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Experiences and Challenges of Community-Based Child Growth Monitors and Promoters: Plight of Volunteers in the Zambian Health Care System

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ABSTRACT

Importance: *Amidst the chronic shortage of HRH in Zambia, the health care system has been striving to "Provide cost effective health care services, as close to the family as possible". Children being most vulnerable suffer chronic high child mortality rates still as high as 88 per 1,000 live births. Implementation of Child Survival Programs relay heavily by Community-Based Child Growth Monitoring and Promotion Programs (CCGMP) hence the need to determine challenges that they encounter.*

Objective: *To determine experiences and challenges of CCGMPs' during training and implementation programs for child survival in Zambia.*

Design: *This qualitative study included two methods; Five (5) FGD were conducted and interviews with women. Data recorded on tape, transcribed, grouped and manually analysed thematically using the 'framework method'.*

Setting: *Two districts Lusaka and Chirundu were purposively selected in order to provide a diverse picture of people with different life styles of urban and rural Zambia. Institutions providing PHC were used as entry points.*

Participants: *Fifty participants for each of the two qualitative methods applied gave a total of 100 participants. FGD included 50 CCGMPs leaders in groups of ten and 50 mothers randomly selected for in-depth exit interviews facilitated data collection.*

Main Outcome: *Evidence showed inadequate training which could have resulted in challenges faced by implementation programs which suffered unaddressed problems like; lack of supervision form professionally qualified staff, equipment, protective clothing, no remuneration amoung many others.*

Results: *CCGMPs' expressed evidence that their training was inadequate that during training, they did not cover most of the mandatory topics from their recommended curriculum. Practical experiences were compromised as some were never allocated time or/and supervision to practice what they learnt theoretically in order to sharpen their skills and competencies. They bemoaned training was compromised, coupled by lack of regular and timely refresher course by training organizations.*

Conclusion and Relevance: *The numerous challenges being experienced by CCGMPs expressed in this study can guide policy makers of the Health care systems of countries who rely heavily on Community Health Workers (CHW) for the delivery of Primary Health care.*

Keywords
Zambia, Child growth, Health Care.

Background

Developing countries, like Zambia have been struggling with the negative impact of chronic shortage of Human Resource for Health (HRH), let alone adequately trained personnel to perform tasks to provide quality health care services as close as to the populations as possible (Ferrinho, Siziya et al. 2011). Children being a vulnerable group of the population have suffered the most from the effects of HRH deficit and despite all the efforts being implemented by the government to ensure good health and growth for the Zambia children, child mortality remain unacceptably high at 29, 56 and 89 per 1,000 live births for neonatal, infant and under-five mortality respectively [1]. Implementation of Child Survival Programs (CSP) in Zambia especially in terms of maintaining and promoting health are largely community-based and are referred to as; Community-Based Child Growth Monitoring and Promotion Programs (CCGMP).

These programs heavily relay on community health workers, who are volunteers, as the HRH for the success of their implementation. The strengths and weaknesses in program implementation of activities can be timely and effectively