An Investigation into Community Based Growth Monitoring and Promotion Programme: A Case of Chingola Urban District.

By

Liwoyo Winfridah

UNZA 2004

An investigation into Community Based Growth Monitoring and Promotion Programme: A case of Chingola Urban District.

By

Liwoyo Winfridah

Supervisor – Dr D. M. Sibalwa

A dissertation submitted to the department of Adult Education in partial fulfilment of the requirements of the award of the Diploma in Adult Education.

UNZA 2004

TABLE OF CONTENTS

APPENDICES

CHAPTER 4

APPENDICES

DEDICATION

This report is dedicated to my husband Godfrey and my children Bwalya and Mabila. I thank them for supporting me to continue with my education at the time they needed me most.

ACKNOWLEDGEMENTS

I am deeply indebted to my research Supervisor Dr D. Sibalwa for his professional and guidance during the report writing.

I wish to thank Chingola District Health Management Team for sponsoring this research. Special thanks go to Chingola District Health Manager Administration Mr. K. G. Hamakoko for his patience when I was bothering him over money and his guidance and advice during data collection and report writing.

To Ernest, Lloyd and Petronella thanks for your unfailing friendship.

I wish also to thank my research assistants for without them I would not have managed to work alone.

Lastly, I would like to express my sincere gratitude and appreciation to Christine and Kalipate for typing my work.

ABSTRACT

Chingola District Health Management Team (DHMT) implemented the Community Based Growth Monitoring and Promotion in 2003. Since implementation the programme has not been evaluated and this study sought to investigate the performance of the programme.

Descriptive research design was used in order to ascertain the performance of the programme. The study sampled 5 maternal child health monitoring incharges, 28 community based growth monitoring promotes and 100 mothers with children under 1 year.

The report findings revealed that the current knowledge about community Based Growth Monitoring programme in the district is high. Health staff are not supervising the community Based Growth promoters and that most of them are not trained. It also revealed that kasompe Clinic has no community Based Growth monitoring and promotion post near the health centre and that mothers in Clinic One Catchment area shun the community post.

In conclusion, the study revealed that health staff are not supervising the community growth promoters. It also revealed that most of the community Based Growth Promoters are not trained.

3.7 It is recommended that Chingola District Health Management Team retrain and train more community Based Growth Promoters. The Health Centre Incharges of maternal child health department to visit the community based growth monitoring and promotion posts and that the beneficiaries of health services should be involved in choosing who they want to be the growth promoters in their communities.

CHAPTER 1

1.0 INTRODUCTION

BACKGROUND

Chingola district is found in the Copperbelt Province.

In the district, there are two (2) Hospitals and thirteen (13) Health Centres. One Hospital and three (3) Health Centres are privately owned (by Konkola Coper mines Plc) and the other Hospitals and Ten (10) Health Centres are government owned under the Ministry of Health.

The Ten (10) Health Centres are under Chingola District Health Management Team (CDHMT) and nine (9) non Community Based Growth Monitoring promotion activities. Six are Urban Health Centres and one of these is a Dental and Eye Clinic, they do not offer maternal Child Health activities. The other four (4) are rural health centers.

The urban health centers which do community based growth promotion activities are Kabundi East, Clinic One, Chiwempala, Chawama and Kasompe Clinics.

The Ministry of Health in Zambia's vision is "To provide equity of access to cost effective, quality health as close to the family as possible" (CBOH:L 1992:p-1).

The Ministry of Health started Health reforms in 1992 and the health Reforms encourages individuals to act in Partnership with service providers to desired goals. Health Neighborhood Committees (HNC) were formed in districts.

Chingola District health Management Team formed Health Neighborhood Committees and some of these were trained as community Based Growth Promoters and are supervised by the Health Centre staff on behalf of the District Health Management Team.

In Chingola Urban District, the trained community Based Growth promoters and number of community growth monitoring posts for each Health centre are as in the table below.

Name of Health Centre	Number of trained Community Based Growth Promoters	Number of Community Growth Monitoring Posts
Kabundi East	6	5
Clinic One	2	1
Chiwempala	6	3
Chawama	6	2
Kasompe	3	2

STATEMENT OF THE PROBLEM

Chingola District Health Management Team (CDHMT) implemented the Community Based Growth Monitoring and promotion programme in the district in April, 2003. Since implementation of this programme in the district, it is not been evaluated and this study sought to investigate the performance of the programme.

PURPOSE OF THE STUDY

The purpose of the study was to investigate the performance of the community Based Growth Monitoring and promotion programme in Chingola Urban District. This will help provide enriched knowledge about the performance of the programme to Chingola District Health Management Team Planners.

OBJECTIVES OF THE STUDY

To ascertain the performance of the Community Based Growth Monitoring and Promotion Programme.

To determine current Community Based Growth Monitoring and promotion service utilization rate.

To establish the level of monitoring and supervision of the Community Based Growth Monitoring promoters.

To determine the current knowledge about community Based Growth Monitoring programme in the district.

To make recommendations to Chingola District Health Management Team on the programme.

ASSUMPTIONS OF THE STUDY

The study assumed that good performance of community Based Growth Monitoring and promotion service will encourage the community to utilize the service.

The study also assumed that the current community Based Growth monitoring and promotion service utilization rate was not known and that good monitoring and supervision will improve and promotion service.

RELEVANCE OF THE STUDY

The study was important to be conducted because the findings would add to research knowledge and provide as a guide to Chingola District Health Management Team (CDHMT) planners and supervisors on the performance of community Based Growth Monitoring and promotion services.

The study findings will be used by the district planners in determining relevant and appropriate decisions aimed at providing supportive supervision and continued education for those conducting the programme.

LIMITATIONS OF THE STUDY

Community Based Growth Monitoring and promotion service programme is covering the whole of Chingola District, but this study was limited to the five Urban Health Centres. This was due to limited time within which the study was conducted.

