Angelescu (2009) conclude in a similar study that there is no significant relationship between improvement in happiness and the long term rate of growth of GDP per capita. However, Susniene and

Jurkauskas (2009) conclude that happiness is neither affected by people with good living conditions nor poor living conditions.

Meaning in life

The next factor in the subjective quality of life domain of the integrative quality of life theory is meaning in life. The IQOL theory defines meaning in life as the value a person places on each aspect of his or her life experience, social, economic, psychological, political, and religious life experiences (Ventegodt et al., 2003). Hills and Argyle (2002) illustrate how people place values on their social, economic, psychological, political, and religious life experiences. Socially, they argue that people place value on social relations and often ask whether or not relations with friends or partner are as meaningful as they ought to be?

Economically, they ask whether or not they have the right job, earn good income and satisfied with job. According to Hills and Argyle (2002) people, psychologically, wonder why they are not happy. They pointed out that in religious and moral life experiences, people often ask whether their beliefs in life really are correct, and whether they are doing the right thing in life. Hills and Argyle (2002) further argue that other people place value on every opportunity and potential in their existence. To them such people often ask themselves whether they are using their talents in the right way, whether they understand what they are doing or whether they have purpose in life? Ventegodt et al. (2003) argue that the pursuit of meaning in life results in either meaningful existence or meaningless existence due to some elusions in terms of where one begins the

pursuit, from the outside world of economics and wealth, from the world of religion or both.

Empirical evidence exists concluding on how life to people can be meaningful or meaningless. Constanza et al.'s (2007) study on quality of life in Denmark showed that 1,400 people commit suicide per year due to how some people find life meaningless in the midst of wealth. This means wealth alone cannot give meaning to life. Sen (2009) had also concluded that there are variables in human progress that give people meaning in life (for example happiness, love, and self-worth) than the material things. However, Deneulin and Rakodi (2010), in a study on religion and development concluded that meaning in life is derived from both worlds of physical and spiritual resources.

Fulfilment of needs

According to Ventegodt et al. (2003), fulfilment of needs is the capability, and the access a person has to an intervention in order to address a particular persisting, unsatisfying need or situation in life. Referring to the works of Maslow's (1971; 1954; 1937) on human needs, Ventegodt et al. (2003) perceives human needs to include physiological, safety, love and belongingness, self-esteem, self-actualisation and self-transcendence. However, other scholars include knowledge (education), income, health, freedom and self-worth and dignity (Sen, 1997), and spirituality (Constanza et al., 2007; Skevington, Lofty & O'Connell, 2004; Cummins, 2000; Narayan-Parker, 2000; Nussbaum, 1995).

Three things are drawn from these definitions. First, the definitions portray the fact that human need is multi-dimensional. Each need emerges out of a

complex condition of life that causes dissatisfaction. Second, the causes of dissatisfaction could not be ascertained. However, Ventegodt et al. (2010) had argued that the causes could be economic, social, psychological, political, and religious in nature. Constanza et al. (2007) had pointed out that those causes could overlap and relate. This means that a cause that gives rise to a particular need can not be addressed overlooking the others. Third, those listed needs seem to fall within the general framework of needs given by Maslow, however, while Maslow's needs are ordered others are not. As argued by Wahba and Bridgewell (1976), a need fulfilment does not necessarily follow order. This means that a need fulfilment may not necessarily follow an ordered pattern to the realisation of one's life potential.

Realisation of life potential

The final factor that constitutes subjective quality of life is realisation of life potential. It is defined as achievement of one's dreams and desires in life such as good health, gainful employment, control of one's life and optimistic life (Ventegodt et al., 2010; 2005; 2003). Ventegodt et al. (2010) had pointed out that the realisation of life potential of a person is different for different persons across all cultures. This means that as people engage their community and the environment in which they live for progress, they are confronted with different resources that address a particular need. For instance, some aspire to have gainful employment to increase their income levels but are resourced with a health resource. Others aspire to attain a higher level of education, gain self-worth, and to be a responsible family and community member but they are resourced with

safe drinking water. Some people aspire to be in good health and to have freedom but are resourced with formal education infrastructure.

Some studies such as that of Sen (1999; 2000) have concluded that realisation of life potential correlates human capabilities. Granfield and Cloud (2001) had also concluded that the realisation of one's potential in life correlates with social support (defined as intimacy, trust, empathy, dialogue, freedom and honesty). In the study of Welzel, Inglehart and Klingemann (2003) study on economic growth and human development, they concluded that socio-economic, rising emancipative values, and good democratic governance combine to give a person expanded choices to fulfil his or her potential in life.

Existential Domain of Quality of Life

Having discussed the objective quality of life and subjective quality of life, the final domain in the integrated quality of life is the existential quality of life (Ventegodt et al., 2003). According to Ventegodt et al. (2010; 2005; 2003), existential domain of quality of life indicates the idea of a religious life or a spiritual life emanating from deep within the person. They explained that deep down in a person's nature, at the very centre of life, lies spiritual nature of life, a domain without which there cannot be any physical expression of human progress or quality of life (Figure 1).

Both Constanza et al. (2007) and Cummins (2005) define the centre of life as spirituality, which includes a person's faith in the Transcendent Being, prayer, meditation, interaction with others or nature. However, in this study the

definition is limited to faith in the Transcendent Being. This means that existential quality of life, as shown in Figure 1, holds together the physical and the psychological progress of human life. As argued by Ventegodt et al. (2010; 2005; 2003), human spirituality is a necessary step towards progress and quality of life. It is towards a new humility and respect for the richness and complexity of life.

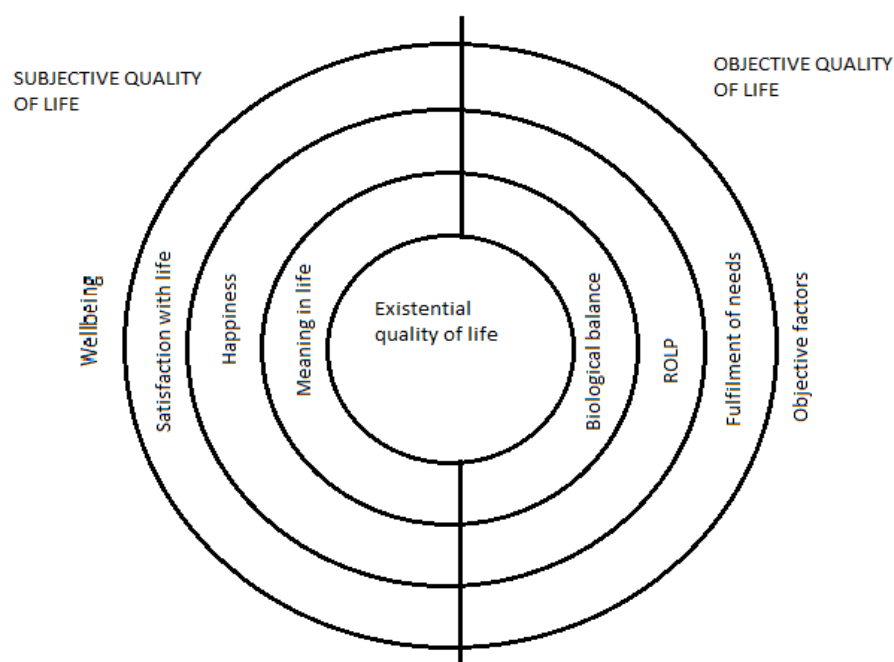


Figure 1: Integrative Quality of Life Spectrum

Source: Ventegodt et al. (2010; 2005; 2003)

Development scholars have pointed out that religion has dominated development discussions in recent years. Deneulin and Rakodi (2010) have argued that the spiritual nature of life, though wordless and real, has become an important factor in human development. Ondigi and Mugenda (2011) had concluded that there is a correlation between religion and quality of life in Kenya

while Myers (2000) concludes that religion correlate with development. Myers (2000) perceives development as reconciliation with the Transcendent Being, humanity, and the environment.

Several studies have concluded in various ways showing the values of human religiosity in development, which affects quality of life. Peterson and Roy (1985) point out that religious practice enables the individual to experience positive emotions like hope, optimism, and solace. It offers many opportunities for people to find meaning in life. Both Belshaw (2005), Park and Folkman (1997) and Park (2005; 2007) have highlighted the importance of religiosity attributing it to the meaning it gives to human life. Dörr (2001) viewed it as a source of moral development.

Hill and Pargament (2003) had concluded that a person's spirituality brings life, strength, and understanding in facing life's difficulties such as illness and death, unemployment and poverty, oppression and marginalisation. It allows religious communities to provide social support. Oman and Thoresen (2005) have also concluded that religious behaviour and a close relationship with a Transcendent Being provide a source of comfort to cope with persistence life challenges, inner harmony, peace, and also to gain self-esteem and satisfaction.

Deneulin and Rakodi (2010) point out that religion transforms development studies. Supported by Holloway, Adamson, McSherry and Swinton (2011), they point out that spirituality provides a context in which people can make sense of their lives, perceive ultimate meaning of life, explain and cope with life's experiences.

The importance of spirituality in development cut across cultures. In Ghana sociologists, theologians and development scholars such as Pobee (1991), Gyekye (1995), Bediako (1999), Nukunya (1992) and Kendie (2008) underscore the importance of a person's religiosity in everyday life in Ghana. In fact, both Pobee (1991) and Soso (2011) assert that Ghanaians are 'radicaliter religiosus' (Ghanaians are notoriously religious) in that they explain or interpret real life issues such as wealth, health, security, progeny, and longevity from the spiritual perspective. Kendie (2008, p. 67) also opined "development interventions have failed in many areas because of this inadequate attention to the social and spiritual dimensions of work".

The importance of religiosity in development is also seen in the way faith based organisations tend to influence development practices with religious beliefs and practices. According to Berger (2003), they influence development practices by their religious philosophies. Thus, as Belshaw (2006) observes, such an aim is not surprise in the sense that most international humanitarian and relief NGOs, such as World Vision and Catholic Relief Services have same development philosophy.

However, from the sociological perspective while some sociologists see the importance of religion as an integrative force in society, others see it otherwise. According to Morrison (2006), Durkheim, from the functionalist perspective of sociological theory, defined religion as an integrative force in society that has the power to shape collective beliefs. According to Morrison (2006), Durkheim argued that religion provides cohesion in the social order by

promoting a sense of belonging and collective consciousness. According to him, Weber also viewed religion in terms of how it supported other social institutions and provided a cultural framework that supported the development of other social institutions, such as the economy.

While Durkheim and Weber articulated the contribution of religion to the cohesion of society, Karl Marx focused on the conflict and oppression that religion provided to societies (Morrison, 2006). According to Morrison (2006), Marx saw religion as a tool for class oppression in which it promoted stratification because it supported a hierarchy of people on earth and the subordination of humankind to divine authority. Thus Marx's famous line "religion is opium of the people" as it soothed them and dulled their senses to the pain of oppression. However, some scholars have recently noted that Marx's thinking of religion is a contradictory or dialectical metaphor, referring to religion as both an expression of suffering and a protest against suffering (Morrison, 2006).

Bellah (1967) had argued that religious texts are not truths, but have been interpreted by people. Thus different people or groups may interpret the same Bible in different ways. Bellah (1967) further argued that civil societies may have civil religions with their own set of sacred "things". Professional sports and rock music may be civil religions of other societies. However, his work has attracted much criticism in the academia. Notably, Marthisen (1989) criticises his work for supporting idolatrous worship of the American nation.

Critique of Integrative Quality of Life Theory

The IQOL theory is criticised for its assumption of subjective factors as objective factors. For example, the placement of biological balance, realisation of life potential, and fulfilment of needs as objective factors in the objective domain of quality of life was confusing in the sense that they could not be objectively measured.

The IQOL theory is also criticised for its assumption that human life was formed from a fertilized egg. It is worthy to note that biblical scholars like Jowers (2005) argued that the formation of human life begins from God who is the Creator. Jowers argued that humans were created in the image of God and bore the likeness of God in many ways including love, justice, goodness, mercy and stewardship. The theory failed to define indicators for religiosity or spirituality.

The IQOL theory appears to be Eurocentric since it missed contextual distinctions in its application. It appeared to be silent on the differences in quality of life needs between developing and developed countries, urban and rural communities, and between individualistic and collectivist societies. According to (Gyekye, 2008; 1995), the western society is largely individualistic while African society is largely communal. The difference in values between individualistic and collectivist societies in terms of their worldviews of life, basic needs and quality of life is a reality. Its premise, largely, encouraged developed and, possibly, middle and upper class characterizations of what it meant to live a good life defined in an objective, subjective and existential sense.

The IQOL assumed quality of life in a homogenous society with homogenous values and failed to take cognisance of heterogeneous societies and their values. It was important to note that what constitute human needs in developed countries might differ from that of developing countries.

The third critical issue emerging out of the application of the IQOL theory in this study was the missing of the idea of role development intervention in the improvement of integrated quality of life. It had been extensively argued by development scholars such as Constanza et al. (2007) that interventions were necessary in the determination of an integrated quality of life. In the light of that argument and the ideas put forward by IQOL theory, it was expected that the theory would address the place of development interventions in the improvement of integrated quality of life. The IQOL theory was silent on the concept of sustainability. Sustainability cannot be ignored in development discourse.

Quality of Life and Rural Development

The linkage between quality of life and rural development lies in what constitute rural development and quality of life. Both are complex issues. However, as discussed in the theories reviewed, the principles of development are that first, humans are both means and end of development; second, growth involves human's collective personality, third, participation is ideal in rural development, and finally, integrated quality of life is the ideal outcome of development. This means that a clear understanding of rural development and holism in quality of life are needed concepts in this study and to this it now turns.

Concept of Rural Development

Rural communities in both developed and developing countries are endemic with low quality of life. Attempts at addressing the low quality of life in rural communities have given rise to various meaning of rural development. Rural development has been defined in many ways and still there is no consensus on a standard definition due to its multi-dimensional nature (Gyekye, 1998). Few definitions that seem widely accepted are briefly discussed in this study.

Okonjo's (1986) defines rural development to include the satisfaction of the fundamental needs of a population in terms of the provision of food, water and sanitation, clothes and shelter, health, education, work and mobility so as to ensure for all individuals in the nation, and so for the nation as a whole, physiological and ecological balance, mental well-being, health, creativity, a strong and developed community feeling and sense of personal and national freedom.

Omo-Fadaka (1990) defines rural development as integrated, well-defined activities by stakeholders such as the state, locals, NGOs, et cetera that bring selective and suitable interventions to rural communities. He cautions, however, that such activities should assume a bottom-up development process as against top-down development processes.

Atchoarena and Gasperini (2003) define rural development as the process that leads to the provision of agricultural, educational, infrastructural and financial, health, and vocational interventions to improve living conditions of the people. It involves also capacity-building for vulnerable groups for other than on-

farm employment. Todaro and Smith (2009) define rural development to include four socio-economic activities namely, development of small-farm agricultural activities, provision of physical and social infrastructure, development of rural non-farm industries, and sustaining and accelerating the pace of these activities.

The above definitions have some implications for improving quality of life in rural communities. First, rural development is enhanced through the provision of relevant interventions that meet the needs of the people. Such interventions, largely, serve as the livelihood of the people (Chambers, 2005). Second, access to rural development interventions (social, economic, political, and religious in nature) to improve quality of life is enhanced through the capabilities of the people (Sen, 1999). When rural people have gained skills, they are able to address their own needs. Finally, sustenance of the interventions enhances sustenance of the level of quality of life of the people (Constanza et al., 2007). This means that improved quality of life people is not a one-time experience but a continuous one.

The concept of rural development, therefore, connotes the idea of developing capabilities, providing access to development interventions, and sustaining quality of life. In line with OECD's (2009) "new rural paradigm" concept, developing capabilities, providing access to development interventions, and sustaining quality of life is based on two important things; (i) a focus on communities instead of sectors, and (ii) a focus on investments instead of subsidies. The concept also connotes provision of basic human needs (Streeten, 1980), empowerment opportunities (Siintonen, 2007), endogeneity (Goulet, 1985;

Ploeg & Long, 1994), and sustainable livelihood (Chambers, 2005). These ideas were briefly discussed.

Basic needs approach to rural development

The literature indicates that the idea of providing basic needs, defined in terms of food, water and sanitation, clothes and shelter, health facilities, education facilities, work and mobility are literal requirements for human survival and improvement of quality of life (Maslow, 1954; Okonjo, 1986; Frey & Stutzer, 2002; Costa, Hailu, Silva & Tsukad, 2009; Stiglitz, et al. 2009; Ahwoi, 2010; Ioana, 2012). A growing number of empirical evidence has shown that there is positive relation between provision of basic needs and improvement in the quality of life of people in rural communities (Ioana, 2012).

In studying the relationship between quality of life and rural development in Meses community in Romania, and using descriptive and SWOT analyses, Ioana (2012) demonstrated that adequate provision of quality education, drinking water, and employment opportunities significantly affect the quality of life of rural people. In a similar study in Kenya, Ondigi and Mugenda (2011) also used simple frequency, histogram, and chi-square to show that the majority of the respondents who were married, had more children, had more income, had high education level, were in good health status, who were more spiritual, indicated more satisfaction with their quality of life.

Empowerment approach to rural development

With shifting approaches to improving quality of life in rural communities, development scholars have shown that empowerment is a necessary

approach (Lennie, 2002; Siintonen, 2000; Sen, 1999). Several meanings have been attributed to empowerment in a development context; however, most attribute it to power 'to do', 'to be able' and of feeling more capable and in control of life situations (Oakley & Clayton, 2000; Sen, 1999; Rowlands, 1997; Craig & Mayo, 1995; Friedmann, 1992; Van Eyken, 1990).

In social development, Oakley and Clayton (2000) have argued that empowerment has become a major purpose manifesting itself in three broad areas: (i) power through greater confidence in one's ability to successfully undertake some form of action (ii) power in terms of increasing relations, which people establish with other people, group and organisations (iii) power as a result of increasing access to economic, social, political, religious, psycho-emotional resources and environmental control. As such empowerment has been operationalized into practical project methodologies and, in terms of its effect and impact, it is beginning to be translated into observable and measurable actions. For example, the Kebkabiya Project in West Sudan by Oxfam (essentially a food security project) was a project seen as part of the process of that community's empowerment in terms of participation in decision making and control (Oakley & Clayton, 2000).

According to Oakley and Clayton (2000), the project represented a successful example of how an Oxfam-managed food security project was transformed into a project in which local communities had become increasingly involved. They noted that whereas at the start of the project, local people, particularly women, had little if any say in project decision making, the project is

said to be now under the management of the Kebkabiya Smallholders' Charitable Society (KSCS). In addition, they indicated that democratic structures had been put in place, notably through the creation of the KSCS, which have improved the accountability of project management to the community. From the perspective of the Oxfam staff involved in the project, that had resulted in community empowerment. The success story of Brazilian rural empowerment concept is being practiced in Ghana and other African countries (Zondi, 2013). In this model, rural people are giving skills and training to proper land tenure system and respecting the worldview of life.

Numerous critiques of the concept of empowerment have been published (Ekumah & Enu-Kwesi, 2008; Gillman, 1996; Gore, 1992; Humphries, 1994; Peters & Marshall, 1991). According to Ekumah and Enu-Kwesi (2008), the empowerment and participation have not yielded the desired results basically because development elites still maintain basic structure of status quo in change. In addition, principles of Modernisation tend to overlook traditional knowledge systems (Kendie, 2008). However, the concept cannot be done away with in practical terms since current rural development thinking delve deep into endogenous approach to development.

Endogenous approach to rural development

Goulet (1985) argues that the idea of endogenous development draws attention to the fact that a genuine development outcome (quality of life) is sought from within the dynamism of the value system and norms of the local community in which the development is taking place. He explains that such an approach to

development includes taking cognisance of the aesthetic values, traditional beliefs, local institution, and popular practices in the society. This includes also the recognition of the potentialities of the local ecology, labour force, knowledge, local patterns for the linking of production to consumption.

Goulet's (1985) idea of endogenous development has some implications for this study. One implication is that quality of life is determined on the basis of what the people in the community perceive as important and adding value to their lives. This means that in seeking to improve quality of life, it is necessary to recognise the "traditional knowledge systems" of the people because as Kendie (2008, pp. 66-69) concludes "failed development interventions" are signs of its negligence. From the physical perspective, development scholars such as Rooij, Milone, Tvrdonova and Keating (2010), Todaro and Smith (2009), and Ploeg, J. D. van de., et al. (1994) have confirmed that endogenous development (from the economic point of view) is founded mainly, though not exclusively, on adding values to locally available resources, increasing goods and services, creating market outlets- centralizing agriculture, increasing labour, modernising implements, establishing proper land tenure systems, and establishing local level industry.

Another implication is that endogenous development comes alongside worldview of people. Chivaura (2006) points out that the concept of endogenous development is adding value to the people's worldview and notion of development, purpose of development, ethics of development and aesthetics of development. Across all cultures and especially in Ghana, the worldview of life

and human progress of the indigenous people is undergirded by a common religion, philosophy of life and culture.

Gyekye (1998) has concluded that the notion of development is one of a creative process with the purpose of uplifting the human community and to enrich the cosmos since the physical and spiritual worlds are inseparable. This means that improving peoples' quality of life by moving away from circumstances widely perceived as degrading towards socially, materially and spiritually improved circumstances is plausible. In terms of philosophy of life, Ryan (2005) has also concluded that the ethics of development and its outcomes are moral uprightness in the community. Aesthetically, he opined that development is appreciation of nature or environmental care and preservation.

The concept of endogenous development plays important role in understanding the values system of people and helping to guide policy making (Constanza et al., 2007). Constanza et al. (2007) have observed that the concept helps in identifying the value systems and norms of the people, which serve as necessary guide to policy making and the right choice of interventions toward improved quality of life. In other words, quality of life is based on the community people's own images of good lives.

Endogenous development is practicable in spite of its criticisms as lacking a theoretical foundation (Sotte, 2003), a rigorous definition, and implementation inconsistencies (Magarian, 2011). It is being practised among women in Hrachovo, a rural community in Slovakia (Rooij, Milone, Tvrdonova & Keating, 2010). It is also being practiced in Abruzzo, a region located in the Apennine

Mountains in Central Italy (Rooij, Milone, Tvrdonova & Keating, 2010). According to Rooij, Milone, Tvrdonova and Keating (2010), one of the critical factors for successful endogenous rural development in Abruzzo is the improvement of existing knowledge, creation of new knowledge, creation of the right conditions in which to apply this knowledge in farming practices and the co-operation given to create synergy between the different knowledge systems.

Sustainable livelihood approach to rural development

To begin with, the definition of what is sustainable livelihood is always open to debate since it encompasses a range of different elements, some of which may conflict. 'Sustainable livelihoods' is thus a normative concept made up of multiple and sometimes contested elements. For this study, Scoones' (1992) definition is adopted. He defines livelihood as capabilities, assets (including both material and social resources) and activities required for a means of living. He argued that livelihood is sustainable when it can cope with and recover from stresses and shocks and maintain or enhance its capabilities and assets, while not undermining the natural resource base.

Carney (1998) also advances the concept of sustainable livelihood on capability building, knowledge, equity and sustainability, each of which is a means and end of development. Carney (1999) explains capability as people's ability or fitness to carry out the project that brings them earnings before and after development agents have handed over to locals as well as the ability to sustain quality of life. This means that the individual is able to be and do in other to improve his/her quality of life. The idea of equity, according to Chambers and

Conway (1991), indicates fairness and satisfaction people have in accessing development interventions. This means that projects interventions and their sustainability, in current development practices, are meant to give beneficiaries equal opportunity to access them to improve their quality of life. However, they are to serve the next generation.

Drawing principles from the Bruntland's report on sustainability, the idea behind sustainable livelihood advances the act of maintaining livelihood from which rural people meet their needs so that it outlives present users to serve the next generation (WCED, 1987). Morse and MacNamara (2009) focus the idea of sustainability on partnership and participation. In their research on 'The Universal Common Good: Faith-Based Partnerships and Sustainable Development', they concluded that mutual respect for people with respect to their worldview and notion of development is the foundation for sustainability (Morse, MacNamara & Acholo, 2009: 46). In other words, when both the development agent and the beneficiaries esteem each other as worthy of the development interventions and the consequent outcome-improved quality of life, livelihood is sustainable.

Discussions on sustainable livelihood have also included ecological sustainability in which the need for ecological use (human engagement of the environmental) and balance is argued (Dauda, Mariwah & Abane, 2013). Ecological sustainability is important because from it livelihood emerge for development. However, Dauda, Mariwah and Abane (2013) argued that the current existing policies and regulations on environmental usage (mining in rural

areas) present serious challenges. They present challenges to waste management from mining and other small rural industries and other negative human activities are of prime concern. Such environmental exploitation has the potential to pose a serious threat to the livelihood of the next generation though industrial products are serving critical areas of human needs.

Sustainable livelihood also implies gender involvement. It has been observed that the involvement of women in development programmes enhances sustainability of livelihood and quality of life of households and communities (Kabeer, Mhmud & Tasneem, 2011). Several reasons account for this assertion, for example, rural women constitute a significant labour force in agriculture and also serve as custodians of traditional and cultural values, (Mba, 2002). Their participation in the planning, implementation, monitoring, and evaluation of the intervention(s) have been observed to be significant (OECD, 2009). Participation here includes mentoring the next generation, promoting the project(s), accounting for and maintaining the project(s).

According to Hedlund-de Witt (2014) people's worldview dictates their understanding of development and quality of life and how this may mean for their understanding of the concept of sustainable development. Although, modernity is invading rural communities with by products like cell phones, money transfer and so on, traditionalism largely holds sway of the people. Thus Hedlund-de Witt argued that inter subjective and intercultural nature of the concept of sustainable development highlights why taking into account worldviews in the context of our

global environmental issues is essential. For instance, in some rural communities, preservation and conservation of nature is their concept of sustainability.

International Fund for Agriculture Development (IFAD, 2007) disaggregates sustainable livelihood concept into four indicators that serve as a criterion for project evaluation. These are, first, institution sustainability, where functional institution is expected to be self-functioning after project ends. The second is household and community resilience, where resilient households and communities take intentional action to enhance the personal and collective capacity of members and institution to respond to and influence the course of change.

The third is environmental sustainability, where an environmentally sustainable system must maintain a stable resource base; avoid overexploitation of renewable resources and preservation of biodiversity. The final is structural change, whereby the structural dimensions of poverty are addressed through the empowerment of poor and marginalized rural households. IFAD (2007) argues that it is not unrealistic to expect the first two dimensions of sustainability to be achieved in one or two project cycles (5-10 years). However, the second two dimensions address larger, underlying issues and may take decades to be realised.

Livelihood sustainability is still a challenge facing organisations providing interventions. Consequently, some projects become abandoned and thus reduce livelihood choices of the rural people in some communities. Boapeah (2006) gives three reasons why sustaining rural livelihood is a challenge. First, he alludes to the fact that projects have proven more than the community can manage or sustain

since in some communities the people have developed an unhealthy dependency on the development agency. Second, some interventions require a level of technical assistance that is considered cost prohibitive and the development agent is incapable of providing or sustaining effective performance. Finally, some organisations have inadequately trained equipped and reliable staff.

Empirical evidence indicates some successes in the application of the rural development concept in some developing countries in Latin America, Africa, Europe (Zondi, 2013; Rooij, Milone & Keating, 2010; Todaro & Smith, 2009; Satterthwaite & Tacoli, 2003; UNDP, 1988). For instance, according to Satterthwaite and Tacoli (2003), northern Tanzania's labour-intensive vegetable oil-processing industry employing mostly women was successful. However, its success was undermined by imported oil from Singapore. They cited the traditional cloth-weaving in southeast Nigeria, which had long been an additional source of income for local women and one which had managed to retain a market niche in the face of competition from imported goods.

Critical issues emerge in the discussion of the concept of rural development. These criticisms have been raised by various scholars (Ploeg et al., 2000; Dax & Kahila, 2011; Margarian, 2011). For instance, citing Sotte (2003), Margarian's (2011) critiques of the concept of rural development were in its lack of theoretical foundation and insufficient analysis of the relationship between it and general development. However, the concept is necessary for this study in the light of the fact that it addresses human progress in holism.

Concept of Holism in Development

The concept of holism in development has dominated development discussions in the academia and development practices with various perspectives. Tran (2013) defines holistic development as a concept that addresses socio-cultural, physical, economic growth, emotional development, and spiritual development needs of the individual. Al-Dahir, Kang and Bisley (2009) define holism in development to include addressing psychological needs of a person such as happiness. Ponsioen (1962) had referred to it as basically a multi-dimensional concept comprising economic, social, political and all other dimensions of addressing human needs.

It is clear from analysing the definitions that the concept of holism in development comes with it several development issues. It comes also with models and intervention approaches in guiding development practitioners in the improvement of quality of life (Bradley, 2014; Swarbrick, 2006). These issues, models, and intervention approaches are briefly discussed here. Concerning issues that the concept has raised, first, with it has emerged a growing realisation of the need to respond to the physical and spiritual needs of humans. Myers (2000) had argued that humans have both physical and spiritual needs that need to be addressed.

Second, the concept suggests the need to look beyond the use of socio-economic indicators in determining the overall quality of life of a person (Ventegodt et al., 2003; 2005). There is a growing realisation of this need in development discussions (GSS, 2014). It is worthy to note that human needs

comprise both economic and non-economic elements. Third, there is the growing acceptance of the concept of holism in development in the health discipline where both physical and spiritual therapies are applied in health care delivery (Zini, Büssing & Sgan-Cohen, 2010). It has been recognised by many health professionals. Finally, there is the growing need for the inclusion of psychological dimension of human development where happiness, peace, and sense of belongingness are measured as part of the overall human progress (Wray, Hallas & Banner, 2007; Lindholdt et al., 2003).

The concept of holism in development has also given rise to various models of addressing human needs. Bradley's (2014) conceptual model of holistic wellness includes addressing the physical, emotional, spiritual, social, environmental needs of humans. Swarbrick's (2006) model includes addressing the emotional, environmental, financial, intellectual, and occupational or employment, physical, social, and spiritual needs of humans. Both models advocate for interventions that will address the various aspects of human needs. The models set forth intervention approaches aimed at achieving development outcomes-integrated quality of life.

According to Kamuzora and Toner (2002) there are five types of rural intervention approaches. These are, first, the project based intervention approach, which focuses on individual intervention and uses project cycle management technique to analyse results over short or intermediate time frame. Second, the programme based approach, which focuses on a set of development interventions that are analysed over a longer time frame and integrated in the expectation that

their outputs would thereby complement one another. Third is the sector wide based intervention approach, which aims at increasing co-ordination amongst donors so that they can make systematic improvements, increase government ownership and support rather than fragment government systems.

The fourth rural intervention approach is the direct budgetary support based intervention, which involves donors pulling resources to assist governments' budget but without linking this to a particular sector. Finally, Kamuzora and Toner (2002) made mention of the sustainable livelihoods based intervention approach, which advocates a set of principles that should underpin poverty focused development activities. It puts poor people at the centre of development project. It builds on people's strengths rather than their needs.

Sustaining livelihood calls for cross-sectoral thinking and understanding of the linkages between policy decisions and local realities. It responds quickly to changing circumstances and ensuring long-term sustainability. In addition, holism in development has raised the awareness among development thinkers and practitioners of the growing need for interventions that address objective, subjective, and existential needs of humans (Myers, 2000; Lindholt et al., 2003; Ventegodt et al., 2003; Cagliero, Cristiano, Pierangeli, Tarangioli, 2011; GSS, 2014). The next section of the study reviews empirical cases related to the study.

Chapter Summary

The chapter reviewed the following theories: Hierarchy of needs theory, human development theory, change theory, and integrative quality of life theory.

The concepts were rural development and holism in development concepts.

CHAPTER THREE

REVIEW OF EMPIRICAL CASES

Introduction

This section presents the empirical base of the study. It reviews empirical cases that reflect outcomes of quality of life in rural communities. The cases reviewed were (i) Quality of life and rural development in Rural West Virginia, (ii) Quality of life and rural development study in Romania, (iii) Quality of life and Happiness in Bhutan (iv) Psychosocial Determinants of Quality of life among Kenyans, (v) Quality of life based on household measures in South Africa (vi) Integrative quality of life studies in Netherlands and (vii) Integrative quality of life studies in Denmark.

Other relevant and related empirical studies were Economic growth and human development Ranis (2004), Microfinance and economic growth by Sen (2000), Socio-economic status and health differentials in China by Lowry and Xue (2009), Democratic practices and human development by Inglehart and Welzel (2009), Accountability Tanzania: Applying 'Models of change' thinking to understand emergent strategies by DFID (2012). All cases were reviewed under the following sub-headings: Quality of life interventions and sustainability, effects of interventions on objective quality of life, subjective quality of life, and existential quality of life.

Quality of Life Interventions and Sustainability

Quality of life of people is improved through provision of appropriate interventions. Interventions are evaluated for various reasons including sustainability. In most of the cases reviewed, interventions provided improved aspects of quality of life. However, it appeared that all the cases reviewed were silent on project sustainability. For example, the empirical works of Bukenya (2003), Ventegodt et al. (2003; 2010), Ioana (2012), Li and Weng (2007) and Sanjrani (1993) did not include a section on intervention sustainability.

Outcomes of Development Interventions on Objective Quality of Life

The empirical research by Ventegodt et al. (2003) identified outcomes that actually can be expected from quality of life measurement. These include objective quality of life, subjective quality of life, and existential quality of life revealed in an improved income level, health status, educational level, wellbeing, satisfaction with life, happiness, meaning in life, realisation of life potential, fulfilment of needs, and religiosity.