DEFINITION OF TERMS

Child Health - is focusing on a child who is 0 to 59 months old and his State of being well from disease (CBOH:1999: P-11)

Community - Geographically as within a catchment area of a particular Health facility or within the boundaries of a district (CBOH: 1997).

Growth Monitoring and Promotion - Is the process of watching the rate at which a child is Growing and developing (ITG : 1997: P-41).

Health Centre - Is a place where the condition of the body with regard to Disease is taken care of (The 2000 Annual Health

Statistical Bulletin : 2001: P - !).

Malnutrition - Is a condition of health resulting from bad feeding with Food that is wrong or too small in amount and is not Enough for the body needs (CBOH : 1999 : P – 17).

Population - Is the number of people living in a particular area or Country (The 2000 Annual Health Statistical Bulletin 2001 : P – 1).

CHAPTER 2

2.0 LITERATURE REVIEW

In this particular chapter, the researcher looked at what people have written on Community Based Growth Monitoring and promotion programme here in Zambia and what other people have written on the same in other countries. In 1978, 134 member states of United Nations met in Soviet Union at Alma Ata where a health charter drew the aim to bring basic health services within reach to every community and individual. This is where the famous phrase was coined "Health for All by the year 2000" (Lankester : 1992 :4).

In 1992, the Health Reforms were started by the Ministry of Health in Zambia. Its vision is "to provide equity of access to cost effective, quality health as close to the family as possible" (CBOH : 1992 :P-1). The Health Reforms encounrages individuals to act in partnership with service providers to achieve desired goals.

Health Neighborhood Committees (HNC) were formed in districts. These people are identified by their communities and receive local support. Some of these were trained as Community Based Growth Promoters and are supervised by the District Health Management Teams (DHMT_.

They weigh the under five children, keep records and give health education in their communities. They refer under five children for immunizations, malnutrition and any illness to the health centre staff for further management. The community Based Growth Promoters keep registers for the children and take monthly reports to the health centre staff where they are attached (The well child facilitator's guide: October 2001: P – 80).

Wood (1981) states that most countries in the world have special clinics to help children stay healthy. Names used such as Under Five Clinics, Well Baby Clinic and Child Welfare Clinics provide services for children at these clinics such as vaccinations, nutrition assessment and advice and referrals to Health Centres for physical problems.

Maternal Child Health (MCH) services aim at improving child health through nutrition, immunization and education (National programme of action fro children in Zambia: June 1993).

The commitment to protect the growth of children should not only depend on government but communities should participate in meeting of a child's needs for adequate nutrition and immunizations, health education and health care (International Child Health : 1995).

Primary Health Care strategy promotes preventive, curative and rehabilitative services in a manner that encourages individuals to act in partnership with service providers to achieve desired goals. According to CBOIH (July 1995), "Good health starts with the household. Individual households and communities are key to better health."

Because of this, community Based growth monitoring programmes were formed throughout Zambia so that these can look at the welfare of the Under Five children in their communities and be able to refer children to health centres for continuity care from the health centre staff. Community Based Health care emphasizes community participation. Community health is described as "Health of the people, by the people, for the people" (Lankester : 1992 :2).

Wood (1981) states that volunteers such as teachers, pastors, even mothers can be used to run a clinic properly. The volunteers must be carefully selected and communities must select the people they want to be trained. These can register, weigh the children and give health education. The volunteers should be taught how to do each of these activities and when they know, they should continue with the programme but it is important for staff to continue indefinitely in the supervisory and supporting role to maintain the quality of service in each of the unit.

If the team approach to community health is to work, there must be some basic factors operating. There must be a common goal and the goal should be the achievement of optimum health for all the members of community. The professionals have the skills necessary to achieve the goal so they must work together with the community volunteers. They must plan, implement and evaluate the programme together. Fromer (1983) states that in order to function effectively, a community health team must develop a sense of unity and cohesiveness. There is need to be one person who knows what everyone else is doing. Without the professionals there would be no way to evaluate the programme.

He is supported by lankester (1992) who acknowledged that all programmes need regular evaluation in order to discover how successfully they are achieving their aims and reaching their target.

According to Mc Ewen (1983), evaluation or feedback is a system to find out how well our health project is achieving what is set out to do. When a programme first starts, appropriate aims and targets need to be set. After regular intervals of 1,3 or 5 years we need to know if we are achieving those targets and if not ways in which we can improve our performance. That is after planning a programme we implement, monitor and then evaluate. After evaluation then we replan.

Growth monitoring and promotion (GMP) is used as a tool for preventing malnutrition through early defection of growth faltering. It emphasizes the need to use information about growth pattern of individual children to provide appropriate counselling to their care takers.

Growth monitoring is described as a scientific and effective way of measuring the nutrition and adequacy of a diet. It is also an indicator of overall health of a child as illness leads to slowing down of growth. (Hart:1975:9).

Ebrahim (1988) wrote from Hong Kong that the purpose of monitoring growth and development in a child is to ensure that the child is growing as well as he/she should and that any slowing of he growth is dealt with early.

According to Wood (1981) the things to use at a community Based growth monitoring post are - a weighing scale

- tally sheets
- weighing bags
- record book
- growth card (Road to Health Chart).

When recording on the growth card, the growth curve reveal any significant changes in the child's pattern of growth, so help must be given in time and this is the easiest and most accurate way of catching any growth failure early.

It is important to note changes in a particular child's growth curve. Loss of weight is a danger signal. Every new born should receive a growth card. The cards are kept safely by mothers. This provides the mother with a good record of child's health and vaccinations if she travels else where.
Besides home based cards, some kind of record must also be kept for statistical purpose and monthly reports if mothers are not coming to bring their children.

Hart (1975) supported him on the things needed at a community Based Growth monitoring and promotion post. These are -:

- Registers
- Weighing Scale
- Weighing Bags
- Under five cards
- Tally sheets.