In the cases reviewed, outcomes of quality of life studies were varied due to focus of the project. In the United States of America, Bukenya (2003) conducted a study on 'analysis of quality of life, income distribution and rural development in West Virginia, USA. Using tables, frequencies, structural equation model, and ordered probit model, the study concluded on several issues. Apart from concluding that quality of life increases with income, health and

education and decreases with being single and unemployed and positively correlating with rural development.

In Pakistan, Sanjrani (1993) studied problems of rural women in lower Sindh. The study adopted a participatory approach and assumed exploratory and descriptive natures. The key findings revealed conditions arising out of unmet needs, which were first, physical needs (lack of safe drinking water, lack of health facilities), economic needs (inadequate income, unemployment). The self-actualisation need could not be applicable due to age old traditions, customs and superstitions bidding women to a pre-determined process of socialisation. The key recommendation was the need to adopt a holistic approach to quality of life.

In Romania, another quality of life and rural development study was conducted by Ioana (2012). The study identified a range of quality of life factors, namely, education, health, satisfaction with life, income, environment, and information communication technology. The study concluded that there was an improved quality of life in terms of health, education, safe drinking water, rural infrastructure with European Union financial intervention. However, there was low satisfaction with life among beneficiaries.

In Europe, D'Elia (nd) conducted a study on quality of life in Northern Ireland sought to measure in a first attempt the quality of life in Northern Ireland and to gauge how that country compared in terms of quality of life with other UK regions and EU countries. It sought also to find out whether Northern Ireland was a good or bad place to live in. The study used three variables, social, economic, and environmental, in determining quality of life. Using percentages, histograms,

correlation, and a baseline, the study concluded that the overall quality of life index for Northern Ireland was not greatly influenced by alterations in the importance given to the different indicators.

The determination of a quality of life index for Northern Ireland demonstrated the importance of moving away from reliance on headline indicators, such as GDP/GNP per capita. The study concluded that the existence of community division and distrust within Northern Ireland undoubtedly exerted negative influences on the overall quality of life of its inhabitants through the impact on housing, crime, etc., and although those aspects of social capital had not been expressly incorporated in the index, the indicators used indirectly reflected their consequences for quality of life.

Another quality of life study was conducted by Li and Weng (2007) who focused on measuring objective quality of life in the city of Indianapolis, United States. Using Pearson's correlation, factor analysis, and regression, the study concluded that environmental care, education, income and household size positively correlated with objective quality of life.

In Kenya, a quality of life study was conducted by Ondigi and Mugenda (2011). The study sought to investigate the psychosocial determinants of quality of life among Kenyans. It was to establish whether psychosocial related factors (emotional status, marital status, and spiritual status, number of children, health status, educational level and income level) contribute to the satisfaction of quality of life among Kenyans. The study concluded that there is a significant

relationship between individual emotional status, marital status, and number of children, health status, educational level and income level and quality of life.

In South Africa, another study by Kironji (nd) measured quality of life based on household-based measures using income, education, employment, health, access to interventions in some rural communities of South Africa. The study used cluster analysis to group households accessing similar quality of life indicators into quality of life groups. It also used discriminant function analysis to identify indicator or indicators which differentiate quality of life conditions among groups.

Findings relating to the influence of household material conditions on perceived quality of life show that proportionately more households in groups with better access to the selected quality of life indicators being satisfied with life than otherwise. The study showed that there was a consistency in the proportion of household which felt that they experienced change after all, irrespective of the group ranks, throughout the reference period.

The study concluded that low levels of education and employment greatly influenced household quality of life in rural communities. It also concluded that poor quality of life is not related to sex of the household heads. The study also concluded that a holistic focus on factors that impede household's ability to improve their living conditions is ideal.

In Latin America, Graham (2008) sought to address issues involved in taking a broader, quality of life-based approach rather than an income-based approach to assessing welfare. Using tools provided by the economics of

happiness and relying on large-scale surveys and field research, the paper showed how a quality of life approach could help to evaluate the welfare effects of factors ranging from income, health, education, and employment status, institutional arrangements such as inequality and opportunity, and happiness.

Nonetheless, inferring policy implications directly from the results was problematic because of factors including norms and expectations based on differences in the way individuals answered questions to surveys and the lack of clarity in the definition of happiness. The study concluded that happiness studies could provide critical insights into quality of life in Latin America, in areas ranging from income, poverty and inequality to public health and political arrangements. It also concluded that average income levels brought happiness in a positive way for small, poor communities.

Ranis' (2004) studies on economic growth and human development concluded that there is a significant correlation among education, income and human development. The results also showed that human development is a necessary condition for long-term sustainable growth. In terms of education, Hannum and Buchmann's (2004) study on education and economic expansion concluded that education enhances the individual's economic and health securities, and demographic benefits.

In addition, Ranis' (2004) study on education and human development concluded that there is a significant link between education and quality of life. The study, further, concluded that improving levels of education of people should have priority or at least move together with efforts to directly enhance growth.

Sen (2000) conducted a study on micro finance and economic growth and demonstrated that increased income level or increased access to micro-finance enhances human development.

Sen's (2000) study concluded that income growth is a significant component that increases the capabilities of individuals, and thus the human development of a nation. Furthermore, the study concluded that at the macro level, increased income distribution from economic growth, has a strong impact on human development. At the micro level Rickman's (2012) study further supported Sen's (2000) conclusion that poorer households spend a higher proportion of their income on goods which directly address their basic needs namely; food security, better health, wealth, security and education.

Outcomes of Development Interventions on Subjective Quality of Life

Ventegodt et al. (2003) conducted quality of life studies among the Danes using the Integrative quality of life theory. The Danish quality of life survey was based on the philosophy of life known as holistic or integrative with six different concepts namely wellbeing, satisfaction with life, happiness, meaning in life, realisation of life potential, and fulfilment of needs. The survey was carried out on 10,000 Danes. Using frequencies, tables, content analysis, exploration and simple narratives, the results showed that for the past decade every Dane came to know the concept of global quality of life. The result has been accepted by the Danish government and the instruments are being updated to measure the concept of purpose of life during the next decade.

Other studies showed that good health enhances economic growth and human development in both developed and developing countries. For instance, Lowry and Xie (2009) examined the socioeconomic status and health differentials in China focusing on convergence or divergence at older ages. With a sample size of 1,366,401 respondents aged 25 and older and using logistic regression, the results showed the predicted probability of reporting good health by income quartile and age for rural respondents. Health differentials by income were minimal until age 60, at which point pattern of divergence was observed. Although probabilities of good health were similar among people earning income in first and second income quartiles, having income in the third, and even more so, in the fourth, quartile were clearly associated with better self-reported health. The pattern became more and more pronounced in old ages.

Empirical studies had shown a significant correlation between democracy and human development. In particular, Harding and Wantchekon's (2010) study on the political economy of human development concluded that the (1) human development is higher under democracy (2) Political institutions matter because they provide structures of accountability and (3) Political institutions provide the opportunities for development, but these opportunities can be missed.

Furthermore, Inglehart and Welzel's (2009) study on democratic practices and human development showed a significant correlation between freedom of expression and human development. In a related work, Harding and Wantchekon's (2010) reviewed studies on political economy of human development. Using content analysis, they concluded that quality of life is higher

under democracy but this opportunity can be missed for lack of information and participation. When people are knowledgeable in how to make decisions that affect their lives, they participate in development matters with meaning.

Stroup (2006) sought to analyse previous cross-country studies on how economic freedom is positively correlated with various measures of prosperity and human welfare in society. His empirical analysis showed a positive correlation between economic freedoms/democratic political rights and objective quality of life defined in terms of health, education and disease prevention.

Outcomes of Development Interventions on Existential Quality of Life

Another quality of life and happiness studies was conducted in the Kingdom of Bhutan by Dorji (2013). The study focused on measuring Gross National Happiness measured in terms of physical and spiritual wellbeing. Interventions used in the study were living standard, health, and education, the use of time, good governance, ecological resilience as well as emotions, spirituality and happiness. Taking a survey of 7000 respondents, the study concluded that material and spiritual development occur side by side to complement and reinforce each other.

In the study of Bukenya (2003) on Quality of life and rural development in Rural West Virginia, a further conclusion of the study was that a positive and a significant correlation existed between religion and quality of life. Similarly, Quality of life study of Ondigi and Mugenda (2011) concluded that there is a correlation between quality of life and spiritual status of a person.

In Ghana, the literature on quality of life studies is admittedly limited as reflected in the background of this study. The work of Takyi (2003) focuses religion and health, Takyi and Addai (2002) focuses on religion, marital status and education, and Gyimah (2007) focuses on religion and child survival.

Challenges to Improving Integrated Quality of Life

Challenges to integrated quality of life improvement in the cases reviewed are many with respect to the context. They are continuous neglect of religion in development, inadequate intervention package and unclear definition of quality of life. The empirical studies above emphasised the importance of both objective and subjective dimensions of quality of life. However, most of them were conducted in areas that were not highly religious. That helps explain the less emphasis those studies placed on the existential domain of quality (spirituality). In other words, the studies failed to establish the role of religious worldview of the people in determining their quality of life. In other words, the studies failed to integrate all domains of human needs. That could help explain why such studies did not integrate all domains of human needs and subsequently adopted quantitative methodological approach in their data analysis. Most of empirical studies also used statistical tools such as discriminant function analysis, factor analysis, correlation and chi-square for the analysis in the analysis of data.

Lessons Learnt from the Empirical Cases Reviewed

The cases reviewed present some lesson for understanding the framework reflecting on outcomes of rural interventions applying the integrative quality of life theory. One important lesson is that reflecting on outcomes of rural development intervention requires regular examination for sustainability. Another lesson learnt was definition of integrated quality of life factors. According to Constanza et al. (2007) overlooking other equally important quality of life indicators such as religiosity defeats the concept of quality of life.

Gaps Identified from Empirical Cases Reviewed

The gaps identified from the case studies reviewed based on the literature on integrated quality of quality of life are as follows: First, an overview of the empirical cases showed a paucity of the important role intervention sustainability plays in the improvement of quality of life. Interventions need to be evaluated for their sustainability and their ability to improve integrated quality of life.

Second, an overview of the empirical cases also showed that existential domain of quality of life (religiosity or spirituality) seems to be overlooked. Literature reviewed has shown that religion plays an important role in development of a person who has a dual nature – physical and spiritual. According to Deneulin and Rakodi (2010), Goulet (2000), Ryan (2003), Myers (2000) and Ventegodt et al. (2003) including religion in quality of life measurement makes complete addressing human needs.

Finally, an overview of the empirical cases showed that integrative quality of life theory has not been used adequately in quality of life studies.

Conceptual Framework for the Study

The conceptual framework for this study has emerged out of the summary of the key dependent and independent variables from the related literature reviewed. The literature thus far has revealed some key dependent variables in the determination of the integrated quality of life (independent variable). The independent variables are the objective quality of life (defined as income, education, and health), the subjective quality of life (defined as well-being, satisfaction with life, happiness, meaning in life, realisation of life potential and fulfilment of needs) as well as the existential quality of life as component outcome of development (defined as spirituality).

The conceptual framework for this study is based on Constanza et al.'s (2007) quality of life as shown in Figure 2. According to them, quality of life is improved as a result of the interaction between human needs and the subjective perception of their fulfilment, as mediated by the opportunities available to meet the needs. The opportunities included built (defined in terms of manufactured goods such as tools, equipment, buildings), social (defined in terms of networks and norms that facilitate cooperative action), human (defined in terms of knowledge and information stored in our brains, as well as our labour) and natural capitals (defined in terms of renewable and non-renewable goods and services provided by ecosystems).

Constanza et al. (2007) argued that the ability of a person to satisfy his/her basic needs comes from the above opportunities. However, these opportunities are influenced by the culture of the people (that is the prevailing norms in the context of the study, how the people perceive life satisfaction), and the policy to guide interventions needed to bring quality of life.

In adapting Constanza et al.'s (2007) conceptual framework with few changes, the conceptual framework for this study, therefore, connotes the idea of a sustained integrated quality of life (IQOL) of the individual. The conceptual frame work suggests that the interaction between quality of life needs (income, education, health, wellbeing, satisfaction with life, happiness, meaning in life, fulfilment of needs and realisation of life potential) of the rural people (as principles of Maslow's (1970) hierarchy of needs) and the improved integrated quality of life subjectively perceived by the individual in three domains of human experience (objective, subjective and existential) as explained by Change theory and Integrative Quality of Life theory and sustained through willingness to contribute leadership & financial support, ownership, and playing advocacy role is mediated by the interventions (micro enterprise, health services, safe drinking water, primary education, vocational training, advocacy and religious interventions) available to meet them (Human Development theory) as shown in Figure 3. However, the process is facilitated or inhibited by the interaction between cultural factors prevailing in the community and policy implementation by development practitioners.

It is worthy to note that the provision of these interventions is facilitated by the culture and policy options that are available in these rural communities (which may enhance or inhibit quality of life at the individual, community, and national levels). It is also important to realize in this conceptual framework that some of the IQOL factors are interrelated.

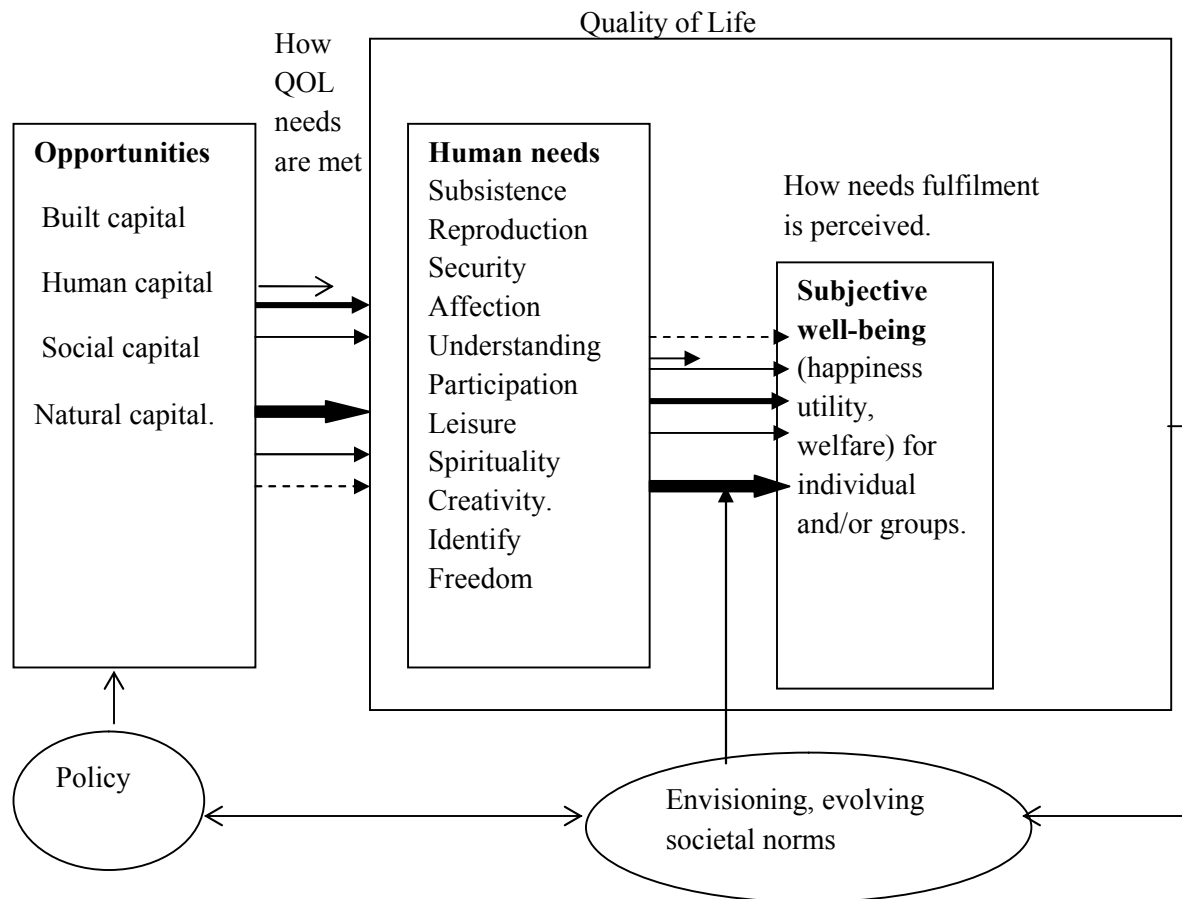


Figure 2: Human Needs and Quality of Life Concept

Source: Constanza et al. (2007)

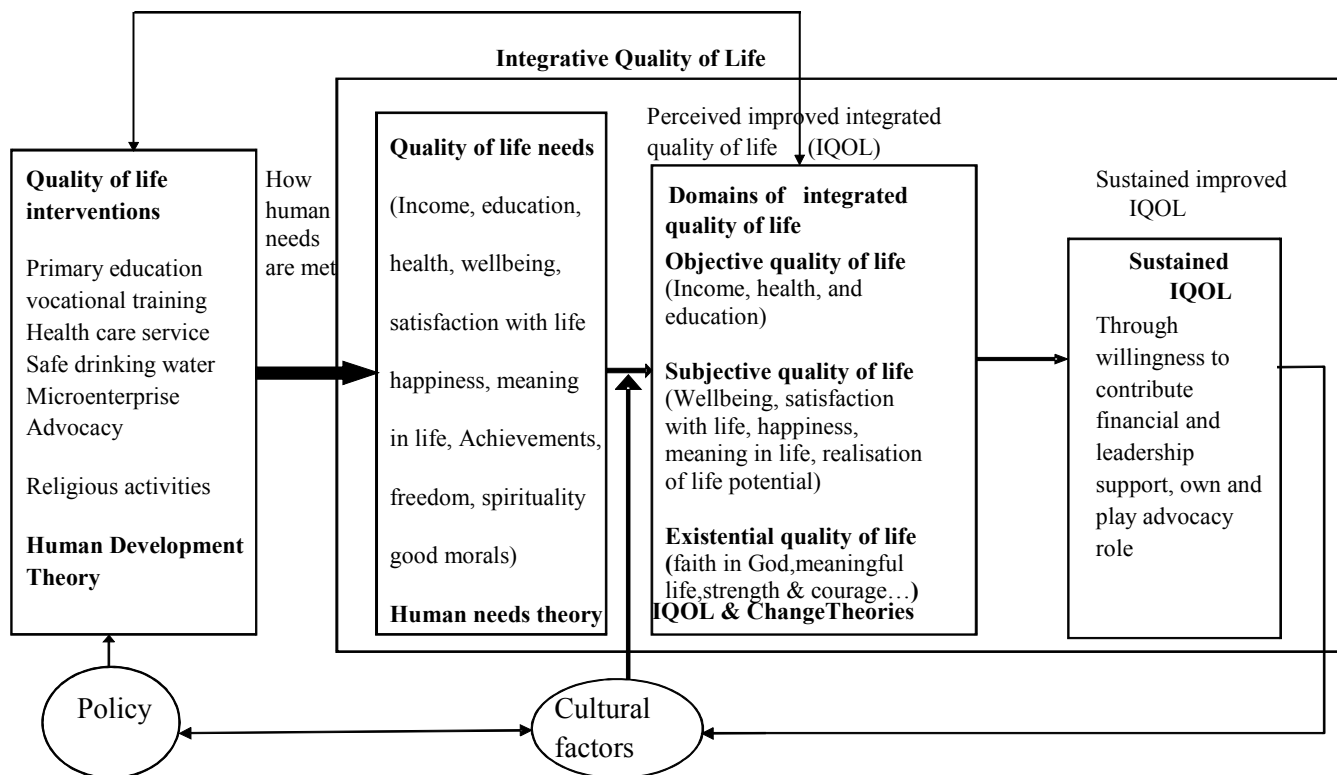


Figure 3: Human Needs, Interventions and Integrative Quality of Life

Source: Adapted from Constanza et al. (2007)

The reason is that there are no completely “objective” measures of the factors because integrated quality of life is by its very nature a normative, subjective concept or construct. Subsequently, the different views of IQOL help this study to identify a minimum set of variables that occur cross-culturally and over time. Put together, the above key variables help to reflect outcomes of GBC’s rural interventions on the integrative quality of life theory.

Chapter Summary

The chapter reviewed empirical cases relevant to the study. The review was done under headings specific to the objectives of the study captured as follows: quality of life interventions and sustainability, outcomes of interventions on objective quality of life, outcomes of interventions on subjective quality of life, outcomes of interventions on existential quality of life, challenges to improving integrative quality of life, lessons learnt from cases reviewed, and gaps identified from empirical cases reviewed. The conceptual framework for the study was next presented. The next chapter presented the methodology to the study.

CHAPTER FOUR

METHODOLOGY

Introduction

This chapter describes the methodology used to address the five objectives of this study. Methodology provides a sound structural frame to research regarding how it is conducted. Furthermore, depending on the kind of research methodology employed, it provides the basis for validity and reliability as well as the generalisability of the research findings (Creswell, 2007; 2009). In this chapter, the methodological issues for this study covered the following topics: philosophy of the study, study area, study population, sample size and sampling procedure, data sources and data collection, research instruments, pre-testing of instruments, ethical consideration, data analysis and techniques.

Philosophy of the Study

The theoretical perspectives that have influenced structures, processes and directions of social researches are many and diverse. However, two perspectives that have dominated research studies until recently have come from the positivists and interpretivists perspectives (Sarantakos, 2005; Creswell, 2007; 2009; Cohen, Manion & Morrison, 2007). The positivist researchers prefer quantitative data and often use experiments, surveys, and statistics in research (Sarantakos, 2005). They seek rigorous, exact measures in an objective research, and they test hypothesis by carefully analysing numbers from the measures.

According to Cohen, Manion, and Morrison (2007), positivists see a system of philosophy as based on experience and empirical knowledge of natural phenomena. They see social sciences as an organised method for combining deductive logic with accurate empirical observations of individual behaviour in order to discover and confirm a set of probabilistic causal laws that can be used to predict general patterns of human activity. However, they are faced with critics. Denzin and Lincoln (2005) charge that positivism reduces people to numbers and that its concerns with abstract laws or formula are often perceived as emphasising structures of reality outside meaning.

Perceiving social research from interpretivists' view, Creswell (2007; 2009) argues that interpretivists describe social research as a systematic analysis of socially meaningful action through the direct detailed observation of people in natural settings in order to arrive at understandings and interpretations of how people create and maintain their social world. Interpretivists argue that social studies are about real people in real life situations. They are concerned with how ordinary people manage their practical affairs in everyday life, or how they get things done. For these reasons, interpretivists often use participant observation and field research in their data collection. Participant observation requires a check list, and field research requires that researchers spend many hours in direct personal contact with those being studied. In addition, others analyse transcripts of conversations or study video tapes of behaviour in extraordinary detail.

As a result of the positivistic and interpretivistic schools of thought, two major methodologies (quantitative and qualitative) have emerged in the social

sciences. Qualitative methods of approach are descriptive and involve the collection and analysis of data. The nature of qualitative data is subjective. The approaches concern themselves with meanings, attitudes and beliefs of people in a real life situation (Creswell, 2005; 2007). Quantitative methods involve numerical counts of variables from which statistical inferences and tests can be drawn.

Despite the general acceptance of quantitative and qualitative methodologies in social researches, social scientists are now aware that epistemological and ontological commitments may be associated with diverse research studies and methods. Therefore, the thresholds are not deterministic and for some time the debate continues on the question of which one of the two, quantitative and qualitative, is the sine qua non methodology in research. This debate has been addressed by the mixed methodology championed by Creswell (2003; 2005; 2007; 2009).

The mixed method research serves both as a methodology and a study approach, and it involves collecting, analyzing, and mixing qualitative and quantitative approaches in a single study or a series of studies (Creswell & Plano Clark, 2007). Both Bryman (2004) and Creswell (2009) conclude that quantitative and qualitative methodologies and approaches complement each other's strengths and address each other's weaknesses in social research. The mixed method approach to research is, generally, thought to produce more valid and reliable results than the use of single methods.

However, critics argue that the mixed method approach in research tends to serve the quantitative community by straying too far from the interpretive

foundation of qualitative research (Denzin & Lincoln, 2005). It is criticised as being time-intensive (Creswell, 2003). In spite of this, the mixed method design in research provides an opportunity for eliciting information of much wider dimension to facilitate the study (Creswell, 2003). As Twumasi (2001, p. 29) stated, “it is...important to note that the selection of a particular method to collect data must be decided upon in the light of one’s problem”.

The philosophical issues discussed above, therefore, gave a good reason for this study to adopt a mixed method approach, which included descriptive, exploratory and explanatory emphasis on outcomes of development interventions (Imas, 2009). The study was to document GBC rural projects that involved description and evaluation. It was also to assess effects of GBC’s rural interventions on beneficiaries. That involved description and explanation of the effects of the interventions on beneficiaries’ subjective and existential qualities of life variables which were limited to well-being, satisfaction, happiness, meaning in life, fulfilment of needs and realisation of life potential. The study was to determine the effects of GBC’s rural interventions on beneficiaries’ objective quality of life variables which were limited to their income, health, and education.

Study Area

Punch (2005) points out that a study area is a general interdisciplinary field of research and scholarship pertaining to a geographical, national or cultural regions within which different topics are identified, research questions developed,

data collected, and findings established. The general field of inquiry for this study was the reflections on the outcomes of GBC's interventions in selected rural communities in Ghana applying the IQOL theory.

The Ghana Baptist Convention provides development interventions in some rural communities in Ghana. According to GBC (2000) development strategy, the country is divided into four main geographical blocks known as Sectors. These include Northern Ghana sector (comprising Upper West, Upper East, and Northern Regions), Mid-Ghana sector (involving Ashanti and Brong Ahafo Regions). The rest are the South East Ghana sector (including Eastern and Volta Regions), and South West Ghana sector comprising Western and Central Regions.

The Ghana Baptist Convention had rural interventions in all nine Regions of Ghana as at the time of the research except Greater Accra. Greater Accra region was excluded because communities with GBC rural programme were above a population of 5000 people. As shown in Tables 1 and 2, each GBC's demarcated sector has a number of rural communities with rural interventions provided by the GBC. Demographic information for these study areas were gathered based on the Ghana Statistical Service (GSS, 2005).

Table 1-GBC's Interventions in some Rural Communities in Ghana

Region	District/Municipality	Rural community	Population	Project
Northern Ghana Sector				
Upper West	Wa	Sombo	1902	Cashew nut farm
Upper East	Kasena-Nankana	Zua Koligo	598	Primary school
		Kumbusumgo	1101	Basket weaving
	Bolgantanga	Zuarungu	4552	Basket weaving
Northern	Tolon-Kimbungu	Kasulyili	2334	Microenterprise
		Tollugu	368	Bore-hole
		Cheshegu	1148	Junior High Sch.
Mid-Ghana Sector				
Brong Ahafo	Jaman South	Baabianiha	2561	Primary school
		Drobo	1335	Mix farming
Ashanti	Ejusu-Juaben	Kumaho	237	Bore-hole
		Femusua	4576	Bore-hole

Source: Ghana Baptist Convention book of Reports, (2010; 2008)

Table 1- Continued

Region	District/Municipality	Rural community	Population	Project
South West Ghana Sector				
Western	Ellembelle	Fiesoro	139	Coconut farm
	Jomoro	Nyame Bekyere	112	Bore-hole
	Half-Assini	Ahwi Tutu	554	Marine fishing
		Ehoaka	1037	Marine fishing
Central	Efutu	Sankor	2683	Hospital
		Nsuekyir	723	Primary school
		Warababa	118	Bore-hole
	Gomoa West	Amanful	217	Bore-hole
	Gomoa East	Kweikrom	715	Sewing centre
	Gomoa Central	Asafo	949	Palmtree farm
	South East Ghana Sector			
Eastern	Assuogyaman	Frankadua	2720	Vocational training
Volta	North Tongo	Galelope	101	Primary school
		Gyirepi	201	Nursery school
	South Tongo	Amanful	219	Water project

Source: Ghana Baptist Convention book of Reports, (2010; 2008)

Frankadua Community

Frankadua is located in Eastern Region, Ghana. It has a population of 2720 (GSS, 2005). From the Assuogyaman District Medium term Development Plan, it is boarded on the north by a mountain, on the south by Podoe rural community, on the west by Apegusu, and on the east Fintey rural community. Frankadua has a river called Alabo, which has become the main source of life activities for the people. This is supplemented by the provision of bore holes. During the dry season, the salinity of the water in these bore holes become high and poses a challenge for the people to use it when the river dries up but improves during the dry season. Pipe borne water is being extended to the community (Assuogyaman District Assembly, 2014).

Frankadua has two rainfall seasons in June-July and September-October each year. On the average the rainfall figure is 60 centimetres per year. The hot dry conditions with average temperature of 25⁰C per annum are also very suitable for farming activities, which are largely seasonal. Most of the farmers engage in the production of maize and cassava, and vegetables. Some of the farmers add value to the cassava by processing it into gari. Other economic activities in Frankadua are petty trading, pottery, and hairdressing. Many of the people are self-employed. In terms of ethnic groupings, the Ewes are the main ethnic group in Frankadua. In relation to health, Frankadua has one health clinic. There are seven health workers headed by a midwife. The health workers include three registered nurses, and two health nurse assistant nurses and a security. According

to the Administrator, the district medical officer visits the health clinic periodically (Assuogyaman District Assembly, 2014).

From the District's layout, Frankadua community is connected to other nearby towns and villages with some major roads such as the Tema-Ho road. Traditional system of governance in Frankadua is led by the Chief, the Elders, and the Queen mother. The relative peace in the community could be a potential platform for development in the area (Assuogyaman District Assembly, 2014).

Religiously, Frankadua has ten Christian churches with other religious faiths groups such as the Muslims and the traditional religion in the minority. There is Trokosi practice in Frankadua. According to Wisdom (2001), trokosi practice in that community has rendered poor the victims and their family. There are five educational institutions in Frankadua ranging from pre-schools to a vocational training. None of the Trokosi girls are allowed to acquire basic education in any of these learning centres. According to Wisdom (2001), they are used as labourers to work on farms belonging to the shrine priests. He indicated that some trokosi girls become forced wives of the shrine priests. They are not allowed to engage the outside community, have their freedom, their sense of respect and self-worth (Wisdom, 2001).

Kasulyili Community

From the Tolon Kumbungu District Assembly Medium term Development Plan, Kasulyili is a flat land community located in the Tolon Kumbungu district, Northern Region. Kasuyili is bordered on the south by Kuguri and Watugu, on the west by Zali, on the east by Jenpu village respectively. It is also boarded on

the north by Namdu village. Kasulyili has one rainfall season, which begins in May and ends in September each year. The area experiences an average rainfall figure of 60 centimetres per year and hot dry conditions with average temperature of 23⁰C per annum conditions which are also very suitable for farming activities (Tolon Kumbungu District Assembly, 2014).

However, farming activities are largely subsistent in nature because the farmers largely depend on manpower to cultivate lands for farming. Farming activities in Kasulyili are also seasonal in nature because the farmers depend on the rainfall pattern in Ghana respectively. With the gradual introduction of mechanised farming by the government in some part of Northern Ghana, it is hoped farmers in the north will soon benefit from it. However, how accessible and affordable are these modern farming implements to the farmers is still a challenge (Tolon Kumbungu District Assembly, 2014).

According to the Medium term development plan, employment in Kasulyili, largely, comes from agriculture farming. It engages most of the population in the community. Thus, the people engage in trading farm produce such as yam, sorghum, millet, groundnuts, and maize. However, these farm produce are transported to Tamale since demand in farm produce in Kasulyili is low. Other economic activities are corn mill operation and selling of water. A typical water selling activity in Kasulyili involves transporting water from distant places to consumers (Tolon Kumbungu District Assembly, 2014).

The main tribal group in Kasulyili are the Dagombas with other few tribal groups in the community. The community is predominantly a male-dominated

one. The compound-based housing structures are an indication of the kind of communal and social solidarity among the people. However, the housing structures also illustrate aspects of low quality of life in Kasuyuli. Kasulyili has a population of 2334 (GSS, 2005). Very few people own their homes. The educational system in Kasulyili is generally poor in terms of the number of schools for the children as compared to those in the urban areas. There is one educational institution in Kasuyuli, the Baptist Child Development Centre. The school is at the prime level, that is, from the nursery to the junior high (Tolon Kumbungu District Assembly, 2014).

According to the Medium Term Development Plan, Kasulyili has no health facility. To a large extent, the people depend on traditional method of healing. Few, who can afford, seek medical attention at Tamale, the capital town of the Northern Region. However, road and transportation challenge access to the Tamale medical centre and efficient mobility of farm produce to markets (Tolon Kumbungu District Assembly, 2014).

Traditionally, Kasulyili has a centralised political system. The structures of traditional governance in Kasulyili are based on a lineage basis. The lineage forms the largest political unit. Political governance in Kasulyili is also represented by the District Chief Executive. Kasulyili is a very religious community. It is predominantly a Muslim community with many mosques. Other religious faiths such as Christianity are in the minority (Tolon Kumbungu District Assembly, 2014).

Baabianiha Community

The Jaman South District Assembly Medium term Development Plan describes Baabianiha as a rural area located in the Brong Ahafo Region Jaman South District Assembly, 2014). According to the medium term development plan, Baabianiha lies 85 kilometers from Sunyani, the capital town of Brong Ahafo Region, Ghana. It is boarded on the north and the south by Japekrom and Dotokrom respectively. It is also boarded on east and the west by Boubonu and a thick forest respectively. Baabianiha has an annual average rainfall figure of 80cm during June-July, September-October with hot and dry conditions during the rest of the months with an average annual temperature of 25⁰C. This creates a suitable climate for the production of cocoa, maize, cassava, and vegetables (Jaman South District Assembly, 2014).