The aim of these clinics is to keep children healthy.
Growth monitoring and promotion therefore anticipates difficulties and provides relevant counselling at specific age periods thus at breastfeeding, weaning and immunization times.

It is a regular and systematic monitoring of growth that helps to detect malnutrition early in children before they become severely malnourished. This is in order to provide information to care takers on the growth and health

of children to help them make informed decisions (Intergrated Technical Guidelines for Frontline Health Workers: July 2001: P-44).

Rohde (1984), acknowledges that growth monitoring is the only recurring activity in primary health care that brings the mother and child with health services in a frequent basis.

Growth monitoring should be carried out from birth to five (5) years. Frequency of attendance at growth monitoring and promotion in Zambia decreases as the child is getting older: 92% (0-11 months), 72% (12 – 25months) and 35% (36 –59 months). The annual frequency of growth monitoring sessions per child is estimated at 6 times (0-11 months), 4 times (12-35 months) and less than 2 times (35-59 months) (Rapid Assessment procedures: 1991).

What is done in Zambia at growth monitoring and promotion service utilities is done in other countries. According to Nervin (1991), a study conducted in two villages in Indonesia, children aged 0-12 months regularly visited an integrated service.

After one year of age they did not visit the post every month because they had completed at the age of one. These understood the benefits of weighing as well as vaccinations.

As shown above, Community Based Growth Monitoring and Promotion is done in other countries too. Now that the same programme has been implemented in Zambia as indicated, in Chingola District the programme was implemented in April 2003 and since then, it has not been evaluated. This research was aimed at investigating the performance of the Community Based Growth Monitoring and Promotion programme in Chingola Urban District.

CHAPTER 3

3.0 METHODOLOGY

POPULATION.

The population that was focused by this study was 1000 mothers with children under 1 year in five communities of Chingola namely Kabundi East, Clinic One, Chiwempala, Chawama and Kasompe Health Centre catchment areas.

SAMPLING POPULATION

The information on the Community Based Growth Monitoring and promotion programme was obtained in five communities in Chingola namely, Kabundi East, Clinic One, Chiwempala Chawama and Kasompe Health Centre catchment areas.

The sample used 128 people which consisted of 5 maternal Child Health department incharges from 5 Health Centres, 23 community Based Growth Promoters and 100 mothers with children under 1 year.

SAMPLING TECHNIQUES

The five communities had thirteen (13) community Based Growth Monitoring posts. A simple random sampling procedure using lottery method was used and eight posts were picked and these posts were used for the study but it was found that one of the posts was not there so seven posts were in the study.

In order to get a representative and generalize the findings for sample to the defined population, a simple random sampling procedure using lottery method

was used. The procedure provided an equal opportunity to each member to be included in the study. The lottery technique was used where a symbol for each unit "yes" or "no" was placed in a container, mixed well and then those who picked "yes" constituted the sample.

According to Achola and Bless (1988), simple random sampling is a sampling procedure which provides equal opportunity of selection for each element in a population.

INSTRUMENTS

In this study, the researcher used questionnaires which had closed ended and few open ended questions for the Health staff, community Based Growth promoters and mothers with children under 1 year. Oral interviews were conducted using an interview Guide for Focus Group Discussions with mothers with children under 1 year.

Eight Focus Group Discussions (F G D) were conducted in the five communities. A check list was used at all the posts visited. This method was used to observe the happenings at the visited posts.

RESEARCH DESIGN

In this study, a descriptive research was used. Nkhata (1977) stated that this type of research's main purpose is to describe a piece of social reality in an effort to clarify a situation where accurate information is lacking.

Both quantitative and qualitative research aspects were used. Bouma and Atkinson (1995) described qualitative research as any social science rearch that produces results that are not obtained by statistical procedures or other methods of qualification. Some of the data may be quantified but the analysis is qualitative.

Quantitative research measurements use objective and standardized instruments to limit data collection to prescribed categories of responses (Merriam and Simpson (1995).

DATA COLLECTION

In this study, data collection was through structural questionnaires, an interview guide for the Focus Group Discussions and a check list was used at the community Based Growth Monitoring and promotion posts. Sancheti (1981) confirms that after all the necessary tasks are completed, the task is then to go into the field and collect data for the study.

CHAPTER 4

4.0 DATA ANALYSIS

Data was sorted out according to the data collecting tools or techniques used. Data from questionnaires was tabulated on tables using frequencies and percentages and data from interview guide for Focus Group Discussions and the checklist was analysed by qualitative analysis. Editing was done as soon as data was collected to check for consistence and accuracy.

A questionnaire for in-charges in maternal child Health Department at the clinic

Table 4.1.1 Distribution of Respondents according to Age.

Age	Frequency	Percentage
26 – 35 years	0	–
36 – 45 years	3	60
Above 45 years	2	40
Total	5	100

In the study 60% of the respondents were between 36 – 45 years, 40% were between 36 – 45 years and none between 26 – 35 years.

Table 4.1.2 Distribution of respondents according to Gender

Gender	Frequency	Percentage
Male	0	–
Female	5	100
Total	5	100

100% of the respondents were female and none male

Table 4.1.3 Distribution of respondents according to Marital Status

Marital Status	Frequency	Percentage
Single	0	–
Married	4	80
Widowed	1	20
Divorced	0	–
Total	5	100

80% of the respondents were married, 20% widows and none single or divorced.

Table 4.1.4 Distribution of respondents according to academic qualifications

Academic qualifications	Frequency	Percentage
Grade 10	0	
Grade 12	2	40
Others (form III)	3	60
Total	5	100

60% of the respondents were Form III, 40% were Grade 12, and none had Grade 10 certificates.

Table 4.1.5 Distribution of respondents according to academic qualifications

Academic qualifications	Frequency	Percentage
Family health nurse	2	40
Registered midwife	2	40
Enrolled midwife	1	20
Others.	0	–
Total	5	100

40% of the respondents were Family Health Nurses, 40% were Registered Midwives, 20% were Enrolled Midwives and none for others.

Table 4.1.4 Distribution of respondents according to academic qualifications

Academic qualifications	Frequency	Percentage
Grade 10	0	
Grade 12	2	40
Others (form III)	3	60
Total	5	100

60% of the respondents were Form III, 40% were Grade 12, and none had Grade 10 certificates.

Table 4.1.5 Distribution of respondents according to academic qualifications

Academic qualifications	Frequency	Percentage
Family health nurse	2	40
Registered midwife	2	40
Enrolled midwife	1	20
Others.	0	–
Total	5	100

40% of the respondents were Family Health Nurses, 40% were Registered Midwives, 20% were Enrolled Midwives and none for others.

Table 4.1.6 Distribution of respondents according to duration of service

Duration of service	Frequency	Percentage
1 – 5 years	0	
6 – 10 years	0	–
11 – 15 years	0	–
16 – 20 years	2	40
Above 21 years	3	60
Total	5	100

60% of the respondents worked above 21 years, 40% between 16 – 20 years and none had served between 1 – 5 year, 6 – 10 years and 11 – 15 years respectively.

Table 4.1.7 Distribution of respondents according to whether community Based Growth Promoters have had adequate training

Adequate training	Frequency	Percentage
Yes	4	80
No	1	20
Total	5	100

80% of the respondents said the community Based Growth Promoters had adequate training and 20% said the training was not adequate.

Table 4.1.8 Distribution of respondents according to whether community Based Growth Promoters take monthly reports to the clinics

Take monthly reports	Frequency	Percentage
Yes	5	100
No	0	
Total	5	100

100% of the respondents said the community Based Growth Promoters take monthly reports to the clinics and none do not.

Table 4.1.9 Distribution of respondents according to whether community Based Growth Promoters are Supervised by the Health Centre Staff.

Supervised	Frequency	Percentage
Yes	2	40
No	3	60
Total	5	100

60% of the respondents said the community Based Growth Promoters were not supervised by the Health Centre Staff and 40% said they were supervised.

Table 4.1.10 Distribution of respondents according to whether community Based Growth Promoters Refer Children to the Health Centre Staff.

Refer Children	Frequency	Percentage
Yes	4	80
No	1	20
Total	5	100

80% of the respondents said the community Based Growth Promoters Refer Children to the Health Centre Staff and 20% said they do not Refer.

A questionnaire for community Based Growth Promoters.

Table 4.2.1 Distribution of respondents according to Gender

Sex	Frequency	Percentage
Male	8	35
Female	15	65
Total	23	100

65% of the respondents were female and 35% were male.

Table 4.2.2 Distribution of respondents according to Age

Age	Frequency	Percentage
20 – 30 years	1	4
31 – 40 years	10	44
41 – 50 years	9	39
Above 50 years	3	13
Total	23	100

44% of the respondents were between the age 31 – 40 years, 39% were between 41 – 50 years, 13% were above 50 years and 4% were between 20 – 30 years.

Table 4.2.3 Distribution of respondents according to Marital Status

Marital Status	Frequency	Percentage
Single	2	9
Married	18	78
Widow/Widower	1	4
Divorced	2	9
Total	23	100

78% of the respondents were married, 9% were single, 9% were widows/widowers and 4% were divorced.

Table 4.2.4 Distribution of respondents according to Education attainments

Education attained	Frequency	Percentage
Primary level	6	26
Secondary level	17	74
Colleges level	0	–
Total	23	100

74% of the respondents had attained secondary level, 26% primary level and none have attained college level.

Table 4.2.5 Distribution of respondents according to Length of Operation at the Post

Length of Operation at the Post	Frequency	Percentage
1 – 4 months	3	13
5 – 8 months	8	35
9 – 12 months	2	9
Over a year	10	43
Total	23	100

43% of the respondents had been at the post over a year, 35% between 5 – 8 month, 13% between 1 – 4 months and 9% between 9 – 12 months.

Table 4.2.6 Distribution of respondents according to how many times they have the activity

No. of times per week	Frequency	Percentage
Once per week	10	43
Twice per week	13	57
Thrice per week	0	–
Daily	0	–
Once per month	0	–
Total	23	100

57% of the respondents said that they have been having the activity twice in a week, 43% said once a week and none thrice a week, daily and once per month.

Table 4.2.7 Distribution of respondents according to whether they have enough materials to use

Enough materials	Frequency	Percentage
Yes	5	22
No	18	78
Total	23	100

78% of the respondents said they did not have enough materials to use and 22% said they had enough materials to use

Table 4.2.8 Distribution of respondents according to whether they have a weighing scale

Having a weighing scale	Frequency	Percentage
Yes	23	100
No	0	–
Total	23	100

100% of the respondents said they have a weighing scale.

Table 4.2.9 Distribution of respondents according to whether the health centre staff in their catchments areas visit them at their posts.

Visited	Frequency	Percentage
Yes	0	–
No	23	100
Total	23	100

100% of the respondents said the health centre staffs in their catchments area have never visited them.

Table 4.2.10 Distribution of respondents according to whether the Chingola District Health Management Team visited them at their posts.

Visited	Frequency	Percentage
Yes	0	–
No	23	100
Total	23	100

100% of the respondents said Chingola District Health Management Team has never visited them.

Table 4.2.11 Distribution of respondents according to whether they record children in registers

Record in registers	Frequency	Percentage
Yes	10	43
No	13	57
Total	23	100

57% of the respondents said they did not record the children in the registers and 43% said they recorded the children in the registers.

Table 4.2.12 Distribution of respondents according to whether they take monthly reports to the health centres where they are attached.

Take monthly reports	Frequency	Percentage
Yes	23	100
No	0	–
Total	23	100

100% of the respondents said they take monthly reports to the health centres where they are attached.