The people of Baabianiha, largely, trade in various farm produce including cassava, maize, mango, and vegetable farming because the people are predominantly farmers. On the minority side some carry on non-farm economic activities including buying and selling of new and used clothing, cell phone units, and sand winning. However, farming activities are largely seasonal because the people depend on the rainfall pattern in Ghana. The Bonos are the main ethnic group in Baabianiha with other ethnic groups like the Ashantis in the minority. It has a population of 2561 (GSS, 2005).

In relation to health, Baabianiha has no health facility. Patients had to walk or rely on public transportation to get to nearby healthcare centre in Drobo. According to the Drobo District Health Directorate report, common diseases in

the area are malaria, diarrhoea, and hypertension. Traditional system of governance is led by the chief with the elders including a queen mother. Political governance is also headed by the District Chief Executive. Relative peace in the community is a necessary sign of quality of life. Religiously, majority of the people of Baabianiha are Christians with Muslims and Tradionalists in the minority.

There are two schools in Baabianiha; primary school run by GBC and the public school. However, the challenges are that some of the children in the community are forced to walk several miles to attend school in Drobo Township because of over enrolment of pupils in the two community schools and lack of infrastructure expansion (Jaman South District Assembly, 2014).

Amanful Community

According to the Gomoa West District Assembly Medium term Development Plan, Amanful is a rural community in the Gomoa West district of the Central Region. It lies one kilometre south of the Accra-Cape Coast highway. The community is approximately eighty-five kilometres west of Accra, the capital city of Ghana in the Greater Accra Region. It is surrounded by hilly features that allow for the collection of erosion water in the valley or man-made holes. It is bordered on the south by Obiri rural community, on the west by Asuosha rural community, on the east by Brofoyedur rural community. It is boarded on the north by Asiakyir rural community. Rainfall figures are quite low (between 50cm to 70cm per year) and the temperatures (with average minimum and maximum

temperatures of 22⁰C and 28⁰C respectively) are hot dry, some prerequisites for a potential safe drinking water crisis (Gomoa West District Assembly, 2014).

The Medium term Development Plan has it that, economically, the majority of the people of Amanful engage in farming activities. Few are, however, engaged in artisanship and petty trading. Youth migration to the cities and even to neighbouring countries is also prominent in Amanful due to the seasonal nature of farming, unemployment and inadequate public services (Gomoa West District Assembly, 2014). The main ethnic group is the Gomoa Akans. Amanful has a population of 217 (GSS, 2005). Each household has an average of 6 people (GSS, 2007) living in it and very few people own their homes. In terms of housing structures, a significant number of the houses are constructed from clay bricks, with zinc or thatch roofs. Out structures for bathrooms and toilet/latrine are detached from the main houses.

The Amanful rural community shares with Fawomanye rural community a primary school standing equidistant from each other (Gomoa West District Assembly, 2014). There is no health facility in the community or nearby. The only nearby healthcare centre is the Apam Catholic Hospital in Apam, a district capital of the Gomoa West District. It is located 20 kilometres east of Cape Coast-Accra main road and 6 kilometres south of it.

Amanful had no source of safe drinking water. They depend on muddy water from the seasonal rains as shown in Plate 4. As conducted by Tenkorang, Kendie and Enu-kwesi (2008), contamination of drinking water results in a compromise in the health of people who drink it. Others walk long distances to

other water holes in other villages to fetch mud water. Another source of water is water packed in sachets from trucks that come through the rural community to sell them.

Amanful is linked to the Accra-Cape Coast road. However, there is only one taxi in the community that serves the people. Amanful is connected to the national power grid. Traditional governance in Amanful is led by the Chief and clan heads. Political governance is also led by the District Chief Executive (DCE). The people of Amanful are religious. The community is endowed with five Christian churches, with one Mosque and a shrine.

Sankor Community

According to the Efutu Municipality Medium Term Development Plan, Sankor lies Sixty-five kilometres west of Accra, the capital city of Ghana and hundred kilometres east of Cape Coast, Central Region. It is boarded on the north and south by Asiebu village and the Gulf of Guinea respectively. It is also boarded on the east and west by Osubunanyin village and Winneba town respectively. The Sankor community is endowed with River Ayensu. River Ayensu helps to irrigate the land and make it good for agriculture. It holds the potential to be also a tourist attraction because of its estuary features such as the mangroves. The sea can also be used for salt-making on commercial scale to give employment to the people (Efutu Municipality, 2014).

The Medium Term Development Plan indicates that rainfall figures are quite low (between 50cm to 70cm per year) because Sankor is a lowland area; this kind of climate is suitable for the production of maize, coconut, cassava, and

vegetables. At the same time, the hot dry conditions (with average minimum and maximum temperatures of 22⁰C and 28⁰C respectively) are also very suitable for salt production. Economically, the majority of the people of Sankor fall below extreme poverty line, which means that the majority of local people are living on less than a dollar a day. Currently, the economic activities in Sankor are fishing, farming, petty trading, fish trading, mobile phone time unit sales, sand winning. Of these economic activities, fishing and farming are the most prominent, employing most of the working population (Efutu Municipality, 2014).

According to the Medium Term Development Plan, 2014, the seasonal nature of both fishing and farming in Sankor has resulted in, among other things, youths' migration to the neighbouring towns, villages and even to neighbouring countries given rise to child labour (Efutu Municipality, 2014). Socially, the Efutus are the main tribal group in Sankor. The population of Sankor community is 2683 (GSS, 2005). The different housing structures illustrate aspects of the poverty in Sankor. Some of the houses are constructed from cement blocks, with zinc or thatch roofs. Others are built with mud and roofed with zinc or thatch roofs but with no bathrooms, kitchen, sitting/living rooms, toilet/latrine, or running water (Efutu Municipality, 2014). Each house has an average of 4.7 people (GSS, 2005) living in it. The housing structures are compound in nature where individual household reside. Very few people own their homes.

In terms of literacy there are four educational institutions in Sankor, (private and public); ranging from pre-schools to junior high level (Efutu Municipality, 2014). In relation to health, Sankor has one mission hospital, that

is, the Baptist hospital. There are 54 health workers including two doctors as against 2683 people in Sankor (excluding the population of the fourteen surrounding villages). The prevalence of diseases, such as malaria, contributes to a high mortality rate (Baptist Hospital, 2009). One factor contributing to the prevalence of diseases is likely to be the indiscriminate dumping of solid waste in the community. Another factor is poor drainage system. These factors give rise to unsanitary areas that breed malaria carrying mosquitoes, as well as other harmful bacteria.

In terms of road infrastructure, Sankor streets are not tarred streets. Transportation system in Sankor connects it to other nearby towns and villages with goods and services. Sankor has traditional system of governance where leadership is exercised by the Chief, the Elders, and the Queen mother. At the government level, leadership is represented by the Municipal Chief Executive (MCE). Religiously, Sankor has eleven Christian churches, a mosque and three cultic shrines.

In summary, the chapter has described the characteristics of rural setting and the study area. The demographic characteristics (in terms of population, number of houses, households and average number of people in a house) of rural communities (Frankadua, Kasulyili, Baabianiha, Amanful and Sankor) with GBC's project are as shown in Table 2. The map showing the locations of the study communities with GBC rural interventions is also shown in Figure 4.

Table 2-Demographic Characteristics of Study Communities with GBC

Intervention

Community	No. of						Intervention
	Population		Houses	Household Av. Size			
	Total	Male	Female				
Frankadua	2720	1244	1476	392	656	4.1	Vocational sch.
Kasulyili	2334	1131	1203	191	294	7.9	Microenterprise
Baabianiha	2561	1211	1350	306	520	4.9	Primary school
Amanful	217	96	121	48	65	3.3	Water project
Sankor	2683	1226	1457	208	570	4.7	Hospital

Source: Ghana Statistical Service, (2005)

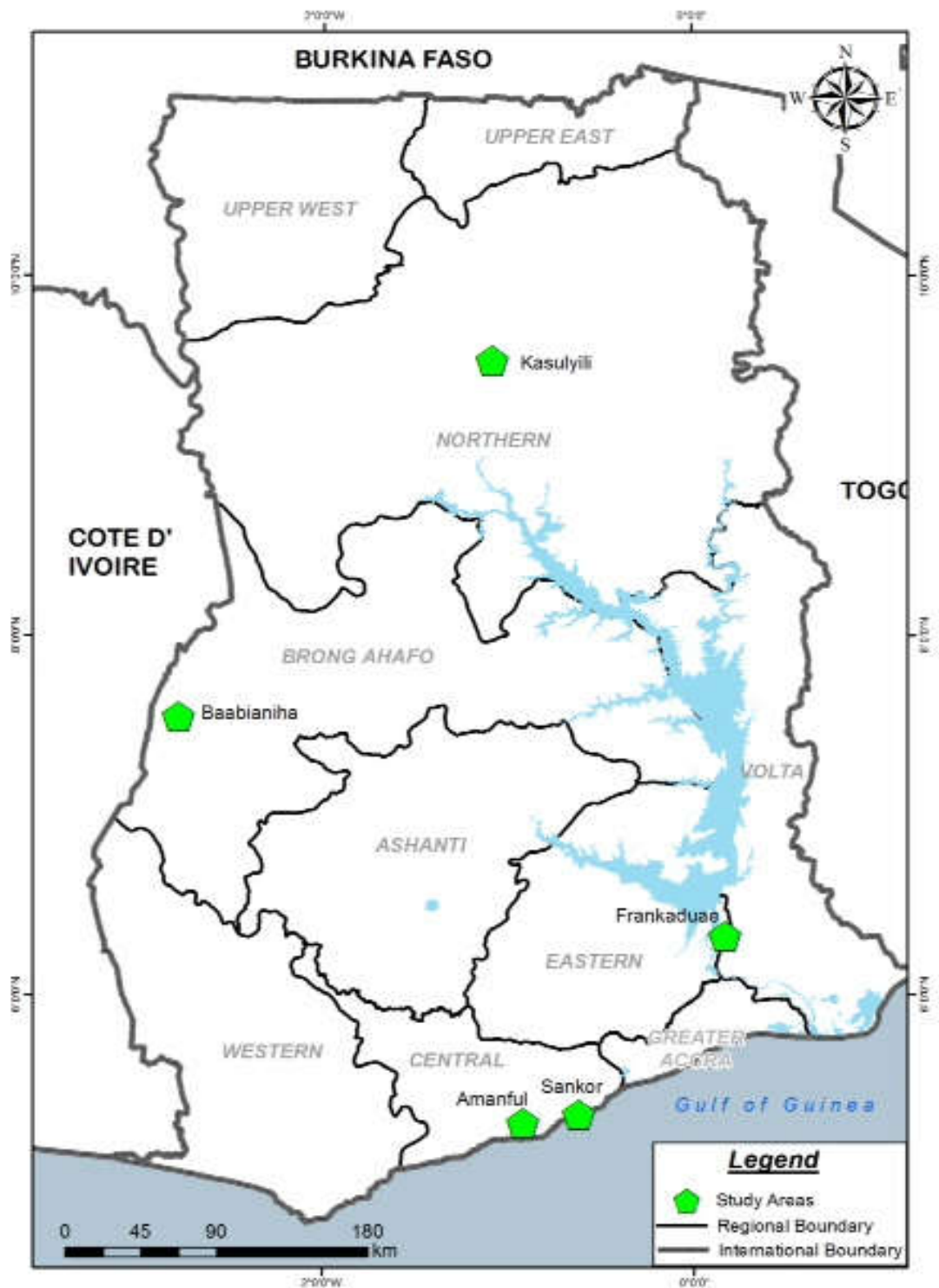


Figure 4: Map Showing Study Areas

Source: Geographical Information System, UCC: Cape Coast (2012)

Study Population

A study population is the number of objects, for example people, or events to be studied (Johnson & Christenson, 2011). Johnson & Christenson (2011) add that a study population needs to be valid, and it must have the ability to generalise the results to those that will not be included in the study. Therefore, they define study population as the larger population to whom the study results are to be generalised.

Based on Johnson & Christenson (2011) definition, the population for this study included beneficiaries 18 years of age and above accessing GBC's rural projects in the selected communities. The beneficiaries included people irrespective of sex, religion, ethnicity and who were at least 18 years of age. The total study population was, therefore, 946 households as shown in Table 3.

Table 3-Distribution of Study Population by Community

Community	Project	Study population
Frankadua	Vocational	54
Kasulyili	Microenterprise	86
Baabianiha	Primary school	171
Amanful	Water project	65
Sankor	Hospital	570
Total		946

Source: Ghana Statistical Service, (2005)

Unit of Analysis

Trochim (2006) defines 'unit of analysis as the 'who' or the 'what' is being analyzed for the study. There can be more than one unit of analysis in a research study because, as Davidson and Wiklund (2001) emphasized, the unit of analysis determines the kind of research design to be adopted. Unit of analysis in a research work consists of individuals, groups, artifacts (books, photos, newspapers) geographical units (village, town, census tract, state) social interactions (relations, divorces, arrests). In this study, the units of analysis were individual key informants, beneficiaries of GBC's interventions, and field photos.

Sampling Procedures

The sampling procedures for this study were in three stages. The study adopted a multi-stage, simple random (lottery), and systematic random sampling procedures to select the regions, communities and beneficiaries/households respectively. Multi-stage sampling was used to select four out of the nine geographical regions with GBC projects. The reason for the selection of four regions was that homogeneity characterised the rural communities and the choice of regions happened to cut across from southern through to the northern part of Ghana.

The next stage of the sampling procedure was to select five communities from the regions through simple random (lottery method). The rationale was that it was physically impossible to study entire rural population in all nine regions,

which had more than one rural community with a least a GBC project. There was also a challenge of cost and time.

Rural communities selected were Frankadua in the Assuogyaman district, Eastern region, Kasulyili in the Tolon-Kumbungu district, Baabianiha in the Jaman South district, Brong Ahafo, and Amanful in the Gomoa West district Central region, and Northern region, Sankor in the Effutu municipality.

The next stage was to select beneficiaries/households through a systematic random sampling technique in arriving at the determined number of aggregate sample size for each community. Beneficiaries/households of GBC's interventions included people in community irrespective of sex, age, religion, ethnicity, and socio-economic status. According to Johnson and Christenson (2011) a sample size is a reasonable proportion of the study population to be studied, and that is ideal to generalise results for the study population.

Several reasons are given for the need of a sample size in research studies. Machin, Campbell, Fayers, and Pinol's (1997) give finance, fairness and accuracy that the study should be guided by as reasons. In addition, Sarantakos (2005:153) gave a reason that sample size "produces comparable and equally valid results" and "offer more detailed information". Sample size in a research study also determines whether the research is worth undertaking or not irrespective of its size.

However, the question about the right sample size for a research concerns every survey methodologist in terms of how large or small for representation (Sarantakos, 2005). Sarantakos (2005) concludes that there is seldom a definite

answer about how large a sample should be for any given study as it depends on the nature of that study. However, Fowler (1993) had argued that the first requirement for determining a sample size is the “analysis plan” which deals with the outline of subgroups within the total population. This is for the obvious reason that results of the analysis are concentrated on the minimum sample sizes that are tolerated for the smallest subgroups of importance.

In the light of the above, the sample size determination for study population of Sankor and Amanful included people (household heads) in the community who were 18 years and above even though the interventions (hospital and safe drinking water) serve all the people. The sample size determination for the study population of Baabianiha (with Primary education intervention) included household heads of beneficiaries since the children were less than 18 years of age. The study population of Frankadua (with vocational training), and Kasulyili (with micro enterprise) included direct beneficiaries of the interventions each of the communities.

The sample size ‘n’ of each study population in each of the communities was based on the formula:

$$n = \frac{N}{1+N\alpha^2}$$

where n is the sample beneficiaries of GBC’s rural projects ideal for the study; N is the number of beneficiaries in the community accessing GBC’s rural project; and α is the margin of error estimated at 5 percent and confidence level estimated 95 percent. For most social sciences studies adopt the 95 percent confidence level

based on the fact that, most studies involve human beings and as a result, there is the possibility of error occurring in the course of the study.

With the study population in Table 4, the sample size for each was determined as followed Sankor (570 households) was 86 households, Amanful (65 households) was 40 households, Baabianiha (171 households) was 63 households, Frankadua (54 beneficiaries) was 35 beneficiaries, Kasulyili (86 beneficiaries) was 47 beneficiaries.

Therefore, the total expected sample size as shown in Table 4 for this study was 271. The sample size of 271 for the study was considered adequate because according to Weiers (2006), if the research process is operating properly, the means of samples of $n \geq 30$ should tend to be normally distributed for a test of statistical significance. Also according to Hair, Anderson and Tatham (1987), a sample size of at least 100 is recommended to conduct a test of statistical significance.

The next step of the was to use systematic sampling technique to select respondents using the formula $N=nk$. Where N =study population; n =sample size, and k =sampling interval. For each community, N was numbered from 1,2... N . A random number (x) was selected between 1 and k in each community. So the first unit whose serial number was x for each community was selected. Subsequently every k^{th} unit after x^{th} unit in each community was selected. For example, for Sankor community, $N=570$, $n=86$, $k=6.63$. Since humans could not be a fraction of a whole, $k=6$ and $k=7$. The $x_s=2$, where x_s = first unit of respondent in Sankor community, therefore, 2nd, 8th, 9th, 14th, 15th, 20th, 21st...till n is achieved.

Table 4-Sampling of Study Population by Community

GBC's Project	Community	Study population	Sample size
Hospital	Sankor	570	86
Safe drinking water	Amanful	65	40
Primary school	Baabianiha	171	63
Vocational school	Frankadua	54	35
Micro enterprise	Kasulyili	86	47
Total		946	271

Source: Author's Field work, Enim (2012)

The second stage of the sampling procedure was non-probability. The sampling technique for the selection of key informants for the study was purposive. According to Babbie (2007), social researchers describe respondents as people who provide information about themselves, allowing the researcher to construct a combined picture of the group those respondents represent. Babbie (2007) further argues that in sampling for key informants, it is usually important to select informants typical of the group that one is studying. In the light of these assertions I used purposive sampling technique because the key informants chosen were people considered to have more knowledge and experience in the subject area for this study.

The key informants selected in addition to the 271 household heads and beneficiaries, therefore, included selected officials from the District and Municipal Assemblies, Community Based Organisation, Local council of

churches, GBC, Chiefs, and Queen mothers (including community women leader).

The rationale for the various sub-categories key informants were that each community had a chief, queen mothers, GBC field Coordinator and a local council of churches chairman making a total number of five. One field coordinator for the community based organisation was chosen because there was only one such organisation in one study area. In addition, one executive director was chosen for Ghana Baptist Convention because the organisation had only one executive director position. The total number of 27 key informants was chosen as shown in Table 5.

Table 5-Distribution of Key Informants

Key informants	Number
Chiefs	5
Queen mothers	5
Local council of churches leaders	5
Field coordinator of community based organisation	1
Field coordinators of Ghana Baptist Convention rural projects	5
Executive director of the Ghana Baptist convention	1
District Assembly coordinators	5
Total	27

Source: Author's Fieldwork, Enim (2012)

Sources of Data

The sources of data collected for this study were both primary and secondary. The primary sources of information were obtained from chiefs, queen mothers (women group leaders), officials of GBC, CBOs, NGOs, leaders of local councils of churches, Assembly officials (District Chief Executive, District Coordinating Director), and beneficiaries of the interventions. The Primary data source provided a better understanding of the people's perception of what constitute integrated quality of life in the rural communities and thus allowed for a better analysis of factors and themes.

The secondary data sources constituted records, minutes, and reports of GBC's rural development programme. Others included textbooks, written dissertations, published articles in some of the dailies, journals, magazines, official documents from other development partners such as the District Assemblies, FBOs, NGOs, and CBOs, library and internet search, government publications and other related literature. The secondary data sources provided information on how much quality of life studies have been done to guide this current study.

Methods of Data Collection

According to Criswell, Shope, Plano, Clark, & Green (2006), data collection follows a systematic approach by which the researcher collects important data to achieve the purpose of the research. The methods include questionnaire administration, interview schedule, Observation, and Reading. This

study chose the interview schedule, observation and reading methods because respondents were semi-illiterates and I wanted to obtain first hand information about the people, object and eventful happening like market days. By these methods distortions of informations may be minimised.

According to Creswell (2007), there also six strategies in data collection in a mixed method research, namely, sequential explanatory strategy, sequential exploratory strategy, sequential transformative strategy, concurrent triangulation strategy, concurrent embedded strategy, and concurrent transformative strategy. The study adopted the concurrent embedded startegy. It is a data collection strategy that employs both quantitative and qualitative approach simultaneously (Creswell, 2009). In other words, both the qualitative and quantitative data collection methods were employed in this study simultaneously. The quantitative data collection method was embedded in the qualitative one.

However, the quantitative and qualitative data were collected simultaneously to “enrich the description of the sample participants” and to “describe issues that could not be quantified” easily (Creswell, 2003: 218; 2009). The intent is to better understand this research problem by converging both quantitative (broad numeric trends) and qualitative (detailed perceptions) data.

Having chosen the mixed method approach, the design for the data collection adopted the concurrent nested strategy for both the instruments employed in the data collection method.

Research Instruments

According to Criswell, Shope, Plano, Clark, & Green (2006), data collection instruments in any research include questionnaire administration, interview guide, Observation guide, and desk review. A typical research may use one or more instruments in collecting data. Data collection instruments used for this study included desk review, interview guide, and Observation guide. The study did not use questionnaire administration because respondents were semi-illiterates. Those instruments were briefly discussed below.

Desk Review

The study used a desk review to gather data on the topic under investigation. It reviewed related documents, and records of Ghana Baptist Convention. It also reviewed journals, articles, books, international and national development documents on rural development to have a wider scope of data on the topic under investigation. The instrument was meant to collect data on Ghana Baptist Convention's rural interventions and effects they have on beneficiaries in order to address the objectives of the study.

Interview Guide

There were two sets of interview guide, namely, unstructured and semi-structured interview guide. With the unstructured interview guide, an in-depth interview was scheduled for GBC, and CBOs officials and Chiefs, queen mothers, and leaders of local council of churches within the district respectively. The unstructured interview guide comprised open-ended questions to allow for in-depth discussions in addressing the objectives of the study. The questions in the

unstructured interview guide were adapted from WHOQOL, QOL 5, The Oxford Happiness Questionnaires, and COMQOL questionnaire in the light of the conceptual framework for this study.

The unstructured interview guide allowed for deviation as key informants addressed issues on GBC rural interventions and the effects those interventions had on beneficiaries. Unlike the structured interview guide, the unstructured interview guide allowed the interviewees to provide much more information in a one-on-one discussion. Although unstructured interview guide cannot substitute for questionnaire administration, they often provide information that cannot be obtained any other way.

To ensure validity and reliability of the data from respondents, control questions were asked or the triangulation approach was used to confirm or modify responses. The control questions that followed the unstructured interview guide ensured that the respondents understood the issues very well and that the moderator or the recorders did not misrepresent their responses.

With semi-structured interview guide, both structured and unstructured interview guide questions were administered to beneficiaries who were 18 years and above in each of the five GBC projects. The questions were adapted from Lindholt, Ventegodt and Merrick's (2003) quality of life five (QOL 5), The Oxford (2001) Happiness questionnaires, and Cummins' (1997) comprehensive quality of life (COMQOL) questionnaires. The semi-structured interview guide questions covered the objective, subjective and existential quality of life factors including well-being, satisfaction with life, happiness, meaning in life,

spirituality, realisation of life potential, and fulfilment of needs. Another section also included marital status, education, religion, income, health, and livelihood sustainability.

There was one set of semi-structured interview guide questions administered in this study. The structured interview guide had sections A and B. Section A consisted of questions on demographic characteristics of respondents. Section B consisted of structured interview guide questions on view of quality of life factors with fixed responses based on the Likert's scale. The respondents were expected to choose an option from a range of options as follows: 1=strongly disagree; 2=moderately disagree; 3=slightly disagree; 4= slightly agree; 5=moderately agree; and 6=strongly agree. After, which an interview was scheduled for respondents to give a further explanation of their perceptions on quality of life with an unstructured guide.

Interview guide was chosen as an instrument in this study for several reasons; first, because the research approach was a mixed method. Second, the respondents were semi-illiterate. The instrument was effective for securing factual information about the topic under study for which the respondents were presumed to have knowledge. Another reason for choosing semi-structured interview guide was that it was the case where the interviewer acted "like robot" and the same time acted "freely in the context based on certain research point (Sarantakos, 2005). Finally, when dealing with a large number of respondents, the semi-structured interview guide was the best and appropriate technique. However, one of the weaknesses of the instrument was complete retrieval of data from

respondents was sometimes not possible. It helped provide quality and in-depth data about what people are doing or perceiving the phenomenon under study

Field observation guide

Some visits were made to the communities with GBC's rural development project(s). The field observation guide or check list instrument comprised farms, grocery stores, school-going children, employment, religious activities, small business project, and construction of projects. The field observation guide offered first-hand knowledge on how the people accessed the projects and how those project(s) had enhanced improvement in the quality of life. It also provided understanding to the real life situation of the beneficiaries. The rationale was for a more detailed description

Pre-Testing of Research Instruments

The term pre-testing refers to mini versions of a full-scale study (also called feasibility studies), as well as the specific pre-testing of a particular research instruments (Sarantakos, 2005). It is conducted to determine the reliability and consistency of the research instruments. It is also conducted to give advance warning about where the main research project could fail, where research protocols may not be followed or whether proposed methods or instruments are inappropriate or too complicated. The pre-testing of the instruments was done for the researcher to be aware if there might be any possible advance warning about where the main research project could fail, and where research protocols might

not be followed or whether proposed methods or instruments were inappropriate or too complicated.

In this study, pre-testing of research instruments was conducted in Kweikrom. Kweikrom is a rural community in the Gomoa West District in the Central Region, Ghana. It is bordered on the south and the north by the sea and Accra-Cape Coast highway. It is also bordered on the east and the west by Gyangyanade, and Ojobi rural communities respectively. The reason for the choice of Kweikrom was that it had common social, economic, political and religious/cultural, structures similar to those in the regions randomly selected for this study. GBC has an on-going development projects (safe drinking water, child development centre, and a vocational training centre) in Kweikrom since 2003. Fifty (50) beneficiaries were selected for the pilot study. After the pre-test of the instruments, a few changes were made to make the instruments more accurate and appropriate for the study.

Ethical Considerations

There is the moral or ethical dimension to social research. This is aside the technical dimensions discussed in this chapter so far. According to Creswell (2007; 2009) research study should be devoid of ethical constraints. Creswell (2007; 2009) cautions researchers to be cautious about the following: (a) the use of language or words that are biased toward respondents, (b) suppressing, falsifying, and inventing findings to meet researcher's or audience's needs, (c) the importance of anticipating repercussions of conducting the research on certain

audience and not use the results to the advantage of one group or another, (d) the study should not exploit the labour of colleagues and provide authorship to individuals who contribute substantively to the study, (e) the demonstration of research design for credibility of the study.

The second ethical consideration in research was that of informed consent of the interviewees. For moral and legal reasons, respondents should not be coerced into participating in social research. Not only must subjects understand that their participation was voluntary, they ought to be given enough information about the research to make an informed decision about whether to participate or not. In other words, researchers ought to obtain an explicit or implicit informed consent of their subjects to take part in an investigation (Creswell, 2010).

The issue of informed consent was catered for in this study by making sure that the respondents for the study were briefed on the purpose of the research. The chiefs and queen mothers (Megaziah), CBOs officials, GBC officials, Assembly Members were contacted through appropriate offices. The right to privacy of the individual in terms of his/her right to decide when, where, to whom, and to what extent his/her attitude, belief and behaviour would be revealed was observed.

I was also sensitive to many possibilities that might have invaded the privacy of the research participant and essentially guarded ways in which his actions could violate this basic right of the research participant. I with my research assistants protected the right to privacy, anonymity, and confidentiality of the individual research participant. Cooper and Schindler (2003) recommends

that in research of this nature the researcher and research assistants should protect the right to privacy, anonymity, and confidentiality of the individual research participant.

Fieldwork and Community Entry Protocol

This study followed entry protocols such as seeking audience with the chief and elders in the community and acquainting them with the purpose of the researcher's presence. Those steps facilitated the collaboration of the key informants in the data collection exercise. Before the actual field work began, I with my research assistants had field visits to the project sites for familiarization, identification of some beneficiaries, and the recruitment of research assistants. An introductory letter was obtained from the Institute for Development Studies, Faculty of Social Sciences, College of Humanities & Legal Studies, University of Cape Coast, Cape Coast. With the help of the Presiding Member, I took time to explain the purpose of the study to the Municipal/District Assembly members. The same introductory letter was sent to project coordinators, explaining the purpose of the study and the need for them to participate.

The participants freely consented to participate before the research was conducted. Interviews were conducted by experienced field assistants who were thoroughly briefed by the researcher prior to the beginning of the fieldwork. It was ensured that interviewers were thoroughly familiar with the projects and beneficiaries selection procedures, call back procedures, and the structure of the questionnaire, including routing and filtering. Interviewer training was conducted

in three days. The training included a practice session in conducting the interview with the interview guides and what to observe with the observation guide.

The field assistants administered the structured interview guide to themselves in turns so that all of them would be able to detect the flaws in the styles of questions when it comes up during the fieldwork. In addition, a recorder and a note taker were included to record and take notes respectively of the salient points that emerged from the interviews. The actual fieldwork followed a schedule, which consisted of interview dates with officials of GBC and CBOs, with chiefs, religious leaders, Assembly members, and queen mothers. The fieldwork lasted from November 1, 2012 to December 1, 2012. The structured, the semi-structured interviews and field observation guide were carried out.

The collection of the secondary data and information from the necessary project coordinators, agencies and departments began in August, 2012 and went on until October, 2012. The delay was due to the typical “it is not ready yet”, “the officer has not come”, and “come tomorrow” attitude of some officials at those agencies and departments, and institutions. However, it should be noted that the responsible agents were very cooperative.

Objectivity, Validity and Reliability of Study

Though, I used to play active part of the organisation I, later, realized that over the past decade reflections on outcomes of GBC’s rural interventions in line with its vision of holistic tranformation had not been done empirically. In undertaking this study, I was objective because according to Sarantakos (2005:

94), “objectivity of a study is the research principle that requires that all personal values and views of the investigator were kept out throughout the research process”. This means that research processes are not manipulated.

In the light of those facts, I was objective because I stated the course and the elements of the research process, and allowed peers, supervisors and internal and external assessors to judge its quality. I pursued the course of finding “what is” and not “what ought to be” (Srantakos, 2005) by following a mixed method research process.

In terms of objectivity in the quantitative section of this study, I set out to discover objective truths from objective reality in the communities through the use of instrument/indicator procedure. For objectivity in the qualitative section of the study, I made sure the topic, methodology, including research design, sampling, data collection and analysis, interpretation and reporting, were done in a process which was free from personal biases, views, experiences and preference because these steps were discussed by peers, lecturers and supervisors.

Validity of any study according to Sarantakos (2005:83) is the “property of a research instrument that measures its relevance, precision and accuracy”. The validity of the study was checked by pre-testing the instruments in Kweikrom community. They were found to be reliable after some modifications. Generally, the instrument/indicator measured factors of integrative quality of life discussed the literature review of the study. The analysis of the data by the use of findings corroborated with other studies thus argued for could be credibility, applicability, and trustworthiness. Content and construct and not empirical validity were

employed in this study because it measured all possible dimensions of quality of life and the quality of life construct, namely, income, education, health, wellbeing, satisfaction with life, happiness, meaning in life, realisation of life potential, fulfilment of needs, and spirituality it supposed to measure.

Data Preparation and Analysis

Both qualitative content analysis and manual approaches were used for the analysis of data gathered for this study. Qualitative content analysis is a research method for the subjective interpretation of the content of data through the systematic classification process of coding and identifying themes or patterns. In the analysis of the data from the in-depth interview (IDI), qualitative approach was adopted based on direct content analysis approach of the qualitative content analysis since the study was based on a theory (Sarantakos, 2005).

Qualitative research is based on the theoretical and methodological principles of interpretive perspective. As a result, qualitative analysis contains a minimum of quantitative measurements, standardisations and mathematical techniques. In most cases, its processes bring together collection and analysis of data in such a way that identifying data automatically leads to their analysis. The analysis in turn directs the researcher to the area in which new data should be sought and identified, in order to be analysed again to address the specific objective of the study (Carspecken & Apple, 1992 cited in Sarantakos, 1997; 2005). The results from the IDIs and the field observation were coded and

categorised into appropriate themes and analysed using a combination of predetermined and emerging codes as guide (Creswell, 2009).

The data from the beneficiaries' survey was edited, coded and entered into the Microsoft Excel programme. In other words, The Microsoft Excel Office suite was used for data entry, frequencies and tables to attain good visual impression regarding the presentation of results and findings. The analysis of the effects of the interventions on beneficiaries' objective, subjective, and existential qualities of life was done.

Field Experiences and Challenges

Clearly, I anticipated some foreseeable obstacles in the process of data collection. The first challenge had to do with arranging for respondents to engage in the in-depth interview. As one can imagine with interview schedules, it was very difficult to arrange a meeting with chiefs, queen mothers, the officials of GBC, Local council churches, and Assembly members as a result of their tight schedule during that election year.

Moreover, most of the interview sessions were often interrupted by phone calls and drop-in visitors, which sometimes made the interviewer, lose focus of the topic under discussion. Sometimes, we had to break and reschedule the interview for another day, which stretched the data collection period beyond the planned date. For the beneficiaries, sometimes the selected person may not be in the house at the time of data collection, implying that another visit should be made (in some instances, two visits were made before the right person was met).