Table 4.2.13 Distribution of respondents according to whether immunisations are done at the posts

Immunisations are done at the posts	Frequency	Percentage
Yes	0	–
No	23	100
Total	23	100

100% of the respondents said immunisations are done at the posts.

Table 4.2.14 Distribution of respondents according to whether they were trained before they started the programme.

Trained respondents	Frequency	Percentage
Yes	10	43
No	13	57
Total	23	100

57% of the respondents said they were not trained before starting the programme and 43% said they were trained before starting the programme.

Table 4.2.15 Distribution of respondents according to whether they were training was adequate.

Training was adequate	Frequency	Percentage
Yes	7	30
No	16	70
Total	23	100

70% of the respondents said the training was not adequate and 30% said the training was adequate.

Table 4.2.16 Distribution of respondents according to refresher courses

Refresher courses	Frequency	Percentage
Yes	0	–
No	23	100
Total	23	100

100% of the respondents said they have not had any refresher courses since they were trained.

Table 4.2.17 Distribution of respondents according to satisfaction of the way the programme is running

Satisfaction respondent	Frequency	Percentage
Yes	2	9
No	21	91
Total	23	100

91% of the respondents said they were not satisfied with the way the programme was running and 9% said they were satisfied with the way the programme was running.

Table 4.2.18 Distribution of respondents according to whether they were managing the post well.

Satisfaction respondent	Frequency	Percentage
Yes	9	39
No	14	61
Total	23	100

61% of the respondents said they were not managing well the posts and 39% said they were managing well the posts.

A questionnaire for mothers with children under 1 year.

Table 4.3.1 Distribution of respondents according to Gender

Sex	Frequency	Percentage
Male	11	11
Female	89	89
Total	100	100

89% of the respondents were female and 11% were male.

Table 4.3.2 Distribution of respondents according to Age

Age	Frequency	Percentage
14 – 30 years	63	63
31 – 40 years	26	26
41 – 50 years	11	11
Total	23	100

63% of the respondents were between the age 14 – 30 years, 26% were between 31 – 40 years and 11% were between 41– 50 years.

Table 4.3.3 Distribution of respondents according to Marital Status

Marital Status	Frequency	Percentage
Single	17	17
Married	49	49
Widow/Widower	11	11
Divorced	23	23
Total	100	100

49% of the respondents were married, 23% were widows/widowers, 17% were single and 11% were divorced.

Table 4.3.4 Distribution of respondents according to Education attained.

Education attained	Frequency	Percentage
Primary level	52	52
Secondary level	39	39
Colleges level	9	9
Total	100	100

52% of the respondents had attained primary level, 39% secondary level and 9% attained college level.

Table 4.3.5 Distribution of respondents according to Length of time being attended at the Post

Length of Operation at the Post	Frequency	Percentage
1 – 4 months	18	18
5 – 8 months	45	45
9 – 11months	47	47
Total	100	100

47% of the respondents have been attending the post between 9 – 11months, 45% between 5 – 8 month and 18% between 1 – 4 months.

Table 4.3.6 Distribution of respondents according to who informed them about the posts

Informers	Frequency	Percentage
Nurses	77	77
Friends	23	23
Growth promoters	0	–
Total	100	100

77% of the respondents said that they were informed of the posts by nurses, 23% by friends and none by Growth promoters.

Table 4.3.7 Distribution of respondents according to whether after weighing they tally on the under five cards.

Under five card tally	Frequency	Percentage
Yes	100	100
No	0	–
Total	100	100

100% of the respondents said the community Growth promoters tally on the under five card after weighing the children.

Table 4.3.8 Distribution of respondents according to whether advice is given after weighing the children

Advice given	Frequency	Percentage
Yes	23	100
No	0	–
Total	100	100

100% of the respondents said they were advised after a child is weighed.

Table 4.3.9 Distribution of respondents according to whether the health education is given before starting the clinic.

Health education given	Frequency	Percentage
Yes	39	39
No	61	61
Total	100	100

61% of the respondents said Health Education was not given before starting the clinic and 39% said Health Education was given before starting a clinic.

Table 4.3.10 Distribution of respondents according to whether the Health centre staff visited the posts.

Health centre staff visited the posts	Frequency	Percentage
Yes	0	–
No	100	100
Total	100	100

100% of the respondents said the Health centre staff do not visit the posts.

Table 4.3.11 Distribution of respondents according to whether the Growth promoters inform the mothers when the children are due for immunization.

Record in registers	Frequency	Percentage
Yes	100	100
No	0	–
Total	100	100

100% of the respondents said the Growth promoters informed them when the children were due for immunizations.

4.4 DISCUSSIONS OF FINDINGS

The study sought to investigate the performance of the community Based Growth Monitoring and promotion programme in Chingola Urban district. The researcher discusses the findings under themes, which are in line with the research objectives.

- Ascertaining the performance of the Community Based Growth Monitoring and promotion programme.

At the community posts, there were no tally sheets and some posts had no registers. This is not in line with the Ministry of Health's Health Information Systems management. It is possible that the reports the community Based Growth Promoters take to the Health Centres monthly are faulty because at the time of the study, the researcher did not find any tally sheets being used and a few posts had registers but most of them did not have.

Using the checklist, at the posts some children were found using photocoped under five cards (at Chilemba market).

A system should be put in place so that the time the children go for weighing in their respective posts they have under five cards.

According to 4.2.14 from the questionnaire for community Based Growth promoters. 57% of the respondents stated that they were not trained before starting the programme and 43% stated that they were trained. And 4.2.15 from the same questionnaire 70% of the respondents stated that the training was not adequate and 30% said it was adequate.

This could be the contributing factor for community Based Growth promoters tallying wrongly on some Under Five Cards.

- To determine current Community Based Growth monitoring and promotion service utilization rate.

Looking at table 12 for the questionnaire for mothers with children under 1 year the study revealed that 83% of the respondents were happy that the children were weighed in the community and 17% were not happy.