Secondly, refusal of some of the selected beneficiaries to take part in the survey was a big challenge to the study. In some cases, some of the beneficiaries in the community feared the field researchers and were not willing to take part in the interview. Others also demanded a token. In such instances, the researcher resorted to replacement. Thus, a new beneficiary that was not initially selected was then included to make up for the number. As a result, the study achieved nearly 100% response rate.

Finally, some of the issues in the semi-structured interview guide made the respondents have a different perception about the research. For example, some of the respondents were not willing to disclose the exact amount of their monthly income (most of them tended to underestimate it) because they thought it will be used as a basis for denying access to GBC's projects. This situation arose from the fact that some of the issues in the semi-structured interview guide touched on ability to meet one's basic daily expenses. This, however, did not compromise the quality of the data as most of them freely gave out the figure after they were made to understand that the study was purely for academic purposes and not an exercise for the government.

The study had some limitations. Among the fundamental limits of this work was the degree of representativeness of the sample selected for the analysis of quality of life in rural communities. The study randomly chose five rural communities from four regions in Ghana. It could have chosen five regions for a fairer representation but with the simple random approach Central region was picked twice. Another limitation was that the study was not able to measure

quantitatively the subjective and the existential quality of life factors because they were measures based on respondents' perceptions. Therefore, the study measured only one dimension of IQOL- object quality of life.

The selection of the key informant should have involved other pastors who were working in the community but the preliminary survey indicated that most of them were not resident in the community. The officials of urban projects were not included in the study because the initial contact made indicated they did rely purely on those in the rural community because they considered themselves as having inadequate knowledge on the issues bordering on poor living conditions of the people.

Chapter Summary

This chapter described and discussed the research methodology for this study. The discussions centred on the following: introduction, philosophy of the study, study area, study population, unit of analysis, sampling procedures, sources of data, methods of data collection, research instruments, pre-testing of research instruments, ethical consideration, fieldwork and community entry protocol, data preparation and analysis and field challenges. The next chapter presents the data analysis and the interpretation of findings.

CHAPTER FIVE
GHANA BAPTIST CONVENTION'S PROJECTS IN THE
COMMUNITIES

Introduction

This chapter presented the findings that sought to address objective one of the study. Objective one of the study was to examine GBC's rural interventions, which had been provided as a result of its historical and philosophical underpinnings briefly described in the background to this study. Examining the interventions included the description and critical evaluation of the rural interventions of the GBC using IFAD standard.

Ghana Baptist Convention's Rural Interventions

From the literature reviewed, it became clear that proponents of the various theoretical perspectives to development advocate for different approaches to improving the quality of life of people in the rural areas (Cagliero, Cristiano, Pierangeli & Tarangioli, 2011). It became also clear in the background that GBC's development philosophy was holistic transformation of the individual person enhanced through implementation of interventions.

The literature reviewed also indicated that development interventions were critical in any development initiative and outcome (Constanza et al., 2007). Development interventions were critical because, as both Welzel et al. (2003) and Constanza et al. (2007) argued, they provided opportunities for people to address particular needs in order to improve quality of life. In the light of those, it was

important to examine GBC's approach to rural development in order to appreciate the motivation behind its rural interventions. The GBC's rural interventions were examined through description and evaluation. The next section presented the various rural interventions of the GBC grouped under six thematic areas namely Agriculture, Education, Finance, Health, Advocacy, and Religion.

Agriculture

Under agriculture, the study found that the GBC undertook six major types of the agricultural interventions. The interventions consisted of cashew farming, mix farming (fruit and vegetable farming, corn and cassava farming and poultry) palmtree and coconut farming, as well as marine fishing. Each agricultural project was described in terms of the year of establishment, purpose, size of the intervention, workforce and sustainability.

Cashew nut farming

Analysis of GBC Annual Report, 2004 and interviews with project participants indicated that the cashew farming intervention was located on a 40-acre land in Sombo in the Upper West Region. The project was introduced in the year 2003 by GBC in response to a request by Baptist churches in the region. The land was provided by the chief and the elders of the community. The financial capital and the cashew seedlings were provided by GBC while the labour force of 11 was jointly provided by the community and the Baptist churches in the region. The labour force was then trained by officials of the GBC.

According to GBC Annual Report (2004), the project was intended to provide employment opportunities for the people of the region as well as to assist

the 80 Baptist churches in the region. The churches were expected to use some of the profits from sales of cashew nuts to develop educational infrastructures. However, the study found out that there was a break-down of the administrative systems that were put in place to monitor and track the income and expenditure of the project because of lack of qualified personnel. Furthermore, neither the project participants nor officials of the GBC could provide data on the profits that had accrued to project since its inception. According to a key informant, the project was faced with numerous challenges. He said *as at the time of this study, 8 out of the 11 people employed to work on this project had abandoned their responsibilities for unknown reasons.*

According to the key informant, some of the challenges faced by the project included an inability to employ a coordinator with at least a degree in Agriculture to oversee the project, and also difficulties in retaining the 3 workers left out of the original 11 resulting in the delay in the achievement of the main objective of the project-building educational infrastructures. Other challenges identified by the key informant as affected the project negatively include irregular supervision and maintenance of farm equipment such as the tractor and its accessories, as well as the motor bike. According to him, the project had not yet achieved its aim of creating jobs for the people.

Mix farming

Analysis of GBC Annual Reports, 2013 and interviews with project participants indicated that the GBC's mix farming intervention was located in Fumesua in the Ashanti region and was code-named Fumesua Community

Livelihood project. Official records (GBC, 2013) indicated that the project was established in the year 2002. The mix farming project was aimed at providing livelihood for the poor and the marginalised persons in the community of Fumesua. It was also to provide employment opportunities for the unemployed in the area. The project employed 15 farm labourers, a driver, and tractor driver.

According to a key informant, the 15-acre land on which the mix farming project took place was provided by the community chief while GBC provided the financial capital and the training for the project participants. The project comprised fruit and vegetables farm, corn and cassava farming and poultry. The produce of the farm was to be used to set up businesses for the poor and the marginalised and to be given to community traders on whole sale basis. In an interview, the coordinator of the project said; *the project succeeded in achieving its aim for the first three years but failed to continue.*

A key informant cited poor planning, absence of a Project coordinator, managerial control from head office and financial constraint as some of the factors that contributed to the failure of the project after the first three years. Field observation indicated that a delivery van and a slashing machine which were purchased for the project were currently unserviceable. A chicken coup that was constructed for the project together with some purchased farming tools was standing idle on the project site at Fumesua. Review of the report of GBC (GBC, 2008; 2012) showed the dysfunctional nature of the project.

Oil palm and Coconut plantation

The study found that the oil palm project took place in two locations while the Coconut farming took place in one location. An examination of GBC Annual Report (GBC, 2013) indicated that the first palmnut plantation was established on a 176.21-acre project site at Agona Asafo in the Central Region in the year 1990. The second palmnut plantation was established on a 10-acre project site at Fiesoro in the Western Region in the year 2003. The report indicated that the coconut plantation took place in Nyame Bekyere in the Western Region on a 40-acre project site.

Analysis of GBC Annual Report, 2000 and interviews with project participants indicated that the oil palm and coconut projects were to sell farm produce and use proceeds to provide social amenities such as water, health clinics and schools, set up businesses for the poor and the marginalised and to provide employment for the unemployed (GBC, 2000). According to the coordinator, the project succeeded in achieving some of its aims. For instance, the coordinator noted *proceeds from some of the projects were used to provide bore holes, schools, and health clinics in some of the rural communities in the regions*. In a response to the question ‘how GBC’s projects are implemented and sustained’, the coordinator of the project noted

I do not have a document on planning, implementation, monitoring, and evaluation of the projects...they are implemented from the main office in Accra... all funds for projects are controlled from the main office...projects have unending cycles...have no end dates...however, the palmnut farm has since then been privatised due to rising overhead cost in running it.

An examination of GBC Annual Report, 2006 indicated that the Agona Asafo farm in the Central Region was turned over to a private company to run it because it was failing. According to the report, the farm was given to the private company due to the inability of GBC to maintain the project.

Marine fishing

Analysis of GBC Annual Report, 1998 indicated that the marine fishing project was established in 1998 by the GBC in response to the poverty situation among fishermen in the Central and the Western Regions. According to the 1999 GBC's book of reports, the project was aimed at giving the fishing community livelihood to enable them meet their basic needs. The report indicated that the intervention started with one fishing canoe in 1998 at Sankor in the Efutu Municipality, Central region and had since increased to a total of four fishing fleets. The other three fishing fleets were located at Fetteh, Apam, and Half Assini in the Central and Western Regions. All the fleets combined employed a workforce of 120 fishermen.

According to official record of the marine project, the four projects had fulfilled their aims because fishermen had acquired lands, set up businesses, saved at banks, sent children to school and in control of their lives (Author's Fieldwork, November 2012; GBC, 1999). The coordinator of the intervention said: *we started with four canoes but had reduced to two due to old age, poor maintenance, price increases of pre-mix fuel and competition on Ghana waters over fish by foreign trawlers* (Author's Fieldwork, November 2012).

The GBC marine fishing report (2000) had it that the project hitherto had a chaplaincy department that oversee the spiritual aspect of the intervention. The chaplain doubled as a counsellor for the marine fishing project. It had also a department for women who were responsible for the provision of pre-mix fuel for the fishermen and who were also responsible to dispose of the fish to the buyers. The GBC Coordinator for the project said *despite the challenges we face, the project has created jobs for the people, especially, the crew members and their wives and it has also introduced them to faith in God.*

Education

Under education, the rural educational programme of GBC was in three different categories namely, early childhood development centres, primary schools, and vocational training centres. Each category of educational interventions was discussed.

Early childhood development centres

The study found that the GBC had three early childhood development centres. These development centres were located in Sankor in the Central region, Mafi in the Volta region and Kasulyili in the Northern region. A document analysis of GBC, 2004 reports and interviews with Administrators of these centres revealed that these interventions were established in the year 2003 as a response to the poor living standard of children in the beneficiary communities. The aims of the interventions were to give each child a fundamental right to basic universal education and to grow their intellectual, cognitive, social, emotional, and spiritual capabilities (GBC, 2004).

Each of the three childhood development centres employed a total of 24 workers. A document analysis of GBC reports indicated that the early childhood development project was responsible for providing pre-school education, primary education, nutrition, and health (GBC, 2004). According to the intervention coordinator, a total of 750 beneficiaries were children living in the communities. As at the time of this study, the number of children had increased from 750 to a total of 1400 children (GBC, 2012). Some of the children included those of the ex-Trokosi slave girls (GBC, 2004). According to the coordinator of the programme,

There are ten Early Childhood Centres in Mafi area. Four of the centres have grown beyond Kindergarten to lower primary, upper primary and junior high school level and are being supported. However, the project is challenged with permanent staff due to unfavourable working conditions.

Primary education

The study found that the GBC had five primary schools located in Zua koligo in the Upper East region, Baabianiha in Brong Ahafo region, Galekope in the Volta region, and Sankor in the Central region. According to an official of GBC, document on the primary schools in Zua Loligo, Galekope and Sankor were not available due to the fact that they were not recorded. However, an official from the coordinator's office of the Baptist Primary school in Baabianiha said that the school was established in 2002 in response to a need for a primary school in the community to cater for children who had to walk very long distances to access school in a nearby town, Drobo (Author's Fieldwork, November 2012).

The official from the coordinator's office disclosed that the school was run by a management committee and supported by a Teacher-Parent Association (PTA). An official from the District Assembly said that the school also collaborated with the district Ghana Education Service in Drobo in the Brong Ahafo region. An examination of current school records from 2010/2011 academic year to 2011/2012 academic year indicated that the enrolment stood at 171 pupils from 150 pupils with a 15-member teacher workforce.

Ghana Baptist Convention Annual Report, 2012 showed that the Baabianiha School also had a chaplaincy and counselling departments which were put in place to provide spiritual and career guidance to the children. According to the coordinator of the project, the average teacher-pupil ratio at the time of study was one to 11 (Author's Fieldwork, November 2012). For effective teaching and learning, the standard ratio given by UNESCO and the Ministry of Education is one to twenty-five. The finding could suggest an effective teaching and learning.

Vocational Training

The study found that the Baptist Vocational Training Centre (BVTC) was located in Frankadua in Assuogyaman District of the Eastern Region. The training centre was established in the year 1998 to respond to the needs of the trokosi victims (GBC, 2000). The objective of the training centre was to assist released trokosi girls by providing them with skills training. Another objective of the project was also to help fight poverty in the area (GBC, 2012; GBC, 2000). The centre was registered with the National Vocational Training Institute in 2009.

The study found that the GBC vocational training centre in Frankadua had 18 employees (one director, one driver, two caretakers, a security officer, and 13 teachers). The centre also had a chaplaincy department with a chaplain who doubled as the director of the centre. The BVTC training centre was run by various committees. Council members included the chief in the community, the head teacher, an official of the district education office, a social welfare officer, and a well-respected community person.

The study found that the Baptist vocational training centre offered courses in sewing and tailoring, catering, hairdressing, bead making, kente weaving, carpentry, and Batik tie and dye, English language and Information and Communication Technology (ICT). The BVTC had a current enrolment of 54 ex-trokosi girls (GBC, 2012). Trainees were given a two-year training after which they were given start-up money to continue with their businesses (GBC, 2012). Trainees were also instructed in religious and moral virtues in life. According to the coordinator of the intervention, BVTC had until 2012 trained and passed 150 ex-trokosi girls from under-privileged communities in vocational skills at the Baptist Vocational Training Centre at Frankadua (GBC, 2012). These girls were mostly ex-Trokosi slaves from the Afram Plains in the Eastern Region, and Battor and Mafi areas in the Volta Region.

Health and other health related interventions

The study found that the healthcare interventions of Ghana Baptist Convention included hospital in Sankor in the Central region. Other health related interventions such as safe drinking water had been provided in some rural communities throughout the country as shown and discussed in Chapter Three.

Health intervention in Sankor

The health intervention, Coast for Christ Baptist hospital, in the rural community of Sankor near Winneba in the Central Region was established in the year 2000 to respond to the health needs of the people of Sankor (GBC, 2005; GBC, 2010). GBC's book of reports, 2012 showed that, the hospital started with 32 beds; however, as at the time of this study the number of beds had increased to 100 (GBC, 2011). According to the coordinator, the hospital has a 67-person work force made up of nurses, health assistance clinical, doctors, administrators, accountants, driver-mechanics, security officers, orderlies, and Para-health personnel. A review of the hospital records showed that, out-patients attendance had risen from 12,000 a year to 23, 000 a year from 2005 to 2012 (GBC, 2012).

The hospital ran various services such as general medicine, surgery, eye, maternity, and paediatric, medical, spiritual, guidance and counselling (Baptist Hospital, 2010). The coordinator pointed out *the hospital ran and still runs mobile clinics to surrounding rural communities in order to extend their healthcare services to sick and shut-ins*. He also indicated *the hospital had a special NHIS programme for the less privilege community where they were aided to register with NHIS scheme*. According to him the Baptist Hospital is a member of various

health organisations in the country such as the Christian Health Association of Ghana (CHAG) and it had also partnered with other health organisation in USA, UK, and Canada.

The study found that it had one hospital in Nalerigu in the Northern region and three clinics; two in Kumasi, Ashanti region and one in Cape Coast. Although those were in existence and functioning according to GBC book of reports (GBC, 2013), those interventions were in the urban areas therefore could not be classified as rural interventions in this study.

Safe drinking water interventions

The study also found that the GBC had also provided safe drinking water interventions in some rural communities in the country. An interview with the GBC field coordinators revealed that most of the safe drinking water interventions were not documented by GBC except where in the financial book of report the amounts for the projects were noted. An interview with the field coordinator in the Central region revealed that the safe drinking water interventions in Sankor, Nseuekyir, Kweikrom, Ahwir Nkwanta, and Awomberew in the Central region were provided in 2004, 2005, 2006, 2007, and 2008 respectively in response to the safe drinking water challenges facing those communities. He indicated *the communities were provided with boreholes and water cisterns and for the first year of their operations the projects served the communities well.*

However, due to poor maintenance and untrained operators the projects had not been serving the people regularly. He noted also that the water interventions in Obiri, Fawomanye, and Amanful rural communities in the Central

region were provided in the year 2012, 2011 and 2010 respectively. However, those projects were serving the people regularly.

The field coordinator overseeing the safe drinking water interventions in Northern region indicated that the interventions in Tollugu and Cheshegu rural communities in the Northern region were provided in the year 2006. The field coordinators in Kumahu and Fumesua rural communities in the Ashanti region and Fiesoro, Nyame Bekyere, Ahwia Tutu and Ehoaka rural communities in the Western region indicated that those interventions were provided in the year 2005 and 2006 respectively. Documents on planning, implementation and monitoring could not be produced. An examination of GBC's official records also showed that the projects were not documented in terms of planning, implementation, monitoring and evaluation (GBC, 2012). The field coordinator noted

GBC found out that the communities were facing safe drinking water problems. In collaboration with the leaders in the communities GBC provided the interventions for the community and handed them over to the people...When I assumed office as a field coordinator in 2009, I asked for progress reports from the leaders but they could not give me any document even project's account.

Similar situation was prevailing in Tollugu and Cheshegu rural communities in the Northern region, Kumahu and Fumesua rural communities in the Ashanti region, Fiesoro, Nyame bekyere, Ahwia Tutu and Ehoaka rural communities in the Western region. However, interview with field coordinators in the Central, Northern, Ashanti and Western regions showed that Sankor,

Nseuekyir, Kweikrom, Ahwir Nkwanta, and Awomberew had ceased to function due to poor maintenance and untrained operators. Similarly, the safe drinking water in Ehoaka in the Western had ceased to function due to poor maintenance. The coordinator noted: *The operator appointed by the leaders of the community does not give proper account and when he was confronted on the issue he left the community with the money.*

An examination of GBC Annual Report, 201 showed that the Amanful water project was established in the year 2010 as a response to the challenge of water borne diseases the people were facing as a result of the use of mud water. The project involved a borehole and two 2000-gallon water cistern to help the community. The cistern serves as reservoir when the bore-hole is out of use.

According to the coordinator of the intervention, the provision of the intervention had reduced the cases of stomach complains from the people in the community. The intervention had also saved the people time so that they could have more hours to work on their farms. It had helped the children to spend more hours in the classroom. The Amanful water project was found to be managed by representatives from the people and members of the local Baptist church in the community.

The report further had it that the minister of the Baptist church in Amanful served as the chaplain and counsellor of the project in the community. Fieldwork and GBC's book of reports showed that those interventions were in existence, functioning and that they were meeting their goals of providing safe drinking water for the people (GBC, 2008).

Finance

The microenterprise intervention served three rural communities, Kasulyili in the Northern region, Fumesua in the Ashanti region, Sankor in the Central region. The project was introduced in 2003 with the objective to enable the poor to engage in entrepreneurial activities as livelihood for them (GBC, 2004). Ghana Baptist Convention Annual report, 2009 reviewed showed that the intervention gave seed money to some beneficiaries to start small scale enterprises while others were also supported to engage in petty trading after they successfully passed a skills training programme conducted by the project managers (GBC, 2008). According to the report, the microenterprise intervention served 175 beneficiaries in 2008 but the GBC annual report, 2012 report showed that the project served 500 beneficiaries in some rural communities in all regions in Ghana except Greater Accra since GBC had no rural intervention in any rural community in Greater Accra region.

The coordinators of the interventions noted that the projects had religious and counselling departments that served the people. They also indicated that the projects had organised periodic workshops and seminars for the beneficiaries that served the people on issues relating to entrepreneurship, profits and savings. They indicated that the projects were governed by the formation of a board and run by a management committee, and a five-member executive committee.

Advocacy

The GBC advocacy intervention was established in 1995 in response to social injustices, especially the practice of Trokosi, in some parts of Ghana (GBC,

1996). According to GBC book of reports (1998), GBC runs an advocacy intervention for the liberation and empowerment of victims of the Trokosi cult practices (GBC, 1998). The field coordinator of the intervention noted:

GBC organises workshops on the negative effects of Trokosi in the affected communities. The GBC implements the advocacy intervention in collaboration with other partners like the Commission on Human Rights and Administrative Justice (CHRAJ) and the Trokosi Slave Abolishing Fellowship International at Battor.

According to a key informant from the leadership in the community, GBC negotiates with the shrine priests holding the girls and pays a ransom before freeing the slaves. Freed trokosi girls were taken through counselling and vocational training at the Baptist Vocational Training Centre at Frankadua. According to an official from the Vocational training centre, one of the objectives of the training centre is to give the freed Trokosi girls skills so as to reintegrate them into society. She said *those who passed the skill training were given seed money to set up their own businesses*. GBC Annual report, 2009 also showed that the advocacy intervention was sponsored by groups such as the Baptist Union of Denmark, the Danish Mission Council Development Department, and the American Baptist Churches of Massachusetts (GBC Report 2009).

According to a key informant from the leadership office in the community the project was very valuable to both the individuals and the communities who benefitted from the intervention. He commented:

The project has been very beneficial because through this intervention, the GBC has successfully liberated some of the slaves and have empowered them through vocational training as well as with seed money to set up their own businesses. Some of ex-Trokosi slaves have been reintegrated into the society as a result of their participation in this project.

An official from the chaplaincy also noted “*over 100 girls have received training in hairdressing, dressmaking, catering, batik and tie and dye, kente weaving, and literacy at the Baptist Vocational Training Centre at Frankadua*”.

Religion

The religious interventions of GBC were established in response to Jesus’ mandate to preach the Kingdom message to all creatures (GBC, 2013a). According to the GBC’s book of reports (2013), the religious interventions provided by GBC included establishment of churches and practice of religious activities in the communities. The reports showed that GBC’s religious activities included worship, Bible studies, spiritual and moral development of people, teachings and evangelism (witnessing). A GBC official said:

“Religion and development are inseparable and so for every intervention we establish, a religious component was added to address the religious needs of the people...we establish a church in the community to sustain religious and moral training of the beneficiaries”.

According to the GBC’s constitutional preamble, GBC was to establish churches throughout the country and beyond. The GBC (2013b) book of report

indicated that the GBC had over 1400 churches in the country. The constitution of GBC had it that Baptist churches were expected to practice congregational polity, where individual churches were to be autonomous but to cooperate with GBC (GBC, 2013a). The churches were expected to be self-governing, self-propagating and self-supporting to promote growth and cooperation (GBC, 2013a).

Critical Evaluation of GBC Rural Interventions

Ghana Baptist Convention's rural interventions were evaluated to assess whether they were set out to meet their intended goals or the quality of life needs of its intended beneficiaries. The evaluation was carried out using four criteria as discussed in the literature review; holism, intervention approach intervention and sustainability.

Holism

An examination of the various interventions of the GBC's revealed that they could be described as holistic to some extent but not entirely. As discussed in Chapter Two, holistic interventions were defined as those that could be perceived as addressing objective, subjective, and existential needs of humans. In other words, they were those that could address economic, social, political, religious, psychological, and environmental and gender needs. Although the GBC's interventions could meet the economic, social, religious, psychological, and gender needs, it could not meet the environmental and political needs of the people.

Firstly, the GBC's interventions could be considered as holistic because they sought to address the economic needs of beneficiaries. As discussed in the literature reviewed (Table 1), GBC's agricultural interventions such as cashew farming, mix farming, coconut plantation, palm nut farm, microfinance, micro enterprise, basket weaving could be grouped as economic. Those interventions could be considered as economic because they either directly or indirectly provided the beneficiaries with income. For instance, whereas the microenterprise and microfinance interventions directly provided beneficiaries with income and business set ups to undertake entrepreneurial ventures, the beneficiaries in the agricultural modules were to make income from the proceeds of their farming activities.

Secondly, GBC's intervention could be considered as holistic because some of the interventions sought to cater for the social needs of the beneficiaries. For instance, GBC's early child development, primary education, safe drinking water and the hospital interventions and vocational training interventions could be grouped as social. The religious activities at project centres and the establishment of churches catered for the religious needs of beneficiaries while the counselling departments in each project establishment could be classified as psychological. Finally, the rescuing of Trokosi slaves could be considered as a gender intervention because, those slaves were all women who had to endure inhumane conditions because of their sex.

Although, Ghana Baptist Convention provided social, economic, religious, psychological interventions, it had not provided interventions that could be

classified as addressing environmental and political needs. GBC officials attributed reasons to financial and other logistical constraints. For instance, a GBC officer from the main office commented

GBC operates on 25% of Tithes and offerings that member churches contribute to it. Even with that few member churches are regular in payment. With contribution from our international partners, there is always a cut-off point in the partnership agreement and when that happens, it poses a challenge for GBC to embark on implementation of other projects.

Rural intervention approach

The study found that GBC's interventions were not undergirded by any particular rural interventions approach. As indicated in Chapter Two, there were five different rural intervention approaches. These were the project based intervention approach, the programme based approach, the sector wide approach, the direct budgetary support based approach, and the sustainable livelihoods based intervention approach (Kamuzora & Toner, 2002). An examination of some official records relating to projects and field observations revealed that the GBC's interventions were project-based in approach. As earlier found, they were established in response to a need and could not clearly reflect a specific approach.

An examination of GBC rural interventions approach showed that they were not programme-based since possible changes in a particular intervention was not considered in the wider context of others. Kamuzora and Toner (2002) had argued that change from projects to programmes enhances greater efficiency in

the implementation of development interventions and better utilization of resources. Evidence from this study suggested that no attempts were made by the GBC to shift from project focus to programme focus. As indicated earlier, mechanisms to monitor progress and effectiveness of some of the rural interventions were absent. The findings in this study also confirmed an earlier finding of Sebastian (2010) who concluded that the GBC interventions were not coordinated.

In terms of a sector wide approach, the GBC rural interventions could not be described as having a government control and budget allocation. However, with the health intervention, it received some support from Ministry of Health as a member of the Christian Health Association of Ghana. Some of the key informants from GBC admitted that GBC runs its own affairs. They emphasised that GBC was not under government leadership, and was not progressing towards relying on government procedures to disburse and account for all funds. The GBC's rural intervention approach could not also be described as having a direct budgetary support based approach. That was so because GBC was not a government agency neither did it mobilise resources to support government budget but for the sustainability of its interventions.

Intervention sustainability

The literature reviewed indicated that development interventions that serve as livelihood to people give cause for their sustainability (Chambers & Conway, 2005). In measuring GBC's intervention sustainability, the IFAD (2007) model was used that evaluated GBC's and beneficiaries' readiness to sustain the

interventions. As indicated in Chapter Two, the IFAD (2007) model defined livelihood sustainability to include institutional sustainability, household and community resilience, environmental sustainability and structural change.

The study found that GBC's interventions did not meet all of the IFAD criteria for measuring institutional sustainability. Document analysis of the official GBC records and interviews with key informants from GBC revealed that the GBC had no plan in place to ensure effective implementation and handing over of interventions to beneficiary communities before taking on new projects as was expected from the IFAD Model. According to IFAD (2007), interventions are normally for a period (5-10 years) and at the end of that period, they are handed over to the community to continue their running. For instance, the study found that some projects had been going on for several years although they were not effective. According to Baker (2000) projects are to address particular needs, and they are for a period of time. After the set period, the personnel, equipment and facilities for the project are demobilized as a post implementation review organised to measure the success of the project, to see what further improvements can be made, and to learn lessons for future projects. However, those had not occurred with GBC's rural interventions.

In terms of household and community resilience, beneficiaries' of the GBC's rural interventions could be said to be developing capabilities to adjust to challenges in order to improve quality of life. However, based on the sustainability indicators in the conceptual framework, a survey was conducted to assess beneficiaries' willingness to sustain GBC's interventions. The results

showed that out of 271 respondents, majority of the respondents 115 representing fifty-seven per cent (57%) said they were unwilling to sustain the project (Table 7).

Analysing the results by communities, majority of the respondents in Frankadua 30 out of 35 respondents representing (86%) indicated that they were not willing to sustain the Vocational training centre. In Kasulyili 35 out of 47 respondents representing seventy-five per cent (75%) showed that they were unwilling to sustain the microenterprise project, and in Baabianiha 55 out of 63 respondents representing eighty-seven per cent (87%) also indicated that they were unwilling to sustain the primary school. However, majority of the respondents in Sankor, that was 69 out of 86 representing eighty per cent (80%) and Amanful 22 out of 40 representing fifty-five per cent (55%) said that they were willing to sustain the health and the water interventions respectively (Table 6).

In attributing reasons to the sustenance of GBC's rural interventions 254 out of 271 representing 94% in all five communities said that they were willing to sustain the intervention. Respondents in Sankor and Amanful most likely could constitute greater percentage of those willing to sustain the interventions. For instance, a beneficiary in Sankor said *I am proud that I have a hospital in my community...I am willing to do everything to keep it here.* Another said *I participate in any community labour to weed around the hospital.*

Table 6-Respondents' Willingness to Sustain GBC's Interventions

Community	Willing		Not willing	
	Frequency	Percent	Frequency	Percent
Frankadua	5	14	30	86
Kasulyili	12	25	35	75
Baabianiha	8	13	55	87
Amanful	22	55	18	45
Sankor	69	80	17	20

Source: Author's Fieldwork, Enim (2012)

In Amanful, a respondent noted that he contributed some of his cement blocks in the construction of the water project. However, respondents in Frankadua and Baabianiha had no idea of what to do to sustain the interventions in their communities.

The Eighty-one per cent (81%) of the respondents said they were prepared to contribute financially to sustain GBC's rural interventions. Majority of the respondents in Sankor and Amanful said they pay annual levies to sustain the interventions. A respondent in Amanful stated *the community contribute annually to buy spare parts for pump repairs and I pay my part*. Another respondent in Sankor said: *I pay my levy to support the hospital for its community outreach programme*. However, in Frankadua, a respondent said that she had no financial means to support the training centre. One of the few beneficiaries in Kasulyili who was willing to sustain the microenterprise financially said *I contribute a special levy each month to support our workshops and seminars*. Another

beneficiary in Baabianiha noted *I am happy to contribute monthly to the Parent-teacher association to support the school.*

The Ninety per cent (90%) of the respondents said they were participating in the day to day running of the GBC's rural interventions on a regular basis. Majority of the respondents in Sankor and Amanful said they were participating in community outreach programmes and explaining the aims and objectives of the projects to others. A beneficiary in Amanful said *I always attend project meeting to share my ideas.* Similar comments were made by a beneficiary in Sankor. However, respondents Frankadua and Baabianih said that issues about sustainability of the interventions were not part of the training curriculum.

In addition, Nine-three per cent (93%) of the respondents expressed their interest to serve when given leadership role in any of the committees (see Table 33). Many of the respondents in Sankor and Amanful indicated their willingness to serve in the leadership of the projects. In Amanful a respondent stated *I am the treasurer to the annual levy project.* In Sankor, another respondent mentioned that he was the organiser of the management committee of the hospital. Many of the respondents in Baabianiha, Frankadua and Kasulyili were generally not interested in taking up leadership roles in the projects.

The Eighty-nine per cent (89%) of the respondents said they were capable to sustain the intervention because they had acquired knowledge and skills at regular project meetings, seminars and workshops about the interventions. In terms of ownership of the interventions, eighty per cent (80%) of the respondents in all five communities stated that they could own the project (see Table 8). A

beneficiary in Sankor said *the hospital is here to help us...those who brought it will not live with us. They will leave it with us to run it.* Another beneficiary in Sankor said *the hospital is in, with and for the community for the people...and so we are responsible for its expansion.* In Amanful, many respondents were of the view that the water project was for them and therefore had to maintain it. However, In Frankadua, respondents said that they had not acquired enough skills and they were not capable to own the project. In Kasulyili many respondents were also of the view that the intervention was in the community to help but not of the community for them to own it.

Table 7- Respondents' Willingness to Sustain GBC's Interventions by

Indicator	Willing		Not willing	
	Freq.	Percent	Freq.	Percent
Preparedness	254	94	17	6
Financial support	220	81	51	19
Capability	241	89	30	11
Ownership	218	80	53	20
Participation	244	90	27	10
Leadership	251	93	20	7

Indicators

Source: Author's Field work, Enim (2012)

However, an analysis of the responses from the key informants showed a general observation that the GBC's interventions had provided opportunities and had built to some extent beneficiaries' capabilities to meet their quality of life needs. In Frankadua, the coordinator of the Vocational training centre said:

The presence of the vocational training centre in this community is very appropriate...It is exposing the ex-trokosi girls to various skill developments. Last year, the centre graduated 15 trainees with various skills in fashion designing, hair dressing, tailoring, carpentry, basket weaving and batik making.

A leader of the microenterprise beneficiaries in Kasulyili stated ...we receive training in business entrepreneurship every quarter...these trainings have helped us to engage in other income generating businesses in addition to what we have. Now I am able to take stock of my goods. In Baabianiha, a key informant from the community's leadership indicated:

The presence of the school in the community is important because it is exposing our children to knowledge. If education is a key that opens the doors of life opportunities, then I believe our children have started on a good note to respond to their future needs.

Looking at it from a different angle, an informant from the office of the queen mother in Amanful indicated that though the water intervention had not directly developed their skill, it had helped children spend more hours in school to learn instead of walking long distances in search of safe drinking water.

In Sankor, the chairperson of the local council of churches said;

I have observed during counselling period with patients that the easy access to the health facility has, psychologically, calmed down anxieties...It has relieved the people from fear to do other things to survive...a healthy condition is an asset to one's wealth.

Sen (2000; 1999) had concluded that building of human capabilities related to improved quality of life. To Sen (2000; 1999), the development of human capability was to expand human freedom and self-worth so as to be and to do. Findings showed that the GBC's rural interventions had enhanced respondent's freedom and self-worth and that most likely had enhanced sustainability.

In terms of environmental sustainability, a review of official GBC records, responses from the respondents, key informants and field observation indicated that GBC rural programme had not included environmental intervention in its rural activities though it had that as part of its philosophy. Environmental sustainability, as discussed in Chapter Two, ensures environmentally sustainable system, maintains stable resource base, avoids overexploitation of renewable resources, and preserves biodiversity (IFAD, 2007). Bradley (2014) had observed that environmental health impacts other facets of personal health. He had argued that natural environment (fresh air, clean water, and natural beauty) affected positively physical, emotional and spiritual quality of life.

Evaluating GBC's rural interventions in terms of structural change, field observation and responses from key informants showed that GBC's rural interventions were scattered. The study did not find any evidence of a plan by the GBC to coordinate its projects. According Sebastian (2010), projects that were not coordinated most likely die off because it did not receive support. Notwithstanding, sustaining rural interventions for structural change depended on many factors including interventions outcomes.

Discussion

Examining GBC's rural interventions raised some key issues worth discussing. These were examining GBC's interventions, sustaining livelihood and holistic development. First, examining GBC's interventions was important in the sense that their description in terms of location, size, goal and sustainability could provide relevant information for the development agent and the beneficiary at any given time in the response to identified needs as shown in the conceptual framework for the study. The conceptual framework showed that interventions are necessary elements in the improvement of integrative quality of life

The next issue raised was sustainability of GBC rural interventions. The interventions were shown to be livelihood for the beneficiaries. Sustainability was shown in literature to be a necessary factor in quality of life studies (Chambers & Conway, 1991). Examining GBC's rural interventions could lead to sustainability so that beneficiaries who depended on them could have the interventions as their livelihood sustainability. However, findings in this study showed that seeing the interventions as livelihood sustainability had not been part of the development plan of GBC.

Although findings demonstrated that some respondents were willing to sustain GBC's rural interventions, GBC had not put in place a mutual plan to sustain the interventions as showed in chapter six. Studies had also shown that so long as development agents did have cut-off point for projects to be evaluated and handed over to beneficiary communities, sustainability of intervention was

potentially guaranteed for beneficiaries' livelihood (Sebastian, 2010; Boapeah, 2006; Chambers & Conway, 2005).

However, it was noteworthy that sustaining livelihood was a mutual responsibility of both the development agent and the beneficiary. It was the development agent with the technical knowledge who trained the beneficiary to sustain the intervention without compromising its usage for the next generation. That implied willingness on the part of beneficiaries to train, mentor, participate and lead the next generation. That also meant beneficiaries were also prepared to be accountable and to practice good governance in the execution of the interventions. In the literature review and the conceptual framework, it was pointed out that good governance combined with economic growth and emancipative values combine to expand human choices (Welzel et al., 2003). Such combination guaranteed empowerment, popular participation, ownership, commitment and sustenance of development interventions (Ahwoi, 2010; Conway & Chambers, 2005; Welzel et al., 2003).

According to Chambers & Conway (2005) the continuous failure of various interventions to be sustained could be attributed to undervaluing of community concerns in the planning process. When such a situation arose, it led to low community support in sustaining the intervention. That implied that, without giving due concern to the community choices, attitudes and perceptions, a sustainable livelihood might be challenged.

The next issue raised was the challenges faced by some of the projects. The findings showed that human resource and maintenance of equipment were challenges faced by the oil palm, coconut, marine fishing, and cashew nut interventions. Education, among other reasons, could be a potential cause. While human resource and maintenance were the common challenges faced by those interventions, the marine fishing intervention had peculiar challenges not associated with the other interventions. Those were access to pre-mix and competition by foreign trawlers.

The last issue raised in the examination of GBC's rural projects was holism in development. It was worthy to note that various meanings had been read into the term 'holistic' or 'holism' and making it confusing in its usage in development context. As discussed in the literature it appeared some used the word to describe the nature of development interventions while others used it describe a concept of development. In both ways, the term 'holistic' or holism in development seemed to lose its other meaning, which was its role in defining outcomes of development. In other words, if humans were both means and the end of development, and if humans comprised physical and spiritual natures that had needs to be met, then including both natures in the measurement of outcomes of development (integrated quality of life) became normative. That meant that a development intervention could be designed to potentially affect objective, subjective, and existential quality of life needs.

Holism in development approach, interventions and possible outcomes shown in this finding and corroborating with the empirical studies in Kenya by Ondigi and Mugenda (2011) suggested that it was possible to plan interventions in such a way that when appropriately implemented could probably affect the end results in holism. However, it was imperative to note that no single indicator could adequately capture all facets of quality of life of the entire community, but measures such as the above most likely cut across cultures. As Sen (2000; 1999) argued, the choice of the individual as the primary outcome might suggest that the analysis needed to start from the ground up, asking people about what lives they value and what outcomes they wanted to see. It was to be noted that once there was no deliberate attempt to have an accepted standard definition for 'holistic' or 'holism' in development discussions, different meanings might continue to be given.

As shown in the conceptual framework, GBC's rural development programme was expected to engage itself in this direction in terms of providing interventions that could potentially address spiritual, social, economic, social, political, psychological and physical shalom for humans. In other words, that could improve wellbeing, satisfaction with life happiness, meaning in life, realisation of life potential, fulfilment of needs and spirituality. Through its connections to extensive networks of believers, representing a wealth of social, political, financial, psychological, cultural and spiritual capital, GBC and faith based organisation in general embodied the means through which to reach and mobilize significant portions of the world's population. That would represent a

unique concern with the spiritual and moral capacities of those they sought to serve, that is, capacities at the root of man's ability to transform his condition and that of those around him. Such an approach to development presented a meaningful and substantive engagement with religious actors in forging solutions to the multidimensional nature of challenges facing development practitioners in seeking to improve quality of life in holism.

However, the findings of the examination of GBC rural interventions showed that GBC's holistic approach to development did not include elements such as environmental cultivation and preservation. That finding was in direct opposite to the empirical case by Ioana (2012) in Romania. Environmental cultivation and preservation hitherto dominated development discussions. Volumes of literature on this subject had been produced (Kendie & Martens, 2008; Afful & Quarshiegah, 2008; Canterbury & Tuffour, 2008; GLSS6, 2014; OECD, 2014; Tinbergen & Hueting, 1991). Those studies argued that environmental sustainability was a necessary factor in the determination of development outcomes.

Chapter Summary

In summary, the chapter examined the rural interventions of the Ghana Baptist Convention grouped under six thematic areas namely Agriculture, Education, Finance, Health, Advocacy, and Religion. Each agricultural project was described in terms of the year of establishment, purpose, size of the intervention, workforce and sustainability. The examination was carried out using three criteria as discussed in the literature review; holism, intervention approach

intervention effect and sustainability. Some key issues raised and discussed were the importance of documentation of FBOs' development activities, sustainability and holistic development. The findings above suggested the importance of examining rural projects for their sustainance. The next chapter discussed the outcomes of GBC's interventions on the objective quality of life.

CHAPTER SIX
OUTCOMES OF GHANA BAPTIST CONVENTION'S RURAL
PROJECTS ON THE OBJECTIVE QUALITY OF LIFE

Introduction

This chapter presents findings and discussions on outcomes of Ghana Baptist Convention's rural development interventions that address specific objectives two. The chapter is divided into two sections. Section one presents socio-demographic characteristics of the respondents. Section two presents findings on the outcomes of GBC's development interventions relating to the quality of life of beneficiaries. Specifically, it presents findings and discussions on outcomes of GBC's interventions on the objective quality of life of respondents in the study areas.

Socio-Demographic Characteristics of Respondents

The respondents for this study were from the five communities (Frankadua, Kasulyili, Baabianiha, Amanful, Sankor) that were studied (Table 9). Each of the communities also corresponded with different rural development interventions of the GBC. For instance, Frankadua benefitted from vocational training intervention whereas Kasulyili, Baabianiha Amanful and Sankor community had the microenterprise, basic school, water, and health interventions respectively.

Out of a total 271 respondents, most (32%) were from Sankor followed by Baabianiha (23%) and Kasulyili (17%) (Table 8). The following sections

described the respondents according to demographic characteristics such as sex, age, religion, and occupation. The Frankadua community where the vocational training intervention took place recorded the lowest number of respondents, 35 representing 13% of the total 271 respondents.

Sex of respondents

With regards to sex distribution, out of 271 respondents the majority 191 representing 70% were females whereas 30% were male. Apart from Amanful which recorded equal number of 20 respondents for both male and females in all the other communities the majority of respondents were female. For instance, the majority (94%) of the number of respondents in Frankadua community were females. Similarly, in Kasulyili, majority (79%) of the number of respondents were females, Baabianiha recorded 75% females. In Sankor, majority of the respondents (63%) were females.

The community with least male respondents was Frankadua (6%) as shown in Table 8. This is not surprising because the GBC intervention in this community specifically targeted the traditional *'trokosi* 'practice, which involved the use of girls as shrine slaves.

Table 8-Distribution of Sex of Respondents by Community

Community	Female	Percent	Male	Percent	Total
Frankadua	33	94	2	6	35
Kasulyili	37	79	10	21	47
Baabianiha	47	75	16	25	63
Amanful	20	50	20	50	40
Sankor	54	63	32	37	86

Source: Author's Fieldwork, Enim (2012)

Age of respondents

A descriptive analysis of the age of respondents revealed that most of the respondents 84 representing 31% of the total 271 respondents were in the 20-29 ages group followed by the 30-39 age groups which recorded 61 representing 23% of the respondents (Table 10). The least age group was 60+ age group which accounted for 7% of the total number of respondents.

By communities, Frankadua had majority of its respondents (19) in the age group of <20 representing (54.3%) followed by the age group of 20-29 representing 45.7% with none in the age groups of 30-39, 40-49, 50-59, and 60+. In Kasulyili, majority of the respondents (14) representing 29.8% were in the age groups of 30-39 followed by the age group of 50-59 representing 27.7%. The age group of <20 had no respondent.

Regarding Baabianiha, majority of the respondents (26) representing 41.3% followed 19 representing 31.2% fell in the age groups of 30-39 and 20-29 respectively while the least age group of 60+ accounted for 1.6% of the total

respondents. In Amanful community, majority of the respondents (13) representing 32.5% and (10) representing 25% were in the age groups of 20-29 and <20 respectively with the least age groups of 50-59 accounting for 5% of the total respondents. In the community of Sankor, majority of the respondents (32) representing 37.2% were in the group of 20-29. The least age group of 60+ represented 4.7% of the total number of respondents in Sankor as shown in Table 9.

Table 9-Distribution of Age of Respondents by Community

Age group	Community				
	Frankadua	Kasulyili	Baabianiha	Amanful	Sankor
<20	19	0	2	10	19
20-29	16	4	19	13	32
30-39	0	14	26	3	18
40-49	0	8	10	7	7
50-59	0	13	5	2	6
60+	0	8	1	5	4

Source: Author's Fieldwork, Enim (2012)

Marital status of respondents

Out of the total 271 respondents, the majority (65%) were married as against 35% never married. Marital status is an important variable in a quality of life study and the country's development programme (GLSS 6, 2013). It is not only seen as a contract but an institution that defines one status, wealth, self-worth and respect in a community. The marital status distribution of the respondents by

communities showed that in Frankadua, 3 out of 35 respondents representing 9% were married while 91% were singles. In Kasulyili, 41 out of 47 respondents representing 87% were married with 13% never married. As regarding Baabianiha 53 respondents out of 63 representing 83% were married with 17% as singles. In Amanful, 29 respondents out of 40 representing 73% were married with 18% as singles. The community of Sankor had 51 respondents out of 86 representing 59% as married with 41% as never married as shown Table 10.

Table 10-Distribution of Marital Status of Respondents by Community

Marital Status				
Community	Married	Within Community (%)	Not married	Within Community (%)
Frankadua	3	8.57	32	91.43
Kasulyili	41	87.23	6	12.77
Baabianiha	53	84.13	10	15.87
Amanful	29	72.50	11	27.50
Sankor	51	59.30	35	40.70

Source: Author's Fieldwork, Enim (2012)

Religion of respondents

Out of the 271 respondents, the majority 80 percent said they practiced the Christian religion whiles 14% and 6% said they practiced Islam and Traditional religions respectively. By communities, the religion of the respondents showed that in Frankadua 19 respondents representing 53% were Christians whiles the remaining 16 representing 46% were Traditionalist. In Kasulyili, 31 respondents representing 66% were Christians, 15 respondents representing 32% were Muslims while one respondent representing 2% was a Traditionalist. As regards

Baabianiha, 47 respondents representing 75% were Christians, 15 respondents representing 25% were Muslims with and no one as a Traditionalist. In Amanful community, 36 respondents representing 90% were Christians, 4 respondents representing 10% were Muslims with one as a Traditionalist. The religion of the respondents in Sankor were that 84 respondents representing 98% were Christians and 2 representing 2% were Muslims with no Traditionalist. Overall 80% were Christians, 14% were Muslims and 6% were Traditionalists. The findings were not surprising since the pattern of distribution of religion did not differ from the country's statistics. According to the GLSS6 (2013) reports the total percentage of Christianity is 70%, Islam is 17% and Traditional religion is 5% as shown in Table 11.

Table 11-Distribution of Religion of Respondents by Community

Community	Religion			Total
	Christians	Muslims	Traditionalists	
Frankadua	19	0	16	35
Kasulyili	31	15	1	47
Baabianiha	47	16	0	63
Amanful	36	4	0	40
Sankor	84	2	0	86
Total	217	37	17	271

Source: Author's Fieldwork, Enim (2012)

Occupation of respondents

In all 75% of the respondents in all the five communities were self-employed, 15% were trainees and 10% were public servants. As regards

occupation of the respondents in all the five communities, 26 out of 35 respondents representing 74% in Frankadua were trainees at the Baptist vocational training centre. In Kasulyili all 47 respondents representing 100% were self-employed with none as a public servant or as a trainee. Majority of the respondents, 56 out of 63 representing 89% in Baabianiha community were self-employed, 3 representing 5% were public servants and 6% were trainees. The occupation distribution of the respondents in Amanful showed that 35 out of 40 representing 88% were self-employed, 2 representing 3 % were public servants and 3 representing 5% were trainees. In Sankor community, 58 out of 86 respondents representing 90% were self-employed, 21 respondents representing 24% were public servants and 7 respondents representing 8% were trainees as shown in Table 12.

According to FAO (2012), majority of rural Ghanaians are self-employed, either in agriculture or petty trading, and 56% of the rural working population has a second job or more with very few of rural people engage in paid labour. Household heads engaged as private employees and self-employed in non-agricultural sectors are less likely to be poor than those engaged in the agricultural sector. Studies show that household heads who are farmers are not just the poorest in Ghana, but they contribute the most to Ghana's poverty (GLSS6, 2013).

Table 12-Occupation of Respondents by Community

Community	Occupation			Total
	Public servants	Self employed	Trainees	
Frankadua	2	7	26	35
Kasulyili	0	47	0	47
Baabianiha	3	56	4	63
Amanful	2	35	3	40
Sankor	21	58	7	86

Source: Author's Fieldwork, Enim (2012)

Outcome of GBC's Rural Projects on Objective Quality of Life of

Beneficiaries

As indicated earlier objective quality of life is measured by examining variables such as income, health and education. The literature reviewed and the conceptual framework also stressed on the fact that income, health and education are necessary indicators in the measurement of a person's objective quality of life.

The study therefore assessed the effects of GBC's projects on beneficiaries' income, education and health in each community. The study recognised the reality of other possible overt and concealed sources of interventions that potentially could be assessed by respondents to improve on their objective quality of life. To minimise this tendency, data collected on income, education and health variables were restricted to those generated from GBC projects.

Income of beneficiaries of GBC Interventions

In determining the effects of GBC's interventions on beneficiaries' income, this study undertook a comparative analysis of the respondents' monthly income range before the GBC interventions against their monthly income ranges as at the time of the study to determine whether their income levels had changed. A survey was conducted to assess the effect of GBC's interventions on beneficiaries' income level.

The study found that out of the 271 respondents 185 representing 68% said their income levels had increased as compared to 86 respondents whose income levels did not improve. Further descriptive analysis of the income range of respondents indicated that before the GBC's interventions, close to 85% of the respondents were earning less than Gh 500.00 a month. However, after the interventions, 71% of respondents were earning above Gh 500.00 a month as shown in Table 13.

Table 13-*Income of Respondents Before and after accessing GBC's Rural Interventions*

Income Range (Gh)	Before Intervention		After Intervention	
	Frequency	Percent	Frequency	Percent
≤100	161	59.41	47	17.34
101-300	55	20.30	13	4.80
301-500	14	5.17	14	5.17
501-700	19	7.01	47	17.34
701-1,000	7	2.58	61	22.51
≥1,001	14	5.17	85	31.37
Unknown	1	0.37	4	1.48
Summary	271	100.0	271	100.00

Source: Authority Fieldwork, Enim (2012)

Respondents in the five communities attributed the increase in the income ranges to avenues the GBC's interventions had given to make money. Other reasons were more working hours, gainful jobs, and vocational skills. In Kasulyili, some respondents were of the view that the interventions had given them jobs to do, and skills to set up microenterprises. In Baabianiha respondents said that the interventions gave them more working hours to make money because they no longer had to carry their children through long distances to school in a nearby town. Some respondents in Amanful community indicated that the intervention had curtailed their daily long distance walk to access safe drinking water. They said the intervention had reduced incidences of stomach complains and water borne diseases that could have otherwise drained their financial resources.

Further analysis of the income of respondents in the various communities indicated that in all the communities (Frankadua, Kasulyili, Baabianiha, Amanful & Sankor) at least 60% of respondents experienced an increase in their incomes except Frankadua where only 1 of the respondents out of 35 experienced an increase in income (Table 14). That finding was not surprising since the intervention in Frankadua was aimed at providing vocational training for ex-trokosi slave girls. Furthermore, as discussed in Chapter Two of this study, ex-trokosi girls were taken to the shrine as ransom for family curse. They served shrine priests and had no right to education, skill and vocational training. They had no gainful jobs, freedom, self-worth, and selfhood.

Table 14-Effects of GBC's Rural Interventions on Income of Beneficiaries by Community

Community	Increase	Percent	No increase	Percent
Baabianiha	45	71	18	29
Sankor	68	79	18	21
Kasulyili	32	68	15	32
Frankadua	1	3	34	97
Amanful	39	97	1	3

Source: Author's Fieldwork, Enim (2012)

In addition to the above finding from the survey, a careful analysis of the responses from key informants in each study community to the question 'how the GBC's interventions affected income levels' was done. Findings showed that the respondents were of the view that the GBC's interventions had little or no improvement on the income levels of the beneficiaries. A key informant from the leadership of Frankadua observed: *The project in the community has opened up the place for skill development activities but the centre is not an income generating one.* The coordinator of the project admitted that the GBC intervention in the community was meant to give skills for the improvement of quality of life of the trainees.

In Amanful, there was a general consensus from key informants that GBC's intervention had not generally increased income levels although their income ranges before and after the GBC interventions above indicated that all the communities except for Frankadua experienced an increase in income over the period under study. That finding was suggestive of the fact that the interventions could have reduced expenditure or other factors apart from GBC's interventions contributed to the increases in income recorded.

An opinion leader of the Amanful community noted that the safe drinking water intervention had come to facilitate in the meeting of a health need and perhaps some people could turn it into business later. Another key informant among the women group commented that the safe drinking water intervention could potentially improve business activities in the community but for the constraint of financial capital. She explained that:

I want to start selling ice water but I do not have the money to buy deep freezer. I am doing 'susu' but it is not enough. Local money lenders want you to provide surety. They also charge high interest on the money they loan you and you earn up working for them.

In Kasulyili, Sankor and Baabianiha, the general view, expressed by the key informants, was that the GBC interventions had brought added business activities in the community, which could possibly raise income level of beneficiaries. The leader of the women's group in Kasulyili shown in Plate 3 said: *I am now selling pastries before I as jobless.* A coordinator of the health intervention in Sankor commented: *The health intervention has employed some community people as security officers, orderlies, and others have been allowed to sell food at the hospital.* Similarly, a key member in the leadership of the women's group indicated: *My husband is employed in the Baptist hospital as a security person and he has given me financial capital to start trade in firewood.*

Commenting on the effect of the GBC's primary school intervention on income level of the beneficiaries in Baabianiha, an officer from the District Assembly noted: *I have observed reduction in parents no longer spending*

business hours taking children to school. They now spend these hours to work and save money. In Kasulyili, a chairperson of the local council of churches indicated that the micro enterprise project had increased business activities in the community. He said he was optimistic that those activities could potentially raise income level of beneficiaries. Similarly, an official from the leadership in Kasulyili said: *I see many of beneficiaries selling in the market.*

Perceptions of GBC beneficiaries on accessibility to health facilities

Since physical health has a strong correlation with quality of life and a healthy life is viewed as a universal right and an indispensable precondition for enjoying quality of life, the study undertook a survey to assess the effects of GBC's interventions on the physical health of beneficiaries. The effect of GBCs interventions on the physical health of beneficiaries was measured in terms of accessibility, affordability, and the quality of health care service received.

The study conducted a survey to determine the effects of GBC rural interventions on the status of the respondents. The study took notice of the fact that other concealed sources could affect the health status of beneficiaries. That was controlled by asking respondents to indicate whether GBC interventions had affected their health status.

The study found that the physical health of respondents had improved in accessing GBC's rural interventions. The majority, 240 respondents, representing 89% of the total 271 respondents in all the five communities said their physical health had improved. In terms of communities, respondents in Frankadua 29 respondents representing 82% said their physical health had improved through

accessing GBC vocational training centre. Similarly, Kasulyili (92%), Baabianiha (98%), Amanful (77%) and Sankor (87%) all said that GBC interventions had improved their physical health through accessing the microenterprise, the primary school and the healthcare centre respectively (Table 15).

Respondents attributed reasons of the improvement in their health status to accessibility, affordability and quality of healthcare service received in accessing GBC's rural interventions. In terms accessibility, respondents were asked whether in accessing the GBC's interventions they had easy access to quality health care or not. Majority of the respondents in all the five communities, Frankadua (97%), Kasulyili (70%), Baabianiha (94%), Amanful (87%) and Sankor (91%) indicated that they had easy access to health care (Appendix C).

Table 15- Respondents' Perception of Effects of GBC's Interventions on Physical Health by Community

Community	Perceived Improvement		No improvement	
	Frequency	Percent	Frequency	Percent
Frankadua	29	82	6	18
Kasulyili	43	92	4	8
Baabianiha	62	98	1	2
Amanful	31	77	9	23
Sankor	75	87	11	13

Source: Author's Fieldwork, Enim (2012)

In terms of affordability, respondents in all the five communities, Frankadua (100%), Kasulyili (72%), Baabianiha (94%), and Sankor (87%) said they could afford healthcare because GBC's intervention had provided them with

National health insurance registration. However, majority of the respondents in Amanful (63%) said healthcare was not affordable to them (Appendix C).

In receiving the quality of health care, the respondents were asked whether they received quality health care through GBC interventions. Respondents in four out five communities said they received quality healthcare through GBC's interventions. Majority of the respondents in Kasulyili (64%), Baabianiha (100%), and Amanful (72%) and Sankor (92%) indicated that they received quality health care through the means provided through the GBC's interventions. However, majority of respondents in Frankadua (57%) said that they did not receive quality health care through GBC's intervention while 43% said they did (Appendix 3).

Moreover, an analysis of the responses from key informants to the question 'how have GBC's interventions affected beneficiaries' health status' showed a corroboration with the findings from the survey. Key informants were of the perception that GBC interventions had provided National Health insurance registration for beneficiaries and that most likely enhanced beneficiaries' health status through accessibility, affordability and quality health care.

In Frankadua, an officer from the District Assembly, a key informant from the community leadership, chairperson of the local council of churches and the coordinator of the intervention shared similar comments that GBC interventions had, generally, improved physical health of beneficiaries through providing means to access, afford, receive quality health care and prevent illness. They were of the view that the occasional health screening exercises organised by GBC, the regular physical exercises, and mass registration of trainees for the NHIS card

sponsorship by GBC were potential steps to improve beneficiaries' health status. Few of their views were shown here. In Frankadua, a key informant said that he had observed the trainees go through physical exercises each morning, attend health talk and screening exercises and had seen trainees registered for the National Health Insurance. He believed that those healthcare strategies had most likely contributed to the healthy conditions of the trainees.

In Kasulyili, a key member of the leadership, a member from the women's group, a chairperson of the local council of churches expressed a common view on affordability of health care. The chairperson of the local council of churches commented "*the occasional health talks and the mass registration for the NHIS card have helped the people to afford health care cost. These activities have given the people hope and confidence that health needs can be addressed.*" In reference to quality health care, the coordinator of the micro enterprise intervention noted

We ensure that beneficiaries find good health centres where quality care and quality drugs are given to them. Our occasional health talks are meant to reduce preventable illnesses. The mass registration of NHIS cards is meant to help make health care affordable to beneficiaries...we have not suffered any severe health setbacks since running this project.

In Baabianiha, the coordinator of GBC's educational intervention, the leadership of the community, an officer from the District Assembly, and opinion leader commonly noted that the physical exercises the children go through, the

occasional health screening exercises, the mass registration for the NHIS card had given added advantage to health improvement of beneficiaries.

In Amanful, there was general consensus from key informants that GBC water intervention had helped improved health status in the community. A member of the women's group opined: *...we do not have frequent stomach pains...* A key member from the leadership in the community asserted: *Safe water is health and life...we are not complaining of frequent Guinea worm anymore...* An officer from the District Assembly also noted: *...the frequent complain of stomach and skin problems...water is important to human life... It is a key to life...* From the view of the project coordinator

Access to safe drinking water was a problem for the people. Before the water project came to the community we used to hearing frequent sickness...GBC's frequent health talks and screening exercises have helped us a lot. We all need to be healthy in order to work, make money, improve our lives, and to do something for our family and the community.

In the community of Sankor, an officer from the District Assembly, a key informant from the community leadership, and the coordinator of the intervention shared similar comments that the hospital had improved health status of beneficiaries through offering accessible health facility, arranging for mass registration of NHIS cards for the community people, and regular health talks. A key member of the community leadership shown in Plate 6 also commented:

To be healthy is more than to have money and be sick. The presence of the hospital has given us hope and confidence that our health needs will be

addressed. Now, we do not worry where and how to get medical treatment when we are sick.

However, few key informants from Amanful, Kasulyili, Frankadua, and Baabianiha communities were of the opinion that even though the GBC's interventions had facilitated improvement of their health status, they walk and or travel long distances by bicycles and vehicles (and that depend on available one and or how long it takes to get full to set off) to seek medical treatment persists. They claimed that the challenge had forced others to seek health care from prayer camps, traditionalists and herbalists.

A member from the leadership in Amanful lamented "*Lack of health clinic in our community often forces me to leave my farm work behind, carry my child at my back, sometimes my wife and walk a long distance to seek medical treatment.*"

A leader from the women's group in Kasulyili expressed it succinctly "*Sometimes I have to wait at the lorry station for hours before I get to the medical centre. We need a clinic in our community.*"

Perceptions of GBC beneficiaries on accessibility to educational facilities

As indicated earlier, education (limited to formal education) is another variable in the objective domain of quality of life. Education was measured in terms of accessibility, affordability, quality teaching-learning, understanding, and more hours spent in classroom. The study therefore assessed the effects of GBC's interventions on the education of beneficiaries through a survey. The assessment controlled other factors that could potentially affect respondents' education by limiting responses to the effects that GBC interventions had brought.

When asked whether GBC's interventions had improved their education status the majority of the respondents in two of the five communities, Frankadua (74%), and Baabianiha (81%) communities, agreed that GBC's interventions had improved their education status (Table 16).

Table 16-Respondents' Perception of Effects of GBC's Interventions on Education by Community

Community	Perceived Improvement		No improvement	
	Frequency	Percent	Frequency	Percent
Frankadua	26	74	9	26
Kasulyili	13	27	34	73
Baabianiha	51	81	12	19
Amanful	14	36	26	64
Sankor	17	20	69	80

Source: Author's Fieldwork, Enim (2012)

That was not surprising because these were the communities in which the Baptist Primary School and the Baptist Vocational Training Centre were located. It was also not surprising that majority of the respondents in Sankor (80%), Kasulyili (73%) and Amanful (64%) disagreed that GBC's interventions had improved their level of education. That was suggestive that the focus of the interventions in those three communities was not on education and also most of the respondents were past primary education age. The interventions were focused on health, microenterprise and water respectively, which could most likely affect indirectly the educational level of the households.

As regarding reasons for the improvement in educational standard, majority of the respondents in all five communities attributed it to accessibility, affordability, understanding, more hours in school and quality teaching. In terms of accessibility, respondents were asked whether in accessing the GBC's interventions they had easy access to education or not. Majority of the respondents in all the five communities indicated that they had easy access to primary educational facilities in the communities.

Concerning affordability, majority of respondents in four of the five communities said they could afford primary education. In Frankadua, majority of the respondents (86%) could afford primary education through GBC's scholarship. Majority of the respondents in Kasulyili (98%), Amanful (75%) and Sankor (67%) respectively could afford primary education through financial savings while majority of the respondents in Baabianiha (78%) could afford primary education through both GBC's scholarship and financial savings (Appendix C).

About understanding of classroom lessons, the respondents were asked whether they understood classroom lessons. Respondents in three out of five communities said children understood classroom lessons. For instance, in Frankadua (100%), Kasulyili (91%), Baabianiha (100%), majority of the respondents indicated that children understood classroom lessons and had been passing class tests. However, in Amanful and Sankor, minority of the respondents (40%) and (17%) respectively indicated that their children understood classroom lessons and pass class tests. In terms of more hours in school, majority of the

respondents in all five communities said that children spend school hours in classroom because they do not have to walk long distance to school. Majority of the respondents in Frankadua (71%), Kasulyili (64%), Baabianiha (67%), and Amanful (56%) and Sankor (74%) agreed that there was quality teaching in the school because classroom was adequately furnished and teachers-pupil ratio was standard (Appendix C).

In addition to the survey findings, responses from the key informants to the question ‘how have GBC’s interventions affected educational status of beneficiaries’ were carefully analysed by communities. In Frankadua, there was a common theme that ran through comments from key informants that GBC’S intervention had positively affected beneficiaries’ educational status. A key informant from the women’s group, an official from the District Assembly, the chairperson of the local council of churches, and the coordinator of the Baptist Vocational Training Centre intervention attributed the positive effect to formal primary education and vocational skills ex-trokosi girls were receiving at the training centre.

In Kasulyili, a key informant from the women’s group, an official from the District Assembly, the chairperson of the local council of churches, and the coordinator of the intervention were also of the view that the micro enterprise intervention had no effect on the educational status of the beneficiaries. They explained that the beneficiaries had passed school going age. The key informant from the women’s group pointed out “*Personally, the GBC’s micro enterprise has not affected my educational status but it has enabled me to sponsor my child to*

school through little gains I make from business”. The officer from the District Assembly commented:

The micro enterprise has created the enabling environment for beneficiaries to send their children to school. I am proud to see children of beneficiaries going to school... However, I suggest that adult education should be added to help beneficiaries know basic reading and writing. This can be done through collaboration with the District Education Office.

In Baabianiha, majority of the key informants were of the view that GBC primary school had positively affected educational status of beneficiaries. An opinion leader from the community believed that the school had and still helping the younger generation with formal education. Similar views were held by the official from the District Assembly, the coordinator of the GBC’s Baptist primary. They, however, suggested that adult education could also be of help to the adult community. A member from the leadership in the community commented:

With the presence of the Baptist school in the community, I am now able to have more working hours on my farm. I do not walk a long distance to send my child to school before going to farm but I also want to learn how to read and write.

In Amanful, the general view of the key informants was that GBC water intervention had not affected their educational status. The coordinator of the GBC intervention, the women’s group leader, and an official from the office of the District Assembly were of the view that the safe drinking water intervention had

not affected the educational status of the beneficiaries. However, they perceived that it had helped with the children's health and time in school. The official from the District commented:

The water project has helped the children to spend more hours in school. Children no more fall sick frequently from using the mud water. I am proud and happy that we have safe drinking water in the community. Now, our children attend school regularly. Education and training are some of the steps to make it in life.

In Sankor, key informants shared common perception that GBC's health intervention could potentially enhance education through good health. An official from the office of the District Assembly noted "...a healthy mind needs a healthy body..." Another key member from the leadership in the community expressed his view thus "education is key to health and health is key to education." The coordinator of GBC's safe drinking water intervention explained:

The health intervention can help beneficiaries' education status indirectly because children of employees, employees themselves and vendors may use part of their income to pay for their children's tuition or their own tuition.

Discussion

It appeared in the study findings that income maintained its positive effect on quality of life corroborating with findings of the empirical studies of Onidigi and Mugenda (2011) and Ioana (2010). The findings also corroborated with studies of Angelescu and Easterlein (2009), Wolfers and Stevenson (2008), and

Welzel, Inglehart and Klingemann (2003). Findings also reinforced the role of income in the conceptual framework for the study, which suggested that improved income level sustains integrated quality of life.

The GBC interventions were reported to have increased beneficiaries' income levels. However, beneficiaries of few communities such as Kasulyili had enjoyed such increases in income levels but could not meet some basic needs. Majority of beneficiaries in other communities also could not experience increase in income levels and also could not meet some basic needs. Project planning, implementation and monitoring had been shown in literature to enhance efficiency, effectiveness and efficacy of outcomes. As shown in chapter five GBC interventions had no clear cut planning, implementation, and monitoring mechanisms to ensure effective outcomes. It has been proven that level of education, age distribution, family and population and disparity between urban-rural distributions of development interventions affect income levels.