In Zambia, the Health Reform's vision is "To provide equity of access to cost effective, quality health as close to the family as possible" (CBOH):1992:P-1) One of the health Centres was found not to have a post in the community. According to health reform's vision Kasompe Health Centre needs to have a post so that the post is close to the family as possible and the health centre staff will be able to provide equity of access to cost effective, quality health to its clients at the centre.

As for the respondents who did not want to go to the community post from the interview guide for the Focus Group Discussions, those who go to a high cost fee paying Health Centre – Clinic One, there is need to sensitise these people in their health needs and that good health starts with the household. Hence individual households and communities are key to better health. If they insist that they are ready to pay for the service since it is a high cost clinic, then let their money work.

- To establish the level of monitoring and supervision of the community Based Growth Monitoring promoters.

According to Freire (1972), participatory Learning Approach is a method which looks at participation where the participants participate actively with the facilitator guiding them. The health reforms in Zambia encourages individuals to act in partnership with the service providers to achieve desired goals.

The study revealed that the community posts were not visited by the health staff to follow up to see if the community posts were performing as required. This is as in 4.2.9. and 4.2.10 where 100% of the respondents stated that they were not visited by the health staff. This is from the questionnaire for community based Growth Promoters.

The questionnaires for mothers with children under 1 year supports this 4.3.10. 100% of the respondents states that the health staff do not visit the posts.

This has contributed to some under five cards being tallied wrongly and some mothers using photocopied Under Five Cards.

If there was supervision these mistakes would have been corrected from the start.

- To determine the current knowledge about community Based Growth Monitoring programme in the district.

According to 4.3.6 from the questionnaire for mothers with children under 1 year, 77% of the respondents stated that they were informed of the posts by the nurses, 23% by friends and non-by the community Based Growth promoters. This shows that people in the district are aware of the programme.

In the case of the community Based Growth promoters not informing any mothers of the same in their communities shows that before the programme was implemented the community Based Growth promoters and the health centre staff did not sensitize the community before starting the programme. This could as well be that the community did not participate in choosing the Community Based Growth promoters in their communities.

This could be the reason why mothers at Clinic One prefer going to the clinic rather than having the community Based Growth promoters weigh the children in the community.

CHAPTER 5

5.0 CONCLUSION

The study revealed that the current knowledge about Community Based Growth monitoring programme in the district is high.

The performance of the community Based Growth monitoring and promotion programme needs the cooperation of health staff so that the community posts are given adequate materials to use and that the health staff need to supervise and monitor the community Based Growth promoters so that accurate data is given to them in their monthly reports.

The Community Based Growth promoters are volunteers, there is need to work hand in hand with health staff this will motivate them to work harder because they will feel they are part of the programme. The study has also revealed that most of the community Based Growth promoters are not trained and this is contributing to wrong tallying on the Under Five Cards.

5.1 RECOMMENDATIONS

The following recommendations are made to Chingola District Health management Team Planners

- Chingola District Heath Management Team to retrain and train more Community Based Growth promoters.

- The Health Centre staff Incharge of Maternal Child Health department to be supervising the community posts in their catchment areas at least once a month to monitor the performance at the posts so that accurate data is received from the posts.
- Local Health Centres should involve the beneficiaries of health services in choosing who they want to be their community Based Growth promoters in their communities so that implemented programmes do not fail because failed implemented programmes in the communities are hard to resustate.
- Kasompe Health Centre which has no post near their vicinity should have one so that instead of the health centre staff concentrating on Under Five Clinics, they will be able to perform other duties as required of them at the health centre

Clinic One should sensitize the community on the need to use the community Based Growth promotion posts in the community always.

If the mothers insist on going to the clinic then let their be a fee and this will boost the revenue capacity of the clinic.

Midwives in labour wards to make sure babies are given Under Five Cards upon delivery before discharge.

BIBLIOGRAPHY

Achola, P., and Bless, C. (1988). **Fundamental of Social Research Methods; An African Perspective.** Lusaka. Government

Bouma, G., and Atkinson, G. B. J. (1995). **A Handbook of Social Science Research: A Comprehensive and practical guide for students.** New York. Oxford University Press

Central board of Health. (July 2000). **Integrated Technical Guide lines for Frontlines Health Workers:** P. 24

Central board of Health. (1999). **District Health Planning Guide for District Health Office and Health Centre Planners:** V2, P – 1 11, 17

Central board of Health. (1998). **District Action Plan: A District Health Planning Guide for District Health Office and Health Centre Planners:** V2; P – 80.

Central board of Health. (May 1997). **Integrated Technical Guide lines for Frontlines Health Workers: On the Road to Delivering, Promotive, Preventive and Curative Cost Effective Interventions:** P– 47.

Central board of Health. (1992). **District Action Plan: A District Health Planning Guide for District Health Office and Health Centre Planners:** P – 17.

Ebrahim, G. J., et al. (1988). **Maternal and Child Health in Practice: Training Module for Middle Level Workes.** Hong Kong. Macmillan.

Freire, P. (1972). **Pedagogy of the Opressed.**
Middlesex.
Penguin Books

Fromer, M. J. (1983). **Community Health Care and the Nursing Process.**
Toronto.
The C. V Mosby Company.

Hart, R., et al. (1975). **Child Health: A Manual for Medical Assistants and other Rural Health Workers.**
Moshi.
African Medical and Research Foundation.

Lankester, T. (1992). **Setting up Community Health Programmes: A Practical Manual for use in Developing Countries.**
London.
The Macmillan Press Ltd.

Mc. Ewen, J., Martini, C. J. M., and Wilkins, N. (1983). **Participation in Health.**
London.
Croom Helm.

Merriam, S. B., and Simpson, E. L. (1995). **A Guide to Research for Educators and Trainers of Adults.**
Malabar.
Kriegar Publishing Company.

National Programme of Action for Children in Zambia: June 1993.