To date, the disparity between urban-rural communities in terms of development interventions persists (GLSS 6, 2013). Additional evidence regarding low earnings of rural dwellers comes from the studies conducted by the Food and Agriculture Organisation (2012) in Ghana that found that rural dwellers fall under the low earnings classification even after controlling for other socio-demographic variables. With subsistence farming, petty trading in rural Ghana and few small scale industries, as they are, may not be conducive to higher income earnings and thus is not a way of addressing low quality of life

experienced by rural dwellers. Nevertheless, some categories of self-employment work may be more productive.

Food and Agriculture Organisation's (2012) finding reinforces a widely shared conclusions of studies on the inequality in the level of development between rural and the urban communities in Ghana (GLSS6, 2014; Aryeetey et al. 2009). According to GLSS6 (2014), across locality, rural households are deprived more than their urban counterparts. Relatively high levels of poverty reflected in low incomes and poor provision of infrastructure by local and central governments in rural areas imply that rural households' decisions on consumption and access to basic services are curtailed. She concluded that for a range of services such as education, health, water, electricity and others, the proportion of rural households deprived tends to be disproportionately higher than urban areas (GLSS6, 2014).

In the findings, health also maintained its universal acceptance as an important variable defining the objective quality of life. In the conceptual framework and the findings in the empirical works of Bukenya (2003), Ventegodt, Anderson, and Merrick (2003), in the The Netherlands health was shown as strong factor of integrative quality of life with a strong correlation.

The right to health is one of the most fundamentals of all people (WHO, 2014; Badoe, 2013). The findings in this study showed that GBC's rural interventions had improved health status of beneficiaries. However, responses from respondents raised the issue of health care accessibility. Given that the private sector is also involved in health care provision, it is noteworthy that its

health care operations are largely found in urban communities (Inclusion Ghana, 2013). A study conducted by Inclusion Ghana (2013) concluded that health care providers in the private sector continue to operate on the principle of private-for-profit and are largely found in the urban areas (Inclusion Ghana, 2013). This principle seems to compound health care services in the rural communities if not the country as a whole.

Provision of health facilities in rural communities in Ghana continues to be one of the key policies of government. Government is engaged in the provision of hospitals and polyclinics in the Regional and Districts capitals. It is also providing CHPS in some rural communities (GLSS6, 2013). The National Health Insurance Scheme registration seems to be helping health care services. However, statistics show that government's provision of health facilities within the country seems to be targeting more towns than rural communities (GLSS6, 2013). As mentioned in the background to this study, rural communities continue to face the challenge in accessing health care facilities and seeing qualified health personnel (GLSS6, 2013).

Finally, in the findings education maintained its general positive effect on objective quality of life in this study. That finding corroborated with the empirical work of Bukenya (2003) in rural West Virgonia. In the conceptual framework education was project as one of the factors comprising integrated quality of lige. However, the low level of education among beneficiaries could potentially cause the community development and better education. Many rural policymakers have come to view a person's level of educational as a critical determinant of job and

income growth in communities. Higher educational levels contribute to community economic development in several ways.

In the first place, a well-educated labour force facilitates the adoption of new ways of producing goods or providing services among local businesses. In the second place, prospective employers may view a well-educated local labour force as an asset when choosing among alternative locations for new establishments. Both factors could help improve a community's chances of attracting new interventions, particularly those interventions with high income generation that require highly skilled employees. Finally, higher educational levels are almost always tied to geographic clusters of certain key urban towns and cities, which in some cases have generated major economic growth in rural communities. These have happened due the trickle-down effects of economic growth in the urban towns.

The low level of education in the study communities could also be attributed to poor educational infrastructures in the communities. Better schools, for example, can make a difference to parents who want to raise their children in the home environment they once enjoyed, but who also seek the best possible education for their children. Communities may find good schools to be a particularly effective way to capture new settlers or potential development agents.

Current government's educational arrangement in the country supports raising academic standards and well-educated individuals regardless of a community's economic and social profile (GLSS6, 2013). Such an approach holds great potential for helping individuals. The benefit to rural communities,

particularly in distressed areas, could be greatest where human capital improvements are but one of several parallel strategies (such as small scale industries development) aimed at building a local economy with greater job opportunities and higher earnings.

The low level of education in the study communities may cause continued movement of young adults from rural to urban areas for continuous education or apprenticeship training in artisanship. When that happens, much of the community's potential to attract policy makers and implementers to improve schools in rural areas will be lost to the local community. This effect weakens the rationale for supporting good schools, especially if these improvements are perceived to encourage outmigration.

The Ghana Living Standard Survey had shown that young adults who train as artisans or attend senior secondary schools or college no longer resided in their rural communities (GLSS6, 2013). That challenge seemed to face both the developed and developing countries. In USA, studies in rural communities showed that young adults who had not completed high school were about half as likely to reside in a different county, with high school graduates falling in the middle (Gibbs, 2005).

Despite rural gains in educational infrastructures in Ghana, the rural-urban educational attainment gap remains high, and high-skill jobs in large and medium-size cities continue to attract young adults (GLSS6, 2013). Rural communities with significant economic or social distress may find it especially difficult to leverage improvements in school quality without concurrent changes in the local

economy. It has been concluded that provision of quality educational infrastructures in rural communities could be an opportunity to produce educated individuals who could possibly improve their quality of life (GLSS 6, 2013).

The findings in this study concurred with reviewed of related literature and the conceptual framework in this study. Findings agreed with the empirical works of Ioana (2010), Ranis (2004) and Welzel et al. (2003) that concluded that provision of quality educational infrastructure and higher education attainment is potentially associated with improved quality of life.

Findings also agreed with a conclusion of the empirical work of the Ghana Living Standard Survey 6 that Education plays a key role in transforming low-income economic activities in rural communities into higher-income ones (GLSS 6, 2013). Furthermore, the findings in this study also showed that the majority of the workers engaged in self-employment as a main job had not achieved primary education and that was mostly a challenging issue for the improvement of integrated quality of life.

Chapter Summary

In summary, the findings above suggested that beneficiaries in all the five study communities perceived that the GBC interventions had generally and positively improved the objective quality of life. They perceived that their income level, health status and the educational level had positively been affected. However, as indicated earlier, integrated quality of life is measured by examining the three domains of quality of life. Therefore, in addition to the objective quality

of life, there was also the need to examine the subjective quality of life and the existential quality of life of the beneficiaries of GBC's interventions. The analyses and findings of the effects of GBC's rural interventions on the subjective quality of life of beneficiaries were presented in the next chapter.

CHAPTER SEVEN
OUTCOMES OF GHANA BAPTIST CONVENTION'S RURAL
PROJECTS ON THE SUBJECTIVE QUALITY OF LIFE

Introduction

This chapter presents findings and discussions on outcomes of Ghana Baptist Convention's rural development interventions that address specific objective three of the study: The effects of GBC's intervention on the subjective quality of life of beneficiaries. In line with the conceptual framework of the study, factors of subjective quality of life of beneficiaries examined included fulfilment of needs, realisation of life potential, meaning in life, happiness, satisfaction with life and wellbeing. The study undertook to measure the effects of GBC's interventions on those factors. The study recognised the reality of other overt and concealed sources or interventions that potentially could help improve the subjective quality of life of respondents. The findings were based on data generated from GBC projects.

Fulfilment of Needs

As indicated earlier in the literature review human needs comprised deficiency and growth needs whereby indicators of deficiency and growth needs included food, clothing, healthcare, family care, freedom, belongingness, self-respect, and spirituality (Ventegodt et. al., 2010; Maslow, 1954). A survey was therefore conducted to assess the perceptions of GBC beneficiaries on effects of GBC's rural interventions on their fulfilment of their lives' needs.

The study found out that majority 232 out of 271 respondents representing 86% in all five communities were of the view that GBC's interventions had helped them to improve fulfilment of their basic needs such as food, clothing, healthcare, family care, freedom, belongingness, self-respect, and spirituality. By communities, majority of the respondents in Frankadua (82%) said the interventions had improved fulfilment of their food, clothing, healthcare, family care, freedom, belongingness, self-respect, and spiritual needs. Similarly, the majority of respondents in Kasulyili (94%), Baabianiha (90%), Amanful (83%) and Sankor (80%) all said that GBC's intervention had helped improve the fulfilment of food, clothing, healthcare, family care, freedom, belongingness, self-respect, and spiritual needs (Table 17).

Table 17-Respondents' Perception of Effects of GBC's interventions on Fulfillment of Needs by Community

Community	Perceived Improvements		No improvement	
	Frequency	Percent	Frequency	Percent
Frankadua	29	82	6	18
Kasulyili	44	94	3	6
Baabianiha	57	90	6	10
Amanful	33	83	7	17
Sankor	69	80	17	20

Source: Author's Fieldwork, Enim (2012)

Attributing reasons to their improved fulfilment of needs, majority of respondents (88%) in all five communities agreed in statement that GBC's rural interventions had helped them with their food security. For instance, a beneficiary

in Frankadua said “I am grateful to the school for feeding me three meals a day.” Another beneficiary in Kasulyili stated “the micro enterprise project has given me opportunity to work...profits from my business have helped me solve some of my food, clothing, health, family, spiritual and other needs”. Similarly, respondents in Sankor, Amanful, and Baaibianiha expressed the thought that the GBC rural interventions had offered them opportunity to meet their health and food needs. It had secured National Health Insurance cards, safe drinking water and primary school for the people.

The beneficiaries also stated that the interventions had helped them meet their clothing needs. Ninety per cent (90%) of the beneficiaries said GBC’s rural intervention had helped address their clothing needs. A beneficiary in Kasulyili said “*I am able to buy clothes for myself and my children from profits I make from my business.*” Another beneficiary in Frankadua noted “*every festive occasion the training centre help provide me with clothing.*” Another beneficiary in Amanful said “*the water project officer occasionally brings and share used clothing...I now have more farm clothing*”.

Majority of the respondents (62%) believed that GBC’s rural interventions had improved their family relations. A beneficiary in Ksulyili said “*My husband helps me in my pastries work each morning before going to his farm.*” Another beneficiary in Sankor commented “*...when the hospital was not here it was difficult for my family to visit with me...Now they are able to visit with me daily and have family talk*”. Similarly, a beneficiary in Frankadua said “*I am freed from*

the shrine and the shrine priest...now I see my parents, brothers and younger sister and relate to them”.

In addition, nine seven per cent (97%) of the respondents stated that GBC’s rural interventions had improved their self-respect in the community. In Frankadua, a beneficiary narrated:

When I started my own sewing business after my release and training at the Baptist vocational training centre, people were suspicious of me but when the officers from the training centre came and opened my shop people started sending their children to my sewing shop. Trainees call me Madam.

A beneficiary in Kasulyili said “*when I was not in business, my people did not respect my opinion in family discussions and decision making but now I am respected”*. Majority of the respondents (90%) in all five communities said that GBC’s rural interventions had helped them gain their freedom among relatives while Ninety-six per cent (96%) believed that the GBC interventions had enhanced their sense of belongingness (as shown in Table 18). A respondent in Frankadua recounted “*I was not free from the shrine priests. I was forced to do things I did not have interest in them...Now I am free and I have friends”*.”

Field observation shown in Plates 1 and 2 revealed that GBC’s interventions had given opportunities for some beneficiaries to engage in business enterprises such as pastries in pastries, selling of farm produce, expanded farming projects. The interventions had also provided opportunities for some beneficiaries to have access to microfinance, education, and health care.

Table 18- Respondents' Perception of Effects of GBC's Rural Interventions on Indicators of Fulfilment of Needs by Community

Fulfilment of needs Indicator	Perceived improvements		No improvement	
	Frequency	Percent	Frequency	Percent
Food security	239	88	32	12
Clothing	243	90	28	10
Family relations	167	62	104	38
Self-respect	262	97	9	3
Freedom	245	90	26	10
Belongingness	260	96	11	4

Source: Author's Fieldwork, Enim (2012)

In addition to the survey and field observation, the analysis of the responses from key informants to the question 'how have GBC's interventions affected fulfilment of the needs of beneficiaries' suggested that the effects were, generally, positive. Majority of the key informants were of the view that the GBC's rural interventions had helped provide solution to the health, education, employment and religious needs of the beneficiaries.

Perceptions of Key Informants on outcome of GBC's Vocational Training project on Beneficiaries' fulfilment of needs

The key informants in Frankadua were of the view that GBC's Vocational Training Centre intervention had positively enhanced fulfilment of needs of beneficiaries. A key member from the community leadership asserted "*the vocational training centre is providing the girls with a sense of self-respect,*

belongingness, clothing, food, and education". Likewise, the GBC Coordinator for the vocational centre indicated *"the advocacy programme and the vocational training centre are helping to provide freedom, happiness, sense of belongingness, spirituality, self-respect, and skills for the girls to make it in life."*

The chairperson of the local council of churches also remarked:

The freedom of the girls from slavery is secured. They are no more slave girls to the shrine. They are receiving their formal education. They can now read and write. They serve God freely. Thank God for the Baptist training centre.

An official from the office of the District Assembly also observed the opportunities the vocational training centre was offering trainees. He said:

The vocational training centre is giving opportunities to the ex-trokosi girls to gain knowledge, moral virtues, and spiritual insight to life. The centre is also providing the trainees with food, health care resources, social interactions, and psychological well-being.

Perceptions of Key Informants on outcome of GBC's Microenterprise on beneficiaries' fulfilment of needs

In the Kasulyili community, key informants stated that GBC's microenterprise intervention had enhanced beneficiaries' capabilities to create jobs for themselves, improve their health and receive financial capital. For instance, a leader of the women's group of beneficiaries who also doubled as an official of the committee handling market women in Kasulyili said *"the microenterprise project had put beneficiaries to work...some of us are selling*

yam, groundnut, fish and corn". The coordinator of the GBC microenterprise project, an official from the District Assembly and an official from the leadership in the community were of the view that those business activities could help some beneficiaries meet their food, clothing, health, family, spiritual and other needs.

Perceptions of Key Informants on the outcome of GBC's educational facility on beneficiaries' fulfilment of needs

In Baabianiha, key informants were generally of the view that the activities of the primary school in the community had met the educational and health needs through the weekly physical exercise; the occasional health screening exercise the school sponsors. The coordinator of the GBC's primary school intervention stressed "*the school is meeting the mental, emotional, spiritual, health, and social needs of the children.*"

An officer from the District Assembly office noted "*Knowledge is power. Knowledge is wealth. Knowledge is life...Our children in the Baptist school have bright future because of more hours they spend in classroom than on the farms...and the behavioural changes we see shown by them in our homes*". Narrating his experience in affirmation of an educational need that had been fulfilled, the chairperson of the local council of churches opined "*Our children are now attending school in their own community. Parents like me now have more working hours in their businesses and on their farms*".

Perceptions of Key Informants on outcome of GBC's Safe Drinking water project on beneficiaries' fulfilment of needs

In Amanful, the coordinator of the GBC intervention, a key leader of the community, and an official from the District Assembly said that GBC's safe drinking water had reduced incidences of bilharzia in the community. The official from the District Assembly underscored the importance of the water intervention in the community by stating;

Rural people look up to outsiders for help in addressing their health, and financial needs. They look forward to getting better health, employment, achievement, freedom...to decide and right to selfhood needs...people struggle to meet their basic needs in life in rural setting.

Another key informant from the leadership of the Amanful community also explained that water is life and safe drinking water is wealth. He expressed the hope that the water project will reduce incidences of Guinea worms. He said: *the water project had given us plenty of time to work on our farms since we no longer worry over how to get safe drinking water.*

Perceptions of Key Informants on outcome of GBC's health facility on beneficiaries' fulfilment of needs

When asked about the benefits of GBC's Hospital in Sankor, a key person from the leadership in the community commented "*we have a sense of identity, we are assured of our health care, and some of our children have been employed*". The coordinator of the GBC health intervention stressed "*our records shows that the hospital has and continues to provide health care and employment to the*

people...number of patients increase every month, patients receive counselling and spiritual growth”.

Realisation of Life Potential

In addition to fulfilment of needs, another component of the subjective quality of life as defined by the IQOL theory was realisation of life potential. As indicated earlier, the realisation of one’s life potential was defined as the accomplishment of a feat in one’s life dream and desire, skilfulness, optimism, health, control of one’s life, ability to fit in everything one intends to do, and self-actualisation in life (Ventegodt et al., 2003; 2005). The survey conducted to assess the perceptions of beneficiaries on the effects of GBC’s interventions on their realisation of life potential showed that majority 157 out of 271 respondents representing 58% in all five communities were of the view that GBC’s interventions had helped them realised their life potential.

By communities, the study also found that majority of the respondents in three communities Frankadua (91%), Kasulyili (73%) and Babianiha (72%) out of the 5 communities said the GBC’s interventions had helped them to realise their life’s potential through achieved life dream, developed skills, access to healthcare, control of one’s life, and ability to fit in everything one intends to do (see Table 19). Majority of the beneficiaries in Amanful (68%) and Sankor (71%) were of the view that GBC’s rural interventions had not helped them realise their life potential.

Table 19-Respondents' Perception of GBC's Interventions on Realization of Life Potential by Community

Community	Improved		Not improved	
	Frequency	Percent	Frequency	Percent
Frankadua	32	91	3	9
Kasulyili	29	73	11	27
Baabianiha	62	72	24	28
Amanful	20	32	43	68
Sankor	14	29	33	71

Source: Author's Fieldwork, Enim (2012)

Respondents attributed reasons of their agreement to achieved dreams, gain in business skills, good health, gain in job, optimism in life, control of their lives. In terms of achievement, majority of respondents (57%) in all five communities agreed that GBC's rural interventions had helped accomplish a dream in life. For instance, a beneficiary in Frankadua said *"I am no more slave girl at the shrine...now I am learning to become a hair dresser"*. Another beneficiary in Kasulyili stated *"I wanted to establish a grocery store in the community...through the micro enterprise project...Now I have my own grocery store..."* In Sankor, a beneficiary said *"I wanted to become a nurse...through the help of the hospital I am training to become a nurse."* A respondent in Baaibianiha said *"My dream was to send my child to school and to have more working time on my farm...Now I have achieved them"*. In Amanful, a respondent said *"through the water project, I do not have to walk long distances to look for water or worry about stomach troubles"*.

The beneficiaries also stated that the interventions have helped them gain business skills. The Fifty-six per cent (56%) of the respondents said GBC's rural intervention had helped them gain business skills. A respondent in Frankadua said *"I was a slave girl at the shrine but now I am a trainee in dress making"*. In Kasulyili, a respondent said *"the periodic workshops and seminars on how to start a business have helped me gain skills to expand my water business"*. Another respondent in Baabianiha said *"through the school my child has gained basic skills in arithmetic, reading and writing"*. A respondent in Sankor noted *"through the periodic in-service trainings, I have gained skills in handling emergency first-aid"*.

The Fifty-six per cent (56%) of the respondents believed that GBC's rural interventions had improved control of their lives. In Frankadua, a beneficiary narrated *"I am no more under obligation to serve shrine priests...I am training to become a caterer to take control of my life"*. A beneficiary in Kasulyili said *"Formerly I was depending on family members and others to live but now through my business I am in control of my life"*. In Baabianiha, a respondent stated *"I believe the enrolment of my child in the school could lead her to take off in her personal development"*. Similarly, in Amanful a respondent said *"It is possible that the water project may reduce frequent stomach problems anytime I drink the mud water and possibly I can be in control of my life"*. In Sankor, a respondent also said *"through quality healthcare I receive from the hospital, my health status has improved and I am in control of my life"*.

On the contrary, majority of the respondents (54%) were of the view that the GBC's interventions had not promoted good health (see Table 20). In Amanful, a respondent said *“the water project had not healed my sickness but it has reduced the problem of getting clean water”*. Another respondent expressed his view on the effect of the water project on his health. He said *“the water project had not healed the occasional stomachs pains we experience while we use the muddy water with alum but it had relieved our family of the daily struggle to get safe drinking water to use”*.

**Table 20- Respondents' Perception of Effects of GBC's Rural Interventions
on Indicators of Realisation of Life Potential by Community**

Realisation of life potential Indicator	Perceived improvements		No improvement	
	Frequency	Percent	Frequency	Percent
Dream achieved	155	57	116	43
Good health	125	46	146	54
Business skills	153	56	118	44
Job gain	145	54	126	46
Optimism in life	155	57	116	43
Life control	152	56	119	44

Source: Author's Fieldwork, Enim (2012)

In Kasulyili, some respondents were of the view that the GBC's interventions had not given them good health but had given them the opportunity to have good health. A respondent stated *“Through accessing the microfinance project, I have been able to save money with the 'susu' I do. I have been able to register my children and myself with the national health insurance”*.

Field observations revealed that GBC's interventions had given opportunities for beneficiaries to have jobs (Plate 3), access to primary education, vocational training (Plate 2) and healthcare (Plate 6). Pictures from field observation corroborated with literature reviewed in chapter two of the study that quality of life was about empowerment.

Perceptions of Key Informants on outcome of GBC's vocational training project on beneficiaries' realisation of life potential

The key informants in Frankadua were of the view that GBC's Vocational Training intervention had positively enhanced realisation of life potential of beneficiaries. A key member from the community leadership asserted "*the vocational training centre is providing the ex-trokosi girls with opportunities to train in hair dressing, fashion designing, catering, batik making, mason work, carpentry work, and information communication technology*".

Another key informant from the office of the queen mother asserted "*I have seen some trainees who have finished training and established themselves as entrepreneurs in sewing, bakery, and hair dressing*" (Author's Field work, November 2012). Similar comments were shared by the coordinator of the GBC vocational training centre, the officer from the District Assembly, and the chairperson of the local council of churches that the vocational training centre had offered vocational skills to the ex-trokosi girls and the community.

Perceptions of Key Informants on outcome of GBC's microenterprise on beneficiaries' realisation of life potential

The key informants in Kasulyili perceived that the GBC's micro enterprise intervention had enhanced beneficiaries' opportunities to achieve at least a dream in life. For instance, a leader of the women's group in the community said "*Engaging in a petty trading had been my dream and I am now trading in fish by means of the seed money I received from the GBC project*". Similarly, the coordinator of the GBC intervention as well as an official from the District Assembly noticed that the micro enterprise intervention had helped them set up various small businesses. They had observed that the intervention had helped some beneficiaries expand their farming work while others were into grocery, water and pastry businesses.

Perceptions of Key Informants on outcome of GBC's interventions on beneficiaries' realisation of life potential

In Baabianiha, key informants observed that GBC's primary educational intervention was offering opportunities for the beneficiaries to realise their lives' potential. The coordinator of the GBC's primary school intervention stressed "*the school is giving children opportunities to develop and potentially become future leaders, doctors, engineers and other careers*". Acknowledging the fulfilment of an educational dream for children in the community, an officer from the District Assembly office noted "*The primary school established by the GBC is offering our children the opportunity to gain knowledge...Knowledge is power. Knowledge is wealth. Knowledge is life*". Narrating his experience in affirmation of an

educational dream that had come to reality, the chairperson of the local council of churches opined “*the presence of the school has given added opportunity for the children to live close to achieving their dreams...I am optimistic that some of them intend becoming doctors, government officials, clergymen and women*”.

Perceptions of Key Informants on outcome of GBC’s interventions on beneficiaries’ realisation of life potential

In Amanful, the coordinator of the GBC intervention, a key leader of the community, and an official from the District Assembly said: *GBC’s safe drinking water intervention had given the people an opportunity to reduce incidences of water borne disease in the community and enhanced life’s security to achieving one’s life’s dreams*. The official from the District Assembly and the chairperson of the local council of churches stressed that the presence of the safe drinking water in the community was the first step to the community’s life security, growth and progress.

The chairperson of the local council of churches said “*all civilisations began around water...achieving one’s dream of becoming somebody in life begins with water*”. Similarly, another key informant in the community leadership in Amanful explained,

My dream had been to have a safe drinking water for my people so that incidences of water diseases and death will reduce...it is sad to hear that a child is dead because of diseases such as ‘infa’ (Guinea worm) ...Water is life and safe drinking water is wealth...life begins with safe drinking water.

Perceptions of Key Informants on outcome of GBC's healthcare project on beneficiaries' realisation of life potential

When asked about the effect of the hospital on the realisation of life potential of beneficiaries in Sankor, all key informants were of the view that the Baptist hospital had made individuals and the community accomplish at least a feat in life. They noted also that the hospital had attracted socio-economic activities into the community. The coordinator of the GBC health intervention hinted that through the hospital intervention other social amenities such as water and electricity had come to the community.

Citing instances of some individuals who had realised their lives potential, a key informant from the queen mother's office said "*we are grateful to GBC for the hospital because it is sponsoring one of our sons into medical school, two of our daughters to become physician assistants and two of our daughters into community nursing school.*" The chairperson of the local council of churches also said...*one major dream and desire I had was to sponsor my son to medical school...through the hospital my son is now in the medical school.* Another key person in the leadership of the community said:

One of my dreams and desires is to have a hospital in my community. I am proud we (community leaders and people) have worked with the church (GBC) to have this hospital here...One of my dreams is fulfilled...I am assured of an easy access healthcare.

Meaning in Life

As indicated earlier, meaning in life as a component of subjective quality of life involved a person's understanding of the physical and spiritual environment in which he or she lives, and making the most use of the resources available to address a particular need in life (Ventegodt et al., 2010; 2003). Indicators to measure meaning in life included a sense of direction in life, perceiving the world as a good place to live, respect for life, understanding life, and being committed to one's livelihood. Subsequently, the study sought to assess the perceptions of the beneficiaries on whether GBC's rural interventions had improved their meaning in life.

The study found that the majority 214 out of 271 representing 79% of the total respondents said the GBC's interventions had improved their sense of meaning in life. In all five communities, the majority of respondents perceived an improvement in their meaning of life. In Frankadua 20 out of 35 respondents representing 58% agreed that the Vocational Training Centre had brought meaning to their lives.

In the same way in Ksulyili 41 out of 47 respondents representing 88% perceived that the micro enterprise had brought meaning to their lives. Similarly, majority of the respondents in Baabianiha (97%), Amanful (81%), and Sankor (70%) believed that the GBC interventions in their communities (namely, the primary school, safe drinking water and the hospital respectively) had improved their meaning in life (see Table 21).

Table 21- Respondents' Perception of GBC's Rural Interventions on Meaning in Life by community

Community	Perceived improvement		No improvement	
	Frequency	Percent	Frequency	Percent
Frankadua	20	58	15	42
Kasulyili	41	88	6	12
Baabianiha	61	97	2	3
Amanful	32	81	8	19
Sankor	60	70	26	30

Source: Author's Fieldwork, Enim (2012)

The respondents ascribed several reasons to their perception of improved meaning in life after accessing GBC's interventions. The reasons given included a renewed sense of direction, a perception that the world is a better place to live among others, respect for life, understanding of life, and commitment to livelihood as shown in Table 22. When asked whether GBC's interventions had improved their sense of direction in life or not, the majority 59% of the 271 beneficiaries were of the view that the interventions had positively influenced their direction in life.

Table 22- Respondents' Perception of Effects of GBC's Rural Interventions on Indicators of Meaning in Life by Community

Indicator	Perceived improvements		No improvement	
	Freq.	Percent	Freq.	Percent
Sense of direction in life	161	59	110	41
Good to live in the world	159	59	112	41
Respect for life	215	79	56	21
Understanding of life	250	92	21	8
Committed to livelihood	235	87	36	13

Source: Author's Fieldwork, Enim (2012)

A beneficiary in Frankadua said *"the daily activities in the school, the devotion, classroom learning and excursions have helped me to know where I want my life to go."* Another beneficiary in Kasulyili stated *"...through our group meetings, devotional time, workshops and seminars on creating jobs, I now know where I want to go in life."* In Sankor, a respondent said *"with my health improved, I can pursue my goals in life"*. Similar statements were made by beneficiaries in Amanful, and Baaibianiha how the interventions had offered them opportunity to achieve a feat in life.

When beneficiaries were asked also if they think that the world is a good place to live, majority of them (59%) said the GBC's rural interventions had helped them appreciate the world they live in. In Frankadua, a respondent expressed *"I have realised a big difference in my two worlds...the former was an evil place to live...I have good life to live now"*. A respondent in Kasulyili said *"Sometime ago I felt the world was not a good place to live in...but now I*

appreciate living in the world because I have business to do to help my family.” In Baabianiha, a respondent asserted *“my child now has direction in his life through schooling”*. Another beneficiary in Amanful said:

Life in the village is a struggle especially when you do not have clean water...life was meaningless to me because I was not making it in life...but now life is meaningful to me because I can get good water to drink, access health facility with my health insurance card and I am now working.

In Sankor, a respondent said that he felt good living in the community now than before because the presence of the hospital gave him occasional weeding job to do on contract basis. A further reason given by the respondents regarding how meaningful their lives have become was the extent to which they now value and respect their lives. When asked if sometimes they feel like committing suicide, about 80 per cent of the respondents answered in the negative on the grounds that GBC’s rural interventions had helped them to value their lives more.

A beneficiary in Kasulyili said *“At first I spend most of the time crying because I had no gainful job to do to help support the family...but through the microenterprise project I am respected and can also contribute toward family progress.”* Another beneficiary in Frankadua noted *“I had attempted to take my life before because I was suffering as a slave girl at the shrine...but now I am enjoying life with my friends in the school... I am now a human being and no more a slave girl.”* Another beneficiary in Sankor commented *“...I have gained my health back”*.

The majority of the respondents (92%) in all five communities were also of the view that GBC's rural interventions had given them opportunity to gain self-respect in the community. In Frankadua, a beneficiary narrated "*when I was taken to the shrine I lost all my siblings and friends...it is like I was cut off from the community but through the GBC I am now accepted back into the society*". A beneficiary in Kasulyili also narrated "*when I was not in business, my people were not respecting my opinions in family discussions but when I started my corn business and began supporting other family members I am now heard in clan meetings*".

Greater percentage of respondents (92%) believed that the religious activities at project meetings had given them understanding of what life is all about. In the view of a respondent in Frankadua "*...life is to know God, knowing one's destiny and seriously fulfilling it*". In Kasulyili, a respondent admitted "*through the group devotion, I understand life to be working and serving God*". A respondent in Amanful said "*through the project's religious activities, I have understood that God has a plan for my life*".

In Sankor, a respondent narrated his experience "*the morning prayers at the hospital before the day's work have helped me understand that my life is both physical and spiritual*". Comments from a respondent in Baabianiha showed that religious activities at school had given his child a new understanding of life. He said the child goes to church now.

Finally, the majority of respondents also said the livelihood gain through GBC's interventions had given them more meaning in life. Eighty-seven percent

(87%) of the respondents in all five communities asserted that the GBC interventions had given them more commitment to their livelihood. For instance, a respondent in Frankadua said *“I take my training very seriously”*. In Kasulyili, a respondent noted *“this is my livelihood and I am committed to keep it to support myself and family”*. A respondent in Amanful said *“the water has come and I am protecting it to serve me and my children”*. Similar commitment was expressed by respondents in Sankor and Baabianiha communities.

The key informants in the various communities were also of the view that GBC’s rural development interventions (vocational training, microenterprise, primary education, safe drinking water, and healthcare) had given beneficiaries added meaning in life. Analysis of their responses showed that each of the GBC intervention had some positive effects on beneficiaries’ meaning in life.

Perceptions of Key Informants on outcome of GBC’s Vocational Training project on beneficiaries’ meaning in life

The key informants in Frankadua were of the view that GBC’s Vocational Training Centre intervention had given beneficiaries the opportunity to have meaning in life. A key member from the community leadership said *“I believe that with the classroom lessons, morning worship and skill training, the trainees could have meaning in life instead of being slaves”*. The leader of the women’s group in the community also noted *“...the trainees could have a sense of direction now that they are learning a vocation”*.

Similarly, the coordinator of the GBC vocational training centre also said *“I have observed that some of the girls who had completed training are expanding*

their businesses and that could be described as a sense of direction of their lives”.

The chairperson of the local council of churches also remarked, *“I perceive that with seriousness the trainees attach to the worship activities at the centre had given them understanding of life”.* An official of the District Assembly also said *“...once the trainees are serious with their vocational training, it could mean that they understand their lives now”.*

Perceptions of Key Informants on outcome of GBC’s microenterprise on beneficiaries’ meaning in life

In Kasulyili, a leader of the women’s group, the coordinator of the GBC intervention as well as an official from the District Assembly all observed that the micro enterprise project had created business opportunities for beneficiaries to make ends meet. They were of the opinion that the microenterprise intervention had brought additional businesses, employment, skills, and knowledge, health and religious opportunities to the beneficiaries and the community. The chairman and the coordinator of the microenterprise intervention perceived that beneficiaries had gained a sense of direction in their daily lives because they were seen busy with their daily businesses. They believed that monthly Bible reading and prayers at the project meetings could offer them understanding of what to live for.

Perceptions of Key Informants on outcome of GBC’s educational facility on beneficiaries’ meaning in life

In Baabianiha, key informants were generally of the view that the activities of the primary school in the community had given opportunity to the beneficiaries to enhance their effort in having a meaningful life. The coordinator

of the educational intervention stressed “*our record shows increase in children with their parents seeking emotional, spiritual, and social help from our counselling department*”.

An officer from the District Assembly office commented “*I have observed with keen interest the sudden change in direction of children in the community...the positive behavioural changes...*” Similarly, the chairperson of the local council of churches said: *the academic, religious and moral activities in the school are opportunities for meaningful life*. He said he believed that those activities were of themselves opportunities for the children and parents as well to have understanding of what life is all about and how to have a sense of direction in life.