Nkhata, L. (1997). **Methodological Options in Policy: Relevant Social Research.**
Lusaka.
Study Fund World Bank/GRZ.

Rapid Assessment Procedures: **Evaluation of Growth Monitoring Promotion in Zambia.** Ministry of Health, National Food and Nutrition Commissions University of Zambia, UNICEF, WHO: P – 23.

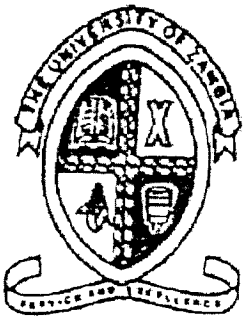
Rohde, J. E. (1984). **Growth Monitoring: World Health: The Magazine of the World Health Organization:** P – 8, 9.

Sancheti, et al. (1981). **Statistics, Theory, Methods and Applications** New Delhi.
Sultan Chand and Sons.

The 2000 Annual Health Statistical Bulletin: A Presentation of Selected Indicators on Disease Epidermiology and Service Delivery: August 2001: P – 1.

The Well Child Facilitator's Guide: October 2001.

Appendix 1



THE UNIVERSITY OF ZAMBIA
SCHOOL OF EDUCATION
DEPARTMENT OF ADULT EDUCATION AND EXTENSION STUDIES

Telephone:292702
Telegrams: UNZA LUSAKA
Telex: UNZALU ZA 44370
Fax: + 260-1-292702
Ref:

P O BOX 32379
Lusaka, Zambia

Your

29th June, 2004.

TO WHOM IT MAY CONCERN

RE: RESEARCH UNDERTAKING

The bearer(s) of this letter is a student in the Diploma/Degree in Adult Education. He/she has been requested to undertake research in your organization as part of his/her learning experience. Your help and cooperation in this regard will be highly appreciated by the department, as this will enable the student to link theory work, which is offered in the class, and practical work, which can only be obtained from organizations like yours.

I look forward very much to a favourable response in this regard.

Yours faithfully,

D.M. Sibalwa (Dr.)
ACTING HEAD OF DEPARTMENT
ADULT EDUCATION AND EXTENSION STUDIES.

Appendix 2

The University of Zambia
School of Education
Department of Adult Education and
Extension Studies
P.O. Box 32379
LUSAKA
30th September, 2004.

The District Director of Health,
Chingola District Health Board,
P.O. Box 10121,
CHINGOLA.
Dear Sir,

REF: LETTER OF APPRECIATION

I hereby write to convey my sincere appreciation to you for allowing me to carry out a research in the District on the Investigation into a Community Based Growth Monitoring and Promotion Programme: A case of Chingola Urban District.

I am grateful for the financial support you rendered to me which made it possible for me to do the research.

Yours faithfully,
INNIFRIDAH LIWOYO (MRS MULENGA)

Appendix 3

TIME LINE OR TIME SCHEDULE

	April	May	June	July	August	Sept	Oct	Nov
Selecting a topic		xxx						
Literature review			xxx					
Developing Instruments				xxx				
Data collection					xxx			
Data analysis						xxx		
Drafting of report							xxx	
Report writing							xxx	
Submission of report								xxx

Year 2004

Appendix 4

RESEARCH BUDGET

Description	Unit Cost	Qty	Days	Total
PERSONNEL				
Research Allowance	20,000	5	8	800,000
Sub Total				**800,000**
TRANSPORT				
Transport Money	30,000		8	300,000
Sub Total				**300,000**
STATIONERY				
Reams of paper	25,000	4		100,000
Binding of proposal	10,000	5		50,000
Binding of report	30,000	5		150,000
Folders	10,000	5		50,000
Sub Total				**350,000**
SECRETARIAL				
Typing proposal	2,500	50		125,000
Typing report	2,500	40		100,000
Photocopying	200	1,000		200,000
Sub Total				**425,000**
Contingency 5%	1,075,000			53,750
GRAND TOTAL				1,928,750

Note – The prices quoted are the ruling in Chingola.

Appendix 5

AN INVESTIGATION INTO COMMUNITY BASED GROWTH MONITORING AND PROMOTION PROGRAMME. A CASE IN CHINGOLA URBAN DISTRICT.

Questionnaire for In-Charges in maternal Child Health Department at the clinic.

GENERAL INSTRUCTIONS.

I am a student from the University of Zambia. The purpose of this research is in partial fulfilment of my diploma in Adult Education programme. The Questionnaire will be used for academic purposes only and the answers shall be treated with confidentiality.

Do not include your name.

Specific Instructions

You are asked to reach each question and decide how you feel about it. Answer questions by circling the appropriate answer of the statement that reflects your opinion.

Write statements in the spaces provided.

1. Age
   a) 26 – 35 years
   b) 36 – 45 years
   c) above 45 years

2. Sex

   a) Male

   b) Female

3. Marital Status

   a) Single

   b) Married

   c) Divorced

   d) Widow/Widowed

4. Academic Qualifications

   a) Grade 10

   b) Grade 12

   c) Other

      (specify).....

5. Professional Qualifications
   a) Family Health Nurse
   b) Registered Midwife
   c) Enrolled Midwife
   d) Other (specify) .....

6. Duration of Service
   a) 1 – 5 years
   b) 6 – 10 years
   c) 11 – 15 years
   d) 16 – 20 years
   e) above 21 years

7. Do you feel the Community Based Growth promoters have had adequate training?
   a) Yes
   b) No

8. If the answer to question 7 is no, why.

.....

9. Do the Community Based Growth promoters bring monthly reports to the clinic?
   a) Yes
   c) No
   d) At times

10. If the answer to question 9 is no or at times, why.

.....

11. Do you supervise the Community Based Growth promoters ?
   a) Yes
   b) No
   c) At times
      (specify).....

12. If the answer to question 11 is no, then why?

.....

13. Do the Community Based Growth promoters refer any children to you?
   a) Yes
   b) No.

14. If the answer to question 13 is yes, then what cases do they refer?
.....

.....

15. What do you suggest should be done about the programme?
.....
.....

16. What are your last comments?

.....

Appendix 6

AN INVESTIGATION INTO COMMUNITY BASED GROWTH MONITORING AND PROMOTION PROGRAMME: A CASE OF CHINGOLA URBAN DISTRICT.

A Questionnaire for Community Based Growth Promoters.

Dear Respondent,

a) This questionnaire is intended to be answered by Community Based Growth Promoters

b) Please feel free to respond to the items as the information will be strictly confidential.

c) It is hoped that this will come up with findings which can be beneficial to the programme.

INSTRUCTION: To answer the questions in this questionnaire you are required to encircle the letter against the answer of your choice or write your answer in the space provided.

1. Sex
   a) Male
   b) Female

2. Age
   a) 20 – 30 years
   b) 31 – 40 years
   c) 41 – 50 years
   d) Above 50 years

3. Marital Status
   a) Single
   b) Married
   c) Divorced
   d) Widow/Widower

4. Education Attainment
   a) Primary level
   b) Secondary level
   c) College level.

5. For how long have you been operating at this post?
   a) 1 – 4 months
   b) 5 – 8 months
   c) 7 – 12 months

d) Over a year

6. What are some of the services you offer?

.....

.....

.....

.....

7. How many times do you have the activity?
   Once per week
   a) Twice per week
   b) Three times a week
   c) Daily
   d) Once per month

8. Do you have enough materials to use?
   a) Yes
   b) No

9. Do you have a weighing scale?
   a) yes
   b) No

10. Do the clinic staff in your catchment area visit you?
    a) Yes
    b) No

11. If they do how often?

.....

12. Have the Chingola District Health Management Team ever visited you?
    a) Yes
    b) No

13. Do you record the children in your register?
    a) yes
    b) No

14. Do you take the monthly returns to the health centers where you are attached?
    a) Yes

b) No

15. Are Immunizations done at this post?
    a) Yes
    b) No

16. Before you started this programme, were you trained?
    a) Yes
    b) No

17. If the answer to question 16 is yes, after working in the field, do you think the training you were given is enough?
    a) Yes
    b) No

18. Ever since you were trained, have you had some more refresher courses?
    a) Yes
    b) No

19. Are you satisfied with the way the programme is running?
    a) Yes
    b) No

20. Are you managing the post well?
    a) Yes
    b) No

21. What would be your last comments?

.....

.....

Appendix 7

AN INVESTIGATION INTO COMMUNITY BASED GROWTH MONITORING AND PROMOTION PROGRAMME: A CASE OF CHINGOLA URBAN DISTRICT.

A questionnaire for mothers with children under 1 year.

Dear Respondent,

a) This questionnaire is intended to be answered by mothers with children under 1 year

b) Please feel free to respond to the items as the information will be strictly confidential

c) It is hoped that this will come up with findings which can be beneficial to the programme

INSTRUCTIONS.

To answer the questionnaire you are required to encircle the letter against the answer of your choice or write your answer in the space provided.

1. Sex
a) Male
b) Female

2. Age
a) 14 – 30 years
b) 31 – 40 years
c) 41 – 50 years

3. Marital Status
a) Single
b) Married
c) Divorced
d) Widow/Widower

4. Education attained
a) Primary
b) Secondary
c) College

5. For how long have you been coming to this post?
a) 1 – 4 months
b) 5 – 8 months
c) 9 – 11 months

6. Who told you about this post?
   a) Nurses
   b) Friends
   c) The Growth Promoters

7. After weighing the child do they tally on the Under Five Card?
   a) Yes
   b) No

8. Do they give you any advice after weighing the child?
Yes
   a) No

9. Do they give health education before starting the clinic?
   a) Yes
   b) No

10. Have you ever seen any health centre staff here to assist in the weighing of the children?
   a) Yes
   b) No

11. When the child is due for Immunizations do the Growth Promoters tell you to take the
   child to the health centre?
   a) Yes
   b) No

12. Are you happy that the children are weighed here in the community, at your step?
   a) Yes
   b) No

13. Are you satisfied with the Growth Monitoring Promotion Services offered here?
   a) Yes
   b) No

14. What are your comments on this Community Based Growth Monitoring and Promotion Service?

.....

.....

Appendix 8

INTERVIEW GUIDE FOR FOCUSED GROUP DISCUSSION (F G Ds) WITH MOTHERS WITH CHILDREN UNDER ONE YEAR AT THE COMMUNITY BASED GROWTH MONITORING AND PROMOTION POST.

1. For how long have you been coming to this post?
2. Who told you about this community post ?
3. How often are the children weighed ?
4. What do you think are the reasons for growth monitoring and promotion ?
5. What are some of the services offered here ?
6. Do health centre staff come to this post ?
7. Do the community Based Growth promoters give health education ?
8. Is the health education they give of any value to you as individuals ?
9. If a child is due for immunizations, what do they do here ?
10. If the child is unwell, what do they do to the child here ?
11. Are you happy that growth monitoring promotion service is being offered in the community ?
12. What are your comments on this community Based Growth Monitoring and Promotion service ?

Appendix 9

CHECK LIST FOR A COMMUNITY BASED GROWTH MONITORING AND PROMOTION POST.

Questions	Yes	No
1. Is there a shelter where the activity is taking place?		
2. Is there a Salter scale?		
3. Is there a standing scale?		
4. Are there enough weighing Bags?		
5. Is there a register for the children?		
6. On observation is health education being delivered accordingly?		
7. How is it delivered, is it in a group?		
8. Any person to person health education seen being delivered?		
9. Do they record each time health education is delivered?		
10. The health education delivered, is it for the right group?		
11. Is there a health education book?		
12. Do they enter the health education delivered in the health education book?		
13. Do they have enough Under Five Cards?		
14. Any child seen being referred to a health centre		