Perceptions of Key Informants on outcome of GBC’s safe drinking water on beneficiaries’ meaning in life

Generally, all key informants in Amanful were of the opinion that the safe drinking water intervention was a prospect for the people to have meaningful life. For instance, a key leader of the community held “*I have observed movements of more people to farms and other businesses than before when people will spend time looking for clean water*”. An official from the District Assembly underscored how meaningful the lives of the people have been with the provision of the water intervention. He stressed: *the presence of the safe water is an opportunity for the people to be healthy and engage in businesses that will make their lives meaningful*.

Perceptions of Key Informants on outcome of GBC's interventions on beneficiaries' meaning in life

In Sankor, the common view held by all key informants was that the hospital in the community had given the people added occasion to experience meaningful lives. A key person from the leadership in the Sankor community noted “*good physical health relates to meaning in life because every part of the body should relate to each other to give an understanding and direction to an action*”. In the view of the chairperson of the local council of churches, the holistic services the hospital offers to the patients in terms of daily reading of the Bible and prayers before healthcare services combine to give an opportunity for patients to experience meaningful lives.

Happiness

In the literature review, happiness was defined as an innate quality of a person associated with non-rational dimensions of life, and aroused through many life experiences such as having access to basic social services, successful closure of the gap between what one wants to achieve and what has been achieved (Hills & Argyle, 2002; Ventegodt et al., 2010; 2005; 2003). The indicators used in the measurement of happiness were laughter, cheerfulness, amusement, joy, good memories, and warm feelings toward people. The study took note of the fact that other factors could contribute to the happiness of the beneficiaries. That challenge was controlled by asking respondents to give information of their perceptions of the effects of GBC's rural intervention on their happiness.

The findings from the survey showed that 229 out of 271 respondents representing 84% said that GBC's rural interventions had brought happiness to their lives. Within the various communities, it was found that the majority of the respondents, in spite of the different interventions, agreed that GBC's rural interventions had brought happiness to their lives. In Frankadua, Sixty-six per cent (66%) of the respondents perceived that the vocational training centre had brought happiness to their lives.

Table 23- Respondents' Perception of GBC's Rural Interventions on Happiness

Community	Improved		Not improved	
	Frequency	Percent	Frequency	Percent
Frankadua	23	66	12	34
Kasulyili	44	94	3	6
Baabianiha	62	98	1	2
Amanful	33	83	7	17
Sankor	67	78	19	22

Source: Author's Fieldwork, Enim (2012)

Similar perceptions were shared by the majority of respondents accessing the microenterprise intervention in Kasulyili (94%), the primary school intervention in Baabianiha (98%), the safe drinking water intervention in Amanful (82%) and the healthcare intervention in Sankor (78%) as shown in Table 23.

They all shared the view that the GBC interventions had brought happiness to the lives.

The respondents attributed their perceived improvement in happiness to laughter, cheerfulness, amusement, joy, good memories, and warm feelings toward people. For instance, the majority of respondents (94%) were of the view that GBC’s rural interventions had brought laughter to them while 89 per cent, 88 per cent, and 90 per cent said the interventions had brought them cheerfulness, amusement and joyfulness respectively (Table 24).

Table 24- Respondents’ Perception of Effects of GBC’s Rural Interventions on Indicators of Happiness

Happiness Indicator	Perceived improvements		No improvement	
	Frequency	Percent	Frequency	Percent
Laughter	254	94	17	6
Cheerfulness	242	89	29	11
Amusement	238	88	33	12
Joy	243	90	28	10
Good memories	208	77	63	23
Warm relations	239	88	32	12

Source: Author’s Fieldwork, Enim (2012)

In Frankadua, a beneficiary said “*I can’t remember when I laughed at the shrine but now I laugh a lot with my friends in this training centre.*” A beneficiary in Kasulyili stated “*the micro enterprise project has given me real opportunity to laugh with my friends...I can now move along with friends*” Similar

sentiments were expressed by beneficiaries in Sankor and Amanful because of the GBC's interventions had reduced their worries over health, water and basic needs they hitherto have. In Baabianiha, a respondent expressed *"I laugh a lot in my excitement to walk my child to school in my community...it has also relieved me of the burden to transport him to Drobo for school"*.

Another reason respondent attributed to their happiness after accessing GBC's interventions was good memories they now had as compared to memories before the interventions. Seventy-seven per cent (77%) of respondents said they now had good memories. A beneficiary of the Vocational training centre in Frankadua narrated:

When I was at the shrine...sometimes I dream of bad things happening to me but now I do not...Each night my room-mates and I talk more of our training and the future things we desire to do...I know from the Bible What God has promised do with me.

A beneficiary in Kasulyili stated *"I used to think and cry and even feel shy going among my friends... but now I wake up thinking about my business...now I have a sense of self-worth"*. In Amanful, a respondent said *"Before I lived in fear that any of my children will in the middle of the night complain of stomach trouble but now I do not"*. Similarly, in Sankor a respondent articulated:

I used to live in fear that because there was no nearby health care centre and easy transportation in the community but now I do not think of such terrible things anymore because there is a mission healthcare centre I can access.

Similarly, a beneficiary in Baabianiha said *“I used to wake up and worry about taking transport and carry my child to school but now with the school in the community I do not have such unpleasant memories”*. A beneficiary in Sankor narrated *“Carrying a sick person in the night and not knowing where to go is a bad memory but with the hospital in this community such bad memories are overshadowed”*. Majority of the respondents (88%) also attributed warm human relations the GBC’s rural interventions had brought into the community. They said those interventions had brought about social interactions. There was corroboration in the findings from the survey with that of the key informant in the sense that key informants were also of the perception that GBC’s interventions had brought happiness to the people.

Perceptions of Key Informants on outcome of GBC’s Vocational Training project on beneficiaries’ happiness

The key informants in Frankadua were of the view that GBC’s Vocational Training Centre intervention had given beneficiaries the opportunity to be happy. A key member from the community leadership asserted *“I visit the training centre often...there is joy among the ex-trokosi girls.”* The leader of the women’s group in the community also noted: *“...I am very happy because now than before our daughters laugh. I visit them often and they appear cheerful in their training”*.

Similarly, the coordinator of the GBC vocational training centre also said *I thank God the girls are happy now and they laugh among themselves and with each other...at first they looked strange and traumatised.* A key informant from the office of the Queen mother said *the training centre has extra-curricular*

activities like excursion, games, and sports that are meant to keep the trainees happy...they are often joyful at such activities. The chairperson of the local council of churches also remarked, *the mood I see when I visit the ex-trokosi girls at the training centre is one of happiness and joy...trainees are excited and active in their skill development.* An official of the District Assembly also said *I can see that the frequent visits to the ex-trokosi girls at the training centre were welcome events because the trainees appear joyful.*

Perceptions of Key Informants on outcome of GBC's microenterprise on beneficiaries' happiness

In the Kasulyili community, key informants stated that GBC's micro enterprise intervention had enhanced beneficiaries' happiness. For instance, a leader of the women's group in the community, the coordinator of the GBC intervention as well as an official from the District Assembly were of the same view that the microenterprise project had given opportunity to beneficiaries to be happy and joyful because they had been involved in socio-economic activities. The leader of the women's group of the micro enterprise intervention also said *we are happy we are self-fulfilled...we laugh a lot at group meetings.*

Perceptions of Key Informants on outcome of GBC's educational facility on beneficiaries' happiness

In Baabianiha, key informants were generally of the view that the activities of the primary school in the community were avenues for the people to be happy. The coordinator of the GBC's primary school intervention stressed: *Both children and parent seem content with quality teaching in the school*

because of the performance in examinations. An officer from the District Assembly office noted: Personally, I am happy with the school because of the strong religious and moral lessons given to the children.

Similarly, the chairperson of the local council of churches opined: *I am happy we have a school in the community. Parents are relieved and can now have more working hours on their jobs...Children are exposed to knowledge (Field work, Enim 2012).*

Perceptions of Key Informants on outcome of GBC's Safe drinking water project on beneficiaries' happiness

In Amanful, the coordinator of the GBC intervention, an official from the District Assembly said that GBC's safe drinking water had offered the people added opportunity to be happy. An official from the District Assembly narrated:

There was happy mood in the community when the water project was in construction and when it was commissioned. In my subsequent visits to the community, I have been observing the mood of the people and it appears that they are content because a clean water need has been met.

From the office of the queen mother, a key informant noted: *Now I see smiles on the faces of my women...They no more suffer stomach problems because they no more add alum to mud water and drink it.*

Perceptions of Key Informants on outcome of GBC's Healthcare project on beneficiaries' happiness

There was a consensus among key informants in Sankor that the GBC's Hospital had brought happiness to the people. A key person from the leadership in the Sankor community stated: *I am happy I am assured of an easy access to a health care centre in the community.* Likewise, the coordinator of the GBC health intervention said: *The hospital in the community has provided health care, employment, joy, and self-worth to the people. It has also provided opportunities for counselling and spiritual growth for patients and their relatives.*

The officer from the District Assembly office noted:

I am happy about reports reaching my office of the good services the health centre is rendering the people in the community. The mass registration of the people for National Health Insurance Scheme organised by and sponsored by the Baptists (GBC). That should make the people happy.

Satisfaction with Life

As indicated in Chapter Two, satisfaction with life is another factor in the subjective domain of integrated quality of life (Ventegodt et al., 2003). The indicators used to assess satisfaction with life were safety in life, contentment with one's life, ability to meet one's life expectations, needs and desires. It also included the individual's ability to live a life close to one's ideals, to be content with what he or she had achieved in life, and the state where an individual would

not be willing to change almost anything about his or her life if given the opportunity to live his or her life over again.

A survey was therefore, undertaken to assess the perceptions of the beneficiaries on the effects of GBC's intervention on beneficiaries' satisfaction with life. It was found that out of the 271 respondents, the majority 199 representing 73 per cent said they were satisfied with life. Similarly, the majority of respondents in all five communities, Frankadua (79%), Kasulyili (72%), Baabianiha (87%), Amanful (68%) and Sankor (64%) agreed that GBC projects had positively affected their satisfaction with life (Table 25).

Table 25- Respondents' Perception of GBC's Rural Interventions on Satisfaction with Life by Community

Community	Improved		Not improved	
	Frequency	Percent	Frequency	Percent
Frankadua	28	79	7	21
Kasulyili	34	72	13	28
Baabianiha	55	87	8	13
Amanful	27	68	13	32
Sankor	55	64	31	36

Source: Author's Fieldwork, Enim (2012)

The respondents attributed their perceived improvement in satisfaction with life to safety at home, in the community, contentment in life, ability to achieve, and living close to life's ideals. When asked whether beneficiaries felt safe at home or in the community, majority of respondents (74%) said that GBC's rural interventions had provided opportunity to be safe at home and in the community. For instance, a beneficiary in Frankadua said: *I believe I am secured*

in the hands of the school authority and I will not be returned to the shrine anymore. Another beneficiary in Kasulyili stated: *The micro enterprise project has given me opportunity to secure my position as a wife in my family and respect in my community...it makes life safe.* In Baaibianiha, a respondent explained his family's satisfaction with life in terms of the security arrangement at the school for the pupils. He held: *The Baptist school had offered security for the children by employing school compound guards.*

In terms of contentment in life, the majority of respondents (94%) said the GBC interventions had given them contentment in life. A beneficiary in Frankadua noted: *I have inner peace and contentment after I had been released from the trokosi shrine.* In Kasulyili, a respondent said: *I am now calm and settled in myself over things as against before when I was anxious.* A respondent in Baabianiha asserted: *I am fulfilled that my child is in school.* Akin to other respondents, a respondent in Amanful noted: *I am happy and at ease because I do not worry and get anxious over how to get water for the family...I am satisfied with the water project in the community.* In Sankor, a respondent said: *I am satisfied with the presence of the hospital in the community.*

The majority of the respondents (78%) also said they were satisfied with life because they were having the ability to achieve goals in life. A respondent in Ksulyili expressed: *With the training I often receive at workshops and seminars, I have now developed the skills to expand my business and make more profit.* A respondent in Amanful said: *With no more struggle for clean water at long distance places, I can now achieve my target of clearing more 'poles' (street light*

poles) of corn and pineapple farms. A respondent in Sankor also indicated: *The easy access I have to the hospital and the quality care I receive have helped improved my health and now I can bring more than two crates of fish unlike before when I could get more than one crate of fish. Now I can go for fishing at sea more regularly.*

Regarding beneficiaries' ability to live close to their ideals in life, only a simple majority (51%) of respondents said the GBC's rural development interventions had provided opportunity for them to live close to their ideals in life. A beneficiary in Frankadua said: *With one more year of my training, I am sure I am living close to my desire of becoming a hair dresser.* In Kasulyili, a respondent noted: *I am left with one month to finish paying back my start-up capital to qualify me for the second one, which I will use to expand my groundnut, yam, and corn business.*

A respondent in Baabianiha noted: *My child in school is a sign of his first step in living close to his desire of becoming an engineer.* Similarly, in expressing his family safety in terms of health security, a respondent in Amanful declared: *My family is safe from health troubles the mud water used to give us in the years past.* In Sankor, a respondent stated that having an easy access to a health facility, enjoying quality health care and having been registered with the national health insurance were enough steps to living close to his ideal life of good health. However, close to half of the respondents (49%) said they were not living close to their ideals (Table 26).

Reasons attributed to their not living close to their ideals, which appeared to be common reasons among respondents, were inability of the interventions to provide them with opportunities for employment, enough financial capital for their business and motivation to participate in decision making.

Table 26-Respondents' perception of Effects of GBC's Rural Interventions on Indicators of Satisfaction with Life

Satisfaction with life		Satisfied		Not Satisfied	
Indicator	Freq.	Percent	Freq.	Percent	
Safety at home	200	74	71	26	
Safety in the community	200	74	71	26	
Contentment in life	254	94	17	6	
Ability to achieve	211	78	60	22	
Living close to ideals	138	51	133	49	

Source: Author's Fieldwork, Enim (2012)

In Amanful, a respondent expressed: *The safe drinking water is important for my health but I need financial capital to expand my farm.* Another respondent reiterated: *I am happy I have good water in my community but I need money to start selling water to the nearby villages.*

A respondent in Amanful pointed out: *The project leaders do not involve us in matters that affect the smooth running of the intervention.* In Sankor, a respondent said: *The healthcare I receive from the hospital is good but I still do not have a gainful job to do to survive...I need money to start chop bar.* Another respondent in Sankor noted: *The hospital has helped me and my family to acquire*

the National Health Insurance Identification card but I have not been able to send my son to learn fitting (auto mechanic). Another respondent said: We are not involved in decision making process in community health matters.

Similar observation was made by few respondents in Kasulyili whose reasons for not living close to ideals appeared to focus on financial capital for their businesses. A respondent said:

The financial capital for my business is not enough because prices of goods are going up and that is reducing the amount of goods I buy...It makes me to invest my profit back into my capital...therefore I do not go forward.

Another respondent stated that the time for repayment was too short for her that she had not saved enough to expand her yam, beans and groundnuts selling business. It appeared majority of those where not living close to their ideals were beneficiaries in communities with GBC's safe drinking water, health, and microenterprise interventions.

In the addition to the findings from the survey, analysis of the responses to the question how has the GBC intervention affected satisfaction with life of beneficiaries, it appeared all key informants in all five communities were of the perception that the effects of GBC's rural interventions on beneficiaries' satisfaction with life had been generally positive.

Perceptions of Key Informants on outcome of GBC's Vocational Training project on beneficiaries' satisfaction with life

The key informants in Frankadua were generally of the view that GBC's Vocational Training Centre intervention had positively enhanced beneficiaries' satisfaction with life. The above assertion was a summary of the various comments from them. For example, a key member from the Frankadua community leadership asserted: *Leadership is satisfied with programmes of the vocational training centre because it is providing opportunities for the ex-trokosi girls to gain self-respect, a sense of belongingness and skills to live their own lives in the future.*

In the same way, the GBC Coordinator for the vocational centre indicated: *Feedback through school's suggestion box indicated that the trainees are satisfied with life while in training.* The chairperson of the local council of churches, a key person from the office of the queen mother and an official of the District Assembly all seemed to stress the fact that the provision of various training courses provide opportunities for trainees to be satisfied with what they want to be in future.

Perceptions of Key Informants on outcome of GBC's microenterprise project on beneficiaries' satisfaction with life.

In the Kasulyili community, the perception of the key informants was that GBC's micro enterprise intervention had enhanced beneficiaries' satisfaction with life. A leader of the women's group in the community, the coordinator of the GBC intervention as well as an official from the District Assembly all observed

that the intervention appeared to have satisfied the people's desire for gainful employment. They said it had created opportunities for beneficiaries to be involved in small scale businesses, commercial farming in tomato, corn and yam, which beneficiaries were not involved some few years back. In the words of the leader of the GBC microenterprise beneficiaries: *We are satisfied because our hands have found work to do for living.* The leader of the microenterprise intervention was also saying that though beneficiaries were satisfied with what they were capable of achieving; they were of the view that the financial capital received from the intervention was inadequate since prices of goods at the markets kept rising.

Perceptions of Key Informants on outcome of GBC's educational project on beneficiaries' satisfaction with life

In Baabianiha, key informants were generally of the view that the GBC's primary education intervention in the community had enhanced the people's satisfaction with life. A key person from the leadership of Baabianiha commented: *We are grateful to the Creator for the school in this community...we are fulfilled that we have not denied our children the opportunity to be what they desire to become in future.* The coordinator of the GBC's primary school intervention stressed: *The school is in the community to satisfy at least a need...it appears the people are satisfied with it because they are enrolling their children in the school.*

An officer from the District Assembly office noted: *We are gratified that the church (GBC) is contributing to development.* A leader from the women's

group in the community noted. . . *I am pleased the school is helping our children to have a future...* Similarly, the chairperson of the local council of churches commented: *Children are now attending school in their own community...Parents now do not worry over road accidents that sometimes involve school children.*

Perceptions of Key Informants on outcome of GBC's safe drinking water project on beneficiaries' satisfaction with life

In Amanful, key informants were of the view that the GBC's safe drinking water had enhanced opportunities for the people to have more satisfaction with their lives. From the office of the Queen mother, another key informant indicated: *Even though we have safe drinking water, we need a market, school, and a clinic.* Similarly, the coordinator of the GBC's water intervention explained: *We are very satisfied with our lives to have a clean water to drink...Before we used to depend on mud water...or walk long distance to buy sachets of water from nearby town.*

Perceptions of Key Informants on outcome of GBC's healthcare project on beneficiaries' satisfaction with life

The coordinator of the GBC health intervention explained: *Comments through our suggestion box suggest that patients are satisfied with services we render to them and the community.* Similar views were expressed by the coordinator of the GBC's health intervention and the chairperson of the local council of churches. However, a leader from the women's group noted: *I am not satisfied with the decisions making process at the hospital on health matters that affect the community because we are not involved.*

Wellbeing

As indicated earlier in the literature review, wellbeing as a component of subjective quality of life was defined to include adventure, excitement, creativity, fantasy, and playfulness (Ventegodt et al., 2010; 2005; 2003). The study therefore undertook a survey to assess the perceptions of the effects of GBC's interventions on the wellbeing of beneficiaries. The findings were that, out of 271 respondents the majority, 211 representing 78% noticed that the GBC's rural development interventions had improved their well-being whereas only 22 per cent said they had not perceived any improvement in their well-being (see Table 27).

**Table 27- Respondents' Perception of GBC's Rural Interventions on Wellbeing
by Community**

Community	Improved		Not improved	
	Frequency	Percent	Frequency	Percent
Frankadua	26	73	9	27
Kasulyili	35	75	12	25
Baabianiha	53	84	10	16
Amanful	32	79	4	21
Sankor	65	75	21	25
Summary	211	78	60	22

Source: Author's Fieldwork, Enim (2012)

In terms of distribution within communities, the majority of respondents in all five communities, Frankadua (73%), Kasulyili (75%), Baabianiha (84%), Amanful (79%), and Sankor (75%), agreed that GBC's interventions had brought improvement in their wellbeing. The beneficiaries attributed reasons to their

perceived improvement in wellbeing to opportunities the interventions had given to them to be adventurous, excited, and creative as well as to have fun and play.

When asked, whether they have been able to embark on adventurous or pleasurable travels, only 33 per cent of the respondents said the GBC's interventions had given them opportunity to take adventures. A respondent at the vocational training centre in Frankadua said: *I am always exited when we embark on excursion to places to see things I have not seen before.* Similar statements were made by a respondent in Baaibianiha. However, in Kasulyili, Amanful and Sankor, respondents were of different views. They all appeared not to have been interested in adventurous activities since they said they were more concerned with working to meet their basic physiological needs.

Citing excitement as one of the reasons for an improved wellbeing, the majority of the respondents (93%) said they were excited because of GBC's interventions. In expressing her enthusiasm, a beneficiary in Frankadua indicated: *I am always eager to sit behind my sewing machine and practice sewing.* In Kasulyili a respondents said: *I am excited that the office is helping me to do better business through training so I am always eager to participate in any workshop organised by the office.* Expressing his excitement over the water project in Amanful, a respondent said: *I cannot describe how I feel inside me about my delight in having access to good water...I feel good.* Similar sentiment was expressed by a respondent in Sankor.

Majority of the respondents (83%) also mentioned their improved creative ability after accessing GBC's interventions as reason for their improved wellbeing. In Frankadua, a respondent said: *I am able to think and do things like sewing dress for myself...I was not doing this when I was at the shrine.* A beneficiary in Kasulyili narrated how creative he had been since accessing the microenterprise intervention. He said: *I am a farmer...I used to sell my corn but through the microenterprise programme I have opened a small chop bar and using my corn to prepare 'tuosafi' [a local dish prepared with corn and bitter leaves and sauce] with the help of my wife.* A respondent in Baabianiha said: *I teach at the school but I thought to open a stationery store in the community, which I have opened.*

Similarly, a respondent in Sankor narrated his creative ability and said: *I thought the hospital staff will need cell phone units so I created one near the hospital and I am in good business.* Majority of the respondents (69%) and (93%) respectively said that the GBC's interventions had created opportunities for them to imagine unreal things and be at play. In terms of fantasy, respondents in Frankadua and Baabianiha appeared to dream about being a role model of some sort. In terms of playfulness, all appeared to appreciate the sports and fun games organised in the package of the interventions. However, majority of the respondents in Kasulyili, Amanful and Sankor said they had not experienced any fantasy in accessing GBC interventions. However, the interventions had given them opportunity to occasionally play and have fun with their families. The summary of their reasons are as shown in Table 28.

Table 28-Respondents' Perception of Effects of GBC's Rural Interventions on Indicators of Wellbeing

Well-being Indicator	Perceived improvements		No improvement	
	Freq.	Percent	Freq.	Percent
Adventure	90	33	181	67
Excitement	251	93	20	7
Creativity	226	83	45	17
Fantasy	188	69	83	31
Playfulness	253	93	18	7

Source: Author's Fieldwork, Enim (2012)

In addition to the findings from the survey, responses from key informants in all five communities (Frankadua, Kasulyili, Baabianiha, Amanful and Sankor) on the effects of GBC's interventions (vocational training, microfinance, primary education, safe drinking water, and health) on beneficiaries' wellbeing were analysed. The findings corroborated with the finding from the survey that the GBC interventions had improved beneficiaries' wellbeing.

Perceptions of Key Informants on outcome of GBC's vocational training project on beneficiaries' wellbeing

The key informants in Frankadua were of the view that GBC's Vocational Training Centre intervention had positively improved the wellbeing of the beneficiaries. A key member from the community leadership had observed the holistic training the ex-trokosi girls were going through. He commented that the social programmes such as games and excursions, the educational and the

religious programmes and the fun as well as the excitement could most likely affect positively the social, educational and religious needs of the trainees.

The GBC Coordinator for the vocational centre said: *The trainees have leisure and fun...they watch television, movies, take time out for excursions and have fun games.* The chairperson of the local council of churches and the officer from the District Assembly office stressed that trokosi slaves were given their freedom. They had been creative in their various careers and their health challenges were addressed. Religious and moral training were on-going. Physiologically, they were being provided with food, clothing, and shelter.

Perceptions of Key Informants on outcome of GBC's microenterprise on beneficiaries' wellbeing

In the Kasulyili community, key informants stated that the GBC's micro enterprise intervention had enhanced beneficiaries' capabilities to improve on their wellbeing. The chairperson of the local council of churches asserted: *I have observed the excitement among some church members since they benefitted from the microenterprise intervention.* In narrating her wellbeing experience, the leader of the women's group of the project and who doubled as an official of the market women association in Kasulyili and surrounding villages said:

The training we have received has helped us to do creative things. I fry dough nuts in addition to my yam selling. I go to other villages to buy food stuffs and sell them during market days on Thursdays. There is also much fun and play among us at group meetings and personally I do have fun and play time with my workers and family members.

The coordinator of the microenterprise intervention as well as an official from the District Assembly commented that the microenterprise project had brought out the creative skills of the beneficiaries, which have enhanced business activities in the community. They commented that during market days (Thursdays) microenterprise beneficiaries were seen engaged in brisk business in sugar, gari, fish, yam, and other items.

Perceptions of Key Informants on outcome of GBC's educational project on beneficiaries' wellbeing

In Baabianiha, key informants were generally of the view that the GBC's interventions had improved their wellbeing through various activities. The coordinator of the GBC's primary school intervention stressed: *Children are receiving mental, emotional, spiritual, health, and social help.* He said that children were exposed to sports, games, and art and craft activities to unearth their creative abilities as well as have leisure and fun. He noted that those activities had won them laurels in the district. An officer from the District Assembly office noted *the children are being exposed to nature through excursions.* The chairperson of the local council of churches opined: *Our children are receiving religious and moral training in addition to the academic training.*

Perceptions of Key Informants on outcome of GBC's safe drinking water project on beneficiaries' wellbeing

There appeared to be a common view expressed by all key informants in Amanful that the GBC's rural interventions had brought along opportunities that had enhanced the wellbeing of the beneficiaries. A key leader of the community

said *we have time to play Ludo, Oware, draft and watch television at a neighbour's compound after our farm work. Now our children have enough time to play Ampe and football after their house chores.* Another key informant from the office of the queen mother in the Amanful community also asserted, *"We now have enough of time to chat and visit with our family members in the evenings...watch serekwakwa (comedy) programme on Adom Television.*

Perceptions of Key Informants on outcome of GBC's healthcare project on beneficiaries's wellbeing

All key informants in Sankor asserted that the hospital had most likely improved the wellbeing of the beneficiaries. The coordinator of the hospital said: *The provision of the hospital in the community had brought much excitement and creativity into the community...people I know who were not vendors are now vendors at the hospital.* A leader from the women's group also pointed out: *Now I have time to do other things...I am able to have fun with my grandchildren and watch television.*

Discussion

Findings in this study showed that subjective quality of life factors maintained their significance in the measurement of integrated quality of life and as such had supported the conceptual framework and other empirical studies of Constanza et. al. (2007), Ventegodt, Anderson and Merrick (2003), Ventegodt, Flensburg-Madsen, Anderson, Nielsen, Morad and Merrick (2005) Ventegodt, Omar and Merrick (2010) projecting wellbeing, satisfaction with life, happiness,

meaning in life, fulfilment of needs and realisation of life potential as factors of integrative quality of life with strong correlation.

Even though findings showed that GBC's interventions improved the subjective quality of life factors mentioned above, a quantitative approach to this kind of study might be interesting in the sense of its objectivity in measuring each subjective factor. In particular, the making of a life satisfaction judgment with the scale used emphasised the person's own standard of evaluation. Furthermore, the respondent drew on the domains he or she found relevant in formulating his/her judgment of individual or community life satisfaction.

The facts stood that life satisfaction judgments were at least partially independent affective measure. Even though, it had several strengths such as being a useful and meaningful psychological issue and showing some degree of autonomy from related subjective quality of life construct such as happiness, respondents could consciously distort their responses to the questionnaires if they were motivated to do so, hence a necessary inquiry followed up.

Several important issues remained for future research in terms of measuring subjective quality of life factors such as satisfaction with life. For instance, a more comprehensive data for satisfaction with life could be ideal. It could also be interesting to explore one's satisfaction with life in terms of different time frames of reference: the past, present, future and both shorter (several weeks) and longer (several years) time perspectives. That could enable determination of stable time frame that could be used to access the time frame used by various study populations.

With the issue of the measurement of the factor happiness, empirical studies by Constanza et al. (2007), Dorji (2013) and Landiyanto, Ling, Puspitasari and Irianti (2010) had shown that happiness was an important component of quality of life in humans. However, it had been argued that happiness might not be enough as a measure of subjective quality of life as could be seen from the case of the 'happy poor' (Susniene & Jurkauskas, 2009). Vulnerable and hungry children hitherto play in rural communities as if nothing in life was at stake.

However, in both the literature review and the conceptual framework, happiness was projected as one of the necessary factors constituting integrated quality of life. Findings corroborated with the empirical work of Constanza et al. (2007) that happiness could be a necessary factor in the determination of quality of life as pointed out in the literature review of the case of the Kingdom of Bhutan whose National Happiness Index determines the country's level of quality of life. Even though happiness could not be the single most important criterion in determining integrated quality of life, taking no account of whether a person was miserable or dissatisfied would surely be lacking an important dimension of human progress.

The findings also showed that meaningful life was perceived as contingent on provision of interventions that meet basic needs in life. However, this finding appears to contradict empirical study of Constanza et al. (2007) and Ventegodt et al. (2003). In such studies, it was surprising how some people with easy access to basic needs in life in some developing and developed countries end up perceiving life as meaningless and unidirectional, despite gains in material wealth.

Chapter Summary

In summary the findings above appeared that the GBC interventions had generally and positively affected the subjective domain of quality of life of beneficiaries in all of the five study communities. However, as indicated earlier, integrated quality of life was measured by examining the three domains of human quality of life. Therefore, in addition to the objective quality of life and the subjective quality of life, the need to assess the effects of GBC's rural interventions on the existential quality of life of beneficiaries was presented in the next chapter.

CHAPTER EIGHT
OUTCOMES OF GHANA BAPTIST CONVENTION'S RURAL
PROJECTS ON THE EXISTENTIAL QUALITY OF LIFE

Introduction

This chapter presents findings and discussions on outcomes of Ghana Baptist Convention's rural development interventions that address specific objective four of the study-the effects of GBC's intervention on the existential quality of life of beneficiaries. The existential quality of life defined in terms of religiosity formed part of the whole process of determining integrated quality of life (Ventegodt et al., 2003).

The indicators for religiosity were faith in a Transcendent Being (God), perceived meaning to life, strength and courage, hope and assurance, satisfaction, and moral values in human progress (Deneulin & Rakodi, 2010; Myers, 2000; Peterson & Roy, 1985; Ventegodt et al., 2003; 2005; 2010). The study recognised the reality of other overt and concealed sources or interventions that potentially could help improve the subjective quality of life of respondents. The findings were based on data generated from GBC projects.

Religiosity

In assessing the effects of GBC's interventions on the religious life of the beneficiaries, the study undertook a survey. The findings (Table 29) indicated that out of the 271 respondents, majority in the respondents 231 representing 85% said that GBC's rural intervention had improved their religious lives.

Table 29- Respondents' Perception of GBC's Rural Interventions on Religiosity by Community

Community	Improved		Not improved	
	Frequency	Percent	Frequency	Percent
Frankadua	29	82	6	18
Kasulyili	41	87	6	13
Baabianiha	56	89	7	11
Amanful	34	84	6	16
Sankor	71	83	15	17

Source: Author's Fieldwork, Enim (2012)

Analysis by communities showed that the majority of the respondents in all five communities, Frankadua (82%), Kasulyili (87%), Baabianiha (89%), Amanful (84%) and Sankor (83) agreed that the GBC's interventions had affected their religious lives positively.

The respondents attributed their perceived improvements in religious lives to faith in the Transcendent Being (God), strength and courage, hope and assurance, satisfaction, and religious moral as a result of the GBC interventions shown in Table 30. In terms of faith in God, majority (72%) said that in accessing the GBC's rural intervention they had been introduced to faith in God. A beneficiary in Sankor narrated: *I visited one of the open air rallies organised by the project...I was introduced to God by the preacher that day and since then I have been attending the Baptist church.* Another beneficiary shown in Plate 5 in Amanful commented: *I came to know more about God through a durbar organised by the project coordinator...since then I do attend the Baptist church in*

the community. In Baaibianiha, a beneficiary noted: Every morning from Monday to Friday the children, at school assembly, go through worship...This has introduced my child to faith in God. He goes to church every Sunday.

Another reason attributed to the improvement in the religious lives of the beneficiaries as a result of accessing GBC's rural intervention was the meaningful lives they now live. About 90 per cent of the respondents said GBC's rural intervention had brought meaning to their lives. A beneficiary in Frankadua noted: *The morning worship services before classroom work, Sunday worship service, and Tuesday's evening bible studies at the training centre have taught me how to live my life in the fear of God.* In Kasulyili, a respondent said: *I am blessed at the monthly project meetings because I am taught how to live my life.* Similarly, in Amanful, Baabianiha and Sankor respondents affirmed that the religious activities at the GBC's project meetings had given meaningful direction to their lives.

The Ninety-three per cent (93%) of the respondents said that religious activities at GBC's projects meetings had given them strength and courage, hope and assurance. A beneficiary in Sankor said: *The staff's attitude toward patients at the hospital and the morning devotions at the hospital do give hope, assurance, strength and courage during my visits.* In Frankadua, a respondent said: *I do not know about others but I can say that the religious activities at this training centre give me hope and courage that when I complete training I will succeed in life.* An elder shown in Plate 4 in Amanful noted *...with the presence of this water project*

I have the strong hope that God will bring other projects to help provide opportunities to enhance my life.

Majority of the respondents (83%) also cited satisfaction in life as a reason for improved religious life. A beneficiary in Frankadua said *...in participating in the religious activities at the vocational training centre, I have found inner peace with myself.* In Kasulyili, a beneficiary also said *...the religious activities at the microenterprise group meeting have healed my many wounds in life.* Citing gain in religious morals as a reason, majority of the respondents (92 %), said that the religious activities had helped improve their religious lives (see Table 31). A beneficiary in Baabianiha said *I have noticed change in the behaviour of my child...he prays, goes to church, respects the elderly.* In Frankadua, a respondent noted *I have learnt to forgive and I do. I have also learnt to love and I do...I have learnt I was created in the image of God and so others...therefore I respect myself and so are others.*

Table 30- Respondents' Perception of Effect of GBC's Rural Interventions on Indicators of Religiosity

Religious life Indicator	Perceived improvements		No improvement	
	Freq.	Percent	Freq.	Percent
Faith in God	196	72	75	28
Meaningful Life	242	89	29	11
Strength and Courage	251	93	20	7
Hope and Assurance	253	93	18	7
Satisfaction in life	224	83	47	17
Religious morals	248	92	23	8

Source: Author's Fieldwork, Enim 2012

In addition to the findings from the survey, field observation revealed that the religious activities in GBC's interventions programme were well patronised by the beneficiaries. Likewise, from the analysis of the responses from all key informants on the effects of the GBC'S interventions on beneficiaries' spirituality revealed a common perception that the interventions had created opportunities for beneficiaries to have faith and hope in the Transcendent Being. The findings were presented by projects.

Perceptions of Key Informants on outcome of GBC's vocational training project on beneficiaries' religiosity

The key informants in Frankadua were of the view that GBC's Vocational Training Centre intervention had positively enhanced beneficiaries' spirituality. A key member from the community leadership asserted:

I am a witness to what religious activities can do to one's life...I believe the trainees' participation in the daily morning devotions (worship service), Tuesday studies and Sundays worship services are most likely to help them have faith in God and courage to succeed in life.

The GBC Coordinator for the vocational centre affirmed *...our records show that...Sundays worship services and our counselling sessions have encouraged trainees to have a personal relationship with God.* He believed those religious activities would inculcate in trainees some religious morals to become change agent in society.

The chairperson of the local council of churches also affirmed: *The trainees are receiving religious instructions...testimonies from the trainees show that they are understanding life and gathering strength and courage to face life's challenges.* An official of the District Assembly also admitted that he had observed the good morals exhibited by trainees in the community and he hoped that those good morals would be sustained. From the office of the queen mother, an official said *...testimonies from the community about trainees who have completed training and are on their own show that they are exhibiting good morals.*

Perceptions of Key Informants on the outcome of GBC's microenterprise project on beneficiaries' religiosity

In the Kasulyili community, key informants generally admitted that the religious component in the micro enterprise intervention had helped improve the faith of beneficiaries in the Transcendent Being. The coordinator of the micro

enterprise intervention asserted: *Our records show that the religious activities proceeding group gatherings every month have brought some beneficiaries to faith in God.* He supposed that such religious activities at group gatherings and the counselling time with some beneficiaries could foster moral values, respect, and love.

Furthermore, a leader of the women's group of the microenterprise beneficiaries stated *through the religious activities at group gatherings, I have come to understand and believe that life is relating well with God and fellow humans and the environment I live in.* In expressing his observation in words, an official from the District Assembly commented that the religious component of the programme was helpful and might potentially enhance beneficiaries' moral life. However, he cautioned that such religious activities should not derail into exploitation of the beneficiaries. A representative from the office of the chief was of the view that the religious activities included in the operations of the microenterprise intervention could encourage more beneficiaries to engage in their personal spirituality and morality. He cited an instance where a beneficiary's (his niece) negative behaviour had changed and how she was now assuming her responsibilities in her marriage home and attending church. The chairperson of the local council of churches also shared similar opinion from his parish.

Perceptions of Key Informants on outcome of GBC's educational project on beneficiaries' religiosity

In Baabianiha, key informants were generally of the view that the religious component in the educational intervention could potentially address spiritual need of the children. The coordinator of the GBC's educational intervention stressed *The morning devotions and counselling sessions from Mondays to Fridays are meeting the moral, social, emotional, and spiritual needs of the children...I have counselled and given directions to some parents and their children.* An officer from the District Assembly office also expressed his belief in the religious activities of the school that it could potentially benefit the children and their parents in terms of their moral development. He said *our records show that the moral standard in the school is high.*

However, he advised against its use to exploit the children and the parents. Narrating her experience of the religious component of the GBC's educational intervention, a key informant from the office of the queen mother affirmed *My grand child's life is changed...now he goes to church with me...and instructs his siblings when they are wrong by referring them to Bible stories.*

Perceptions of Key Informants on outcome of GBC's safe drinking water project on beneficiaries' religiosity

In Amanful, key informants affirmed that GBC' safe drinking water intervention had attracted some community people to the church. They were also of the opinion that GBC's religious activities in the community had improved social interactions among community members through its weekly meetings and visitations. Narrating his observation of the religious component of the programme package of the intervention, a key member from the leadership in the

community commented:

The presence of the project has attracted some community people to attend the Baptist church. I have observed the regular religious and counselling activities at the project office with keen interest and I can say they are helping family members settle issues of concern.

Expressing her view on the effects of the religious activities at the Safe drinking water intervention's monthly meetings, a leader of the women' group pointed out the importance of religious morals in the community. She said:

Our monthly community meetings on water are preceded by religious devotions where we are taught to fear the Creator, love, forgive, do well, respect people especially the elderly, and care for nature and the needy. I have been motivated by these truths and I teach these things through stories and folklore at home and at cultural ceremonies.

A similar view was shared by a leader from the chairperson of the local council of churches. However, contrarily to the views expressed by majority of the key informants, few were of the view that GBC's religious activities were imposing and infringing on the rights of others to practice their religion. Besides, the interventions seemed to serve adherent of the Baptist faith. The chairperson of the local council of churches noted:

At project meetings views of members in other faiths are not respected ...leadership does not recognise the presence of members of other faiths...when one offers to join the church that person receives quick attention than another of different faith.

A field visit and observation in Amanful affirmed scenes of some beneficiaries attending religious gatherings organised by the project committee (Plate 5). It was observed at the gathering that religious activities preceded development discussions and other social concerns that had arisen in the course of the management of the GBC safe drinking water intervention.

Perceptions of Key Informants on outcome of GBC's healthcare project on beneficiaries's religiosity

In Sankor, the views expressed by key informants on the religious component of the GBC's health intervention activities were not different from those expressed by key informants in other communities. There was a general consensus from key informants that the religious component of the healthcare delivery at the hospital reinforces faith in the Transcendent Being. The GBC's coordinator of the health intervention affirmed that the chaplaincy department of the hospital had been resilient in handling traumatised patients and their relatives in cases of terminal illnesses and deaths. He said in such instances victims were giving words of hope and assurance, strength and courage to face health challenges. Likewise, the key informant from the office of the queen mother, the leadership of the community, and an officer from the Municipal Assembly also affirmed the positive effects of the religious activities at the hospital on patients. The key informant from the leadership of the community said:

Sickness and death are part of human life...Some sicknesses are spiritual and others are physical in nature...When I was undergoing surgery at the hospital, I was assured of God's healing and I was prayed for before the

surgery...those religious activities reinforced my faith in God. I used to be unforgiving but now I forgive, I show love and respect for every person as God's child.

Discussion

The major findings corroborated with the conceptual framework and empirical works of Bukenya (2003) and Ondigi and Mugenda (2011) that religion correlates strongly with quality of life. Religiosity as a factor of integrated quality of life raises three issues on existential quality of life; the role of religion and development, role of religion in human experience and measurement of religiosity or spirituality in development studies. The findings showed that existential quality of life reinforced its role in the measurement and the determination of the overall quality of life as based on the emphasises and illustrations in the conceptual framework of the study.

The findings also showed that GBC's religious activities affected positively quality of life. They reinforced findings of other empirical studies of Ondigi & Mugenda (2011), Deneulin & Rakodi (2010), Bukenya (2003), Ryan (2005) and Hills and Arygle (2002) reviewed in chapter two of this study that religion and development positively correlate.

The major findings further showed that influence of religion on human experience and quality of life cannot be overlooked (Plate 5). In the review of related literature, empirical studies by Ondigi and Mugenda (2011), Welzel et al. (2003), Ventegodt et al (2003) and Constanza et al. (2007) pointed out that religion had positive influence on human experiences and needs, especially as it is

used to explain life issues. It is to be noted that much as religion hitherto plays an important role in human experiences, not all sociologists had supported those theoretical assumptions about religion and quality of life. Some researchers had argued that religiosity actually may be the ‘opium of the people’ and as such had deleterious effects on the minds of adherents (Okon, 2013; Sperber, 2013; Eagleton, 2011; Callinicos, 2010; Blackledge, 2006). They may argue from the point of view where religion is used as a tool to cohere people to follow certain pattern of religious practices before being given the opportunities to improve quality of their lives. Religiosity of this nature may not contribute to the overall purpose of development. The influence of GBC’s religious inclinations that tends to overshadow development principles as was indicated in some of the responses about GBC’s biases toward its adherents is an example. It is noteworthy that lack of objectivity in development practices hinders effective outcomes.

The contribution of religion to quality of life remained a source of controversy especially when it came to its measurement. It was acknowledged in this study that measurement of spirituality was technically more involving than addressed. However, by including it as variable in this study first, allowed greater insights into the nature and accuracy of the examined data; second, provided a more detailed understanding of the nature of human beings and their variation in integrated quality of life; and finally, demonstrated the possible neglect of conventional approaches to data analysis that often ignore existential dimension of quality of life (Lindholdt et al., 2003).

Chapter Summary

In summary of the findings above suggest that the GBC interventions had generally and positively improved the existential quality of life of beneficiaries in all of the five study communities. The interventions had improved their faith in the Transcendent Being. It had given them strength and courage to face life challenges, hope and aspiration in life, and had fostered moral values in beneficiaries' life. Having analysed and discussed the findings of the study, the next chapter presented the summary, conclusions and the recommendations.

CHAPTER NINE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This Chapter focused on three main issues. First, it presented the summary of the key findings of this study. Second, it described the main conclusions from the study. Finally, the chapter highlighted a number of recommendations which were relevant to ensuring integrated quality of life in five selected rural communities in Ghana.

Summary of Key Findings

The major findings of this study were summarised under the following headings: Examination of Ghana Baptist Convention's rural interventions, outcomes of GBC's rural interventions on beneficiaries' objective quality of life, outcomes of GBC's rural interventions on beneficiaries' subjective quality of life, and outcomes of GBC's rural interventions on beneficiaries' existential quality of life and the application of Integrative quality of life theory.

Examination of Ghana Baptist Convention's rural interventions

One of the objectives of the study was to examine GBC's rural interventions. The findings showed that most of the interventions were on-going with few that were abandoned due to lack of human and financial resources. GBC's development approach was holistic since findings showed that it was involved in the provision of interventions that addressed the economic, cultural,

spiritual, social, and psychological needs of the beneficiaries. However, the findings also showed that GBC's rural interventions were isolated and managed by officials from the main office. It was also shown that GBC had no intervention that addressed environmental and political needs of the beneficiaries. It had also no formal plan for intervention sustainability or a cut-off point to hand over interventions to the communities. Findings showed that GBC's interventions had not been examined and outcomes of its rural interventions had not been evaluated.

Outcomes of GBC's rural interventions

On the specific issues regarding outcomes of GBC's rural interventions that were meant to address objectives two, three and four, results showed that the objective domain of quality of life of the respondents in all five communities were positively affected as a result of accessing GBC's rural interventions. Specifically, income, health, and education showed that majority of the respondents perceived that they had experienced improvement. However, improvement in respondents' income level was not enough to meet other quality of life needs. It was also found that improvement in the level of income and education and health status depended on the specific intervention in the community.

Outcomes of GBC's rural interventions were shown to affect the subjective domain of beneficiaries' quality of life. Findings demonstrated that GBC rural interventions had positively affected beneficiaries' fulfilment of needs, realisation of their lives' potential, meaning in life, happiness, satisfaction with life and well-being. The findings showed that each intervention was packaged with religious and counselling department to address both material and spiritual

needs of the beneficiaries. It was also shown that respondent were all in favour of all factors defining the subjective domain of quality of life.

The findings in the study also indicated that the outcomes of GBC's rural interventions had positively affected beneficiaries' existential quality of life. The finding showed that religiosity or spirituality was an important component of quality of life. It was shown that majority of beneficiaries expressed faith in the Transcendent Being. There was improvement in beneficiaries' religious lives because their faith in the Transcendent Being, strength and courage, hope and aspiration and religious morals were improved as they accessed the interventions.

Application of integrative quality of life theory

Applying the IQOL theory in this study had helped in the contribution to knowledge in the sense that this study had reinforced the notion that economic growth alone could not measure quality of life in holism. The study had added to the limited knowledge on integrated quality of life in Ghana in general and more specifically in the rural communities selected for this study. The study had shown that IQOL theory could be used in quality of life studies in the rural communities in Ghana selected for this study.

This study had built on existing quality of life studies by Dorji (2013), Ioana (2012), Ondigi & Mugenda (2011), Ventegodt et al. (2010; 2005; 2003). In particular, it was interesting to relate the results to three recent ones that employed a methodology similar to one used in this study: Ioana (2012), Ondigi & Mugenda (2011) and Dorji (2013). Looking at the similarities, the results in this study largely corroborated with the results in the three studies on several grounds. For

instance, as was in the three studies, this study did assert that income, health, education had effects on quality of life.

There were also some important differences in the results. For instance, this study and that of Ventegodt et al. (2010; 2005; 2003), Onidi & Mugenda (2011) and Dorji (2013) found a relationship between religion and quality of life satisfaction. However, Ioana (2012) did not include spirituality as variable in quality of life satisfaction. There were many possible explanations for those divergences in results. The divergences could reflect genuine differences between communities or they could reflect differences in the samples or measurement of the different interventions. As regards interventions, Ioana (2012) used only financial intervention while Ondigi & Mugenda used already existing government's socio-economic interventions such as healthcare, education, income and religion. Ventegodt et al. (2010; 2005; 2003) used health intervention. This study used socio-economic, cultural and spiritual interventions. As regards the measurement of variables, both Ondigi & Mugenda (2011) and Ioana's (2012) did not measure meaning life and realisation of life potential. Both this study and Ventegodt et al.'s (2010; 2005; 2003) did.

The fact was that there were problems associated with adding different dimensions of psychological distress that might not be equally important as the measure of quality of life satisfaction. The current study followed Ventegodt et al.'s lead, hence, avoiding the problems associated with such measures. The single component that differentiated this study from the rest of the previous studies was that those studies addressed the aspect of religiosity by taking it as a

socio-demographic variable and not as a component of quality of life. Ioana's study did not address this issue of religiosity or spirituality. Deneulin and Rakodi (2010) and Ryan (2005) had posited that overlooking religiosity constituted data loss in quality of life measurement.

Conclusions

The conclusions for this study were based on the specific objectives namely; examination of GBC's rural interventions, assessment of the effects of Ghana Baptist Convention's rural interventions on the objective quality of life needs of the beneficiaries, assessment of the effects of Ghana Baptist Convention's rural interventions on the subjective quality of life needs of the beneficiaries and the assessment of the effects of Ghana Baptist Convention's rural interventions on the existential quality of life needs of the beneficiaries.

Conclsions on the examination of GBC's rural interventions were that some of the GBC's rural interventions were in existence and functioning while others were not at the time of this study. The GBC's rural interventions though could be described as holistic in nature, had not addressed environmental and political needs. Those provided were not enough to address the needs of the people in the rural communities. It was further concluded that the beneficiaries were not capable to sustain the interventions. Finally, it was concluded that the GBC had no evaluation mechanism tool for its rural intervention activities and that it had no plan for beneficiaries to sustain the interventions.

Conclusions based on objective two of the study were that of Ghana Baptist Convention's rural projects were generally perceived to have improved

the income level and the health status of the beneficiaries. However, GBC's rural projects could not improve the educational level of majority of the respondents. The study thus concluded that the GBC's rural interventions generally improved the objective domain of quality of life of the beneficiaries.

Based on objective three of the study, assessment of the effects of Ghana Baptist Convention's rural interventions on the subjective quality of life needs of the beneficiaries, GBC's rural projects were perceived to have improved beneficiaries' wellbeing, satisfaction with life, and happiness, meaning in life, realisation of life potential, and the fulfilment of basic needs. It was thus concluded that the GBC's rural interventions addressed the subjective domain of quality of life.

Conclusion based on objective four of the study, assessment of the effects of Ghana Baptist Convention's rural interventions on the existential quality of life needs of the beneficiaries, was that GBC's rural interventions were perceived to have improved the religious lives of beneficiaries. In other words, the religious component of GBC rural interventions helped the beneficiaries gain faith in the Transcendent Being, improve meaning in life, gain strength and courage to face life's challenges, gain hope and assurance, satisfaction, and moral values.

In addition, the study has endeavoured to fill the gap on demonstrating that the IQOL theory and its concepts was applicable in the determination of integrated quality of life of beneficiaries of GBC'S rural interventions living in the rural communities in Ghana where this study was carried out. In other words, religiosity could be included in quality of life measurement.

Recommendations

The findings of the study brought up several policy recommendations that could be adopted by the GBC and perhaps other development partners to address quality of life needs in rural communities in Ghana. First, GBC should examine its rural interventions periodically, develop human resource for the projects, address ecological needs and discuss the findings of this study at annual meetings. These are essential elements in development practice and sustainability.

Second, GBC should provide more income, health, and educational infrastructures to address objective domain of quality of life of beneficiaries. That had proven very successful in most Latin American countries where the Protestants arouse the Catholics through their responses to multidimensional needs of the indigenous people (Trejo, 2009). The churches should lead the way to improve in holism the quality of life of rural people.

Third, GBC should provide and package its rural interventions to promote improvement in the wellbeing, satisfaction with life, happiness, meaning in life, fulfilment of needs and realisation of life potential factors in the subjective domain of quality of life of beneficiaries.

Fourth, GBC should provide interventions that promote improvement of the religious or spiritual factors in the existential domain of beneficiaries' lives.

Fifth, GBC adopt the concepts of the IQOL theory as baseline for reflecting outcomes of its rural interventions.

Sixth, GBC should collaborate with development partners like the government to refocus social policy around the goal of integrated quality of life by influencing public policies on quality of life so that a shift from the socio-economic growth approach to the holistic approach in improving quality of life becomes achievable. This means that GBC should be more involved in activities organised by the government on quality of life improvement. That had been proven in Denmark where churches had led the way, which had resulted in the improvement in the quality of life of Danish population, especially the reduction of suicide rate in the midst of affluence (Ventegodt et al., 2003). It had been a common knowledge and proven in literature that religion correlates development. The rise of Islamic State and the Levant (ISIL), Boko Haram, Ishabab are but few examples in Arab regions where there is the interplay between religion and development.

Finally, GBC should, on the basis of these findings and conclusions, develop a workplan and through training, seminars and workshops implement the suggested recommendations.

Avenues for Future Research

The following avenues for future research were recommended: First, a comprehensive study of this nature is needed to be conducted on district, regional and national basis. This may include also patterns of community behaviour, resistance to change, customs and the preservation of traditions that can help factorise out common rural variables that can give complete picture of rural

reality. Such a study can enable development agents to know how to plan and implement kind of interventions required to meet quality of life needs in rural communities.

Second, a more rigorous research on religion and development was needed since the role of religion in development in Ghana had been a subject of debate in development discussions. The study suggested that first initiatives begin by focusing research on the Ghanaian experience, where (i) religion seems to define people's lives (ii) current development paradigms seem to largely address socio-economic needs (iii) more studies on the churches' involvement in national development were needed, especially when as part of the collectivist society, churches' role in rural development in Ghana is needed. That could ascertain the impact of churches on developing rural communities.

Third, the application of integrated quality of life to sustainability issues presented another vital avenue of research. Answering the question: "What is the role of ecological sustainability for integrated quality of life?" could help integrate the social and scientific policy agenda and hence pay double dividends. An even bigger question involves examining how all of the interventions, along with their attendant policies and macro-conditions, affect individual or community quality of life across district, region and nation. This issue may, in fact, be an umbrella theme for future interdisciplinary work on integrated quality of life.

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APPENDICES

APPENDIX A

QUESTIONNAIRE FOR BENEFICIARIES

INTERVIEW SCHEDULE ON THE TOPIC ‘REFLECTIONS ON THE OUTCOMES OF GHANA BAPTIST CONVENTION’S RURAL PROJECTS’

Interviewer: questions in this interview schedule are to be answered by beneficiaries who are 18 years and above and have been in the project for at least five years. These instruments are prepared by the researcher. It is for academic purposes. And it is guaranteed that your information given will be confidentially treated.

1. Background information

2. (a) District..... (b) Village.....

3. Gender: Male [] Female []

4. Age: []

4. Marital status?

(1) Single [] (2) Married []

5. Highest Educational background:

5. None [] (2) Primary []

6. Secondary [] (4) Tertiary []

(5) Other []

7. Religion_____

8. Occupation_____

B. For beneficiaries of GBC’s micro enterprise in Kasulyili

Instructions

Below are a number of statements about the outcomes of the GBC’s micro enterprise project on the quality of life of beneficiaries. You will need to read the statements carefully because some are phrased positively and others negatively. Don’t take too long over individual questions; there are no ‘right’ or ‘wrong’ answers and no trick questions. The first answer that comes into your head is probably the right one for you. If you find some of the questions difficult, please give the answer that is true for you in general or for most of the time. Please indicate how much you agree or disagree with each by entering a number alongside it according to the following code:

**1=strongly disagree 2=moderately disagree 3=slightly disagree;
4=slightly agree; 5=moderately agree; 6=strongly agree.**

Measuring the effect of the micro enterprise project on the **WELLBEING** of beneficiaries

In accessing the micro enterprise project,

- 8. I do now have opportunity for leisure activities (sightseeing, watching television, hobby, talking with people, movies, and sports) []
- 9. I am able to relax and enjoy myself []
- 10. I am not able to take time out to embark on pleasure travels []

11. I am satisfied with my relationship with my partner at the moment []
12. I do not have more fun with other people []
13. I do creative things []
14. I am able to move along with people without feeling shy []
15. Explain

Measuring the effect of the micro enterprise project on the satisfaction with life of beneficiaries

In accessing GBC's micro enterprise project,

16. I don't feel particularly pleased with the way I am []
17. I rarely wake up feeling rested []
18. I am able to work, earn income and provide support for my family []
19. I have good social contact []
20. I am not safe at home []
21. I am not safe in my community []
22. I seek counseling from the project counseling centre []
23. Explain

1=strongly disagree	2=moderately disagree	3=slightly disagree;
4=slightly agree;	5=moderately agree;	6=strongly agree.

Measuring the effect of the micro enterprise project on the HAPPINESS of beneficiaries

In accessing GBC's micro enterprise project,

- 24. I laugh a lot now than before the project
- 25. I find the business I now do amusing
- 26. I always have a cheerful effect on others
- 27. I often experience joy and elation
- 28. I have good memories of the past
- 29. I have very warm feelings towards almost everyone now
- 30. I do not depend on others for living
- 31. Explain

Measuring the effect of the micro enterprise project on the MEANING IN LIFE of beneficiaries

In accessing GBC's micro enterprise project,

- 32. I do not think that the world is a good place to live
- 33. I do not have a particular sense of direction in my life
- 34. I am always committed and involved in my business
- 35. I feel that life is very rewarding
- 36. I understand the life I live now
- 37. I understand very well what I do
- 38. Sometimes I feel like committing suicide

39. The project is the only means that brings meaning to my life []

Measuring the effect of the micro enterprise project on the RELIGIOUS

LIFE of beneficiaries

In accessing GBC's micro enterprise project,

40. Religious activities at project meetings inspire my hope and aspiration in life []

41. Religious activities at project meetings give me strength and courage to face life's challenges []

42. Religious activities at project meetings give me meaning to life []

43. Religious activities at project meetings foster my moral life []

44. I have enough money and clothing to practice my religion []

45. The project is the only means that enhances my religious life []

46. Religious activities at project meeting in important to me []

1=strongly disagree	2=moderately disagree	3=slightly disagree;
4=slightly agree;	5=moderately agree;	6=strongly agree.

Measuring the effect of the micro enterprise project on the PHYSICAL

HEALTH of beneficiaries

In accessing GBC's micro enterprise project,

47. I am able to save money for my healthcare []

48. I have easy access to quality medical care []

49. I have been able to register with the NHIS []

50. My physical health has improved
- Health talks at project meetings are regular
- I get enough sleep now
- I receive better medical care here than other health care centres

9. Explain

**Measuring the effect of the micro enterprise project on the REALISATION
OF LIFE potential of beneficiaries**

In accessing GBC's micro enterprise project,

55. I am able to achieve all my dreams in life
56. I can now fit in everything I want to
57. I feel that I am not especially in control of my life
58. My dreams and desires are not being realized
59. I am not particularly optimistic about the future
60. I have not achieved anything
61. I dream on big things to do
62. Explain

**Measuring the effect of the micro enterprise project on the FULFILMENT
OF NEEDS of beneficiaries**

In accessing GBC's micro enterprise project,

63. I am able to meet my food needs through my business
64. I am able to meet clothing needs through my business

- 10. I am not able to meet my marital responsibilities
- 11. I have my freedom in the community
- 12. I have sense of belongingness
- 13. I have self-respected
- 14. I am respected among people
- 15. Explain

1=strongly disagree 2=moderately disagree 3=slightly disagree;
 4=slightly agree; 5=moderately agree; 6=strongly agree.

**Measuring the effect of the micro enterprise project on the
 INCOME of beneficiaries**

In accessing GBC's micro enterprise project,

- 16. I have earned enough money to meet my needs
- 17. The project has become my only means of income
- 18. I do not have financial difficulties
- 19. I am satisfied with my financial situation now
- 20. I do not worry about money
- 76. My income/expenditure bracket **BEFORE** is
- 21. Above GH¢ 1000
- 22. GH¢700-GH¢1000
- 23. (3) GH¢500-GH¢700
- 24. (4) GH¢300-GH¢500

25. (5) GH¢100-GH¢300
26. (6) BelowGH¢100
77. My income/expenditure bracket **AFTER** is
27. Above GH¢ 1000
28. (2) GH¢700-GH¢1000
29. (3) GH¢500-GH¢700
30. (4) GH¢300-GH¢500
31. (5) GH¢100-GH¢300
32. (6) BelowGH¢100

Measuring the SUSTAINABILITY of the micro enterprise project

In accessing the micro enterprise project,

78. I am willing to sustain the project
79. through my financial contribution
80. through training of prospects with my acquired skills
81. through owning the project
82. through my participation in project meetings
83. willingness to serve in the project

1=strongly disagree	2=moderately disagree	3=slightly disagree;
4=slightly agree;	5=moderately agree;	6=strongly agree.

Measuring the effect of the micro enterprise project on beneficiary's education

In accessing GBC's micro enterprise project,

- 79. I am passed school going age []
- 80. I can now save money to take care of my child's education []
- 81. My child spends school hours in school []
- 33. My child understands what is taught in school []
- 34. Children who stopped schooling are now in school []
- 35. More children are enrolled []
- 36. Children pass and a promoted forward []
- 37. I no more walk long distance to school []

APPENDIX B

INTERVIEW GUIDE FOR KEY INFORMANTS

38. Background information of coordinator/leader/director

- 1. District..... (b) Village.....
- 2. Gender: Male [] Female []
- 3. Age: []
- 4. Marital status? (1) Single [] (2) Married []

5. Highest educational background:

- (1) None [] (2) Primary []
- (3) Secondary [] (4) Tertiary []
- (5) Other [] Specify_____

- 6. Religion:_____
- 7. Occupation:_____

B. Background information of organisation

- 39. Tick type of organization: (1) NGO [] (2) CFBO [] (3) CBO []
(4) GBC [] (5) GO [] (6) OTHER []
- 40. Type: (1) International [] (2) National []
- 41. Name of Organisation_____
- 42. Country of Origin of organisation_____
- 43. Year of operation in Ghana_____
- 44. Areas of operation in Ghana_____
- 45. What vision and mission undergirds your development activities?

46. What are your objectives?
47. What are your methods of operation?
48. How do you implement a project?
49. What are your sources of funding?
50. What is your plan for sustainability of the projects?
51. How do your projects get to be managed by the community people?
52. How willing are the beneficiaries in sustaining the project?
53. How are they participating in decision-making of the project?
54. How are they involved in the day to day operations of the project?
55. How willing are they to take leadership positions?
56. How are they preparing the next generation of beneficiaries?

C. MEASURING OBJECTIVE QUALITY OF LIFE

Measuring the effect of the GBC's project on the physical health

26. How has the project affected beneficiaries' physical health?

Measuring the effect of GBC's project on the income/expenditure of beneficiaries

57. How has the project improved the income level of the beneficiaries?

Measuring the effect of GBC's project on the education of the beneficiaries

In accessing GBC's project,

37. How has the project improved education of the beneficiaries?

D. MEASURING SUBJECTIVE QUALITY OF LIFE

Measuring the effect of GBC's project on the wellbeing of beneficiaries

58. How has the project affected the wellbeing of the people?

Measuring the effect of GBC's project on the satisfaction with life

21. How has the project affected satisfaction of the people's life?

Measuring the effect of GBC's project on the happiness

22. How has the project affected happiness to the people?

Measuring the effect of GBC's project on the meaning in life

59. How has the project affected beneficiaries' meaning in life?

Measuring the effect of GBC's project on the realisation of life potential of beneficiaries

60. How has the project affected beneficiaries' drive to achieve life dreams?

61. What are some of the achievements of the beneficiaries?

62. How particularly optimistic are the beneficiaries about the future?

63. Measuring the effect of GBC's project on the fulfilment of needs of beneficiaries

64. How has the projects affected beneficiaries' needs fulfilment?

65. How has it affected food, health, clothing, freedom securities?

E. MEASURING EXISTENTIAL QUALITY OF LIFE

Measuring the effect of GBC's project on the religious life

24. How has the project affected the religious life of the beneficiaries?

25. Why do you think religion is important to the beneficiary's quality of life?

APPENDIX C

TABLES SHOWING RESPONDENTS' HEALTH AND EDUCATION

Table showing frequencies and percentages of respondents with affordable healthcare

Community	Accessible Healthcare			
	Agreed		Disagreed	
	Frequency	Percent	Frequency	Percent
Frankadua	34	97	1	3
Ksulyili	33	70	14	30
Baabianiha	59	94	4	6
Amanful	35	87	5	13
Sankor	78	91	8	9

Source: Author's Fieldwork, Enim (2012)

Table showing frequencies and percentages of respondents with affordable healthcare

Community	Affordable Healthcare			
	Agreed		Disagreed	
	Frequency	Percent	Frequency	Percent
Frankadua	35	100	0	0
Ksulyili	34	72	13	18
Baabianiha	59	94	4	6
Amanful	35	87	5	13
Sankor	32	37	54	63

Source: Author's Fieldwork, Enim 2012

Table showing frequencies and percentages of respondents with quality healthcare service

Community	Good quality healthcare			
	Agreed		Disagreed	
	Frequency	Percent	Frequency	Percent
Frankadua	15	43	20	57
Ksulyili	30	64	17	36
Baabianiha	63	100	0	0
Amanful	29	72	11	18
Sankor	79	92	7	8

Source: Author's Fieldwork, Enim (2012)

Table showing frequencies and percentages of respondents with accessible primary education

Community	Accessible primary education			
	Agreed		Disagreed	
	Frequency	Percent	Frequency	Percent
Frankadua	34	98	1	2
Ksulyili	33	71	14	29
Baabianiha	59	94	4	6
Amanful	35	87	5	13
Sankor	78	91	8	9

Source: Author's Fieldwork, Enim (2012)

Table showing frequencies and percentages of respondents with affordable primary education

Affordable primary education				
Community	Agreed		Disagreed	
	Frequency	Percent	Frequency	Percent
Frankadua	35	100	0	0
Ksulyili	46	98	1	2
Baabianiha	49	78	14	22
Amanful	10	25	30	75
Sankor	58	67	28	13

Source: Author's Fieldwork, Enim (2012)

Table showing frequencies and percentages of respondents with quality primary education

Community	Good quality teaching			
	Agreed		Disagreed	
	Frequency	Percent	Frequency	Percent
Frankadua	27	76	8	14
Ksulyili	33	70	14	30
Baabianiha	52	83	13	17
Amanful	28	69	12	31
Sankor	70	81	16	19

Source: Author's Fieldwork, Enim (2012)

APPENDIX D

PICTURES FROM FIELD OBSERVATIONS



Plate 1: Some Trokosi Girls Going through Initiation at Shrine

Source: Author's Fieldwork, Enim (2012)



Plate 2: Ex-Trokosi Girls in Training at the Baptist Vocational Training Centre in Frankadu

Source: Author's Fieldwork, Enim (2012)



**Plate 3: A Beneficiary of the Baptist Microenterprise Project
in a Pastry Business in Kasulyili**

Source: Author's Fieldwork, Enim (2012)



**Plate 4: Water Cistern and Borehole in Replace of Mud Water Hole by
Ghana Baptist Convention**

Source: Author's Fieldwork, Enim (2012)



Plate 5: Religious gathering by beneficiaries of GBC's Safe Drinking Water Project in Amanful

Source: Author's Fieldwork, Enim 2012



Plate 6: A Beneficiary Inspecting Hospital in Sankor

Source: Author's Fieldwork, Enim (2012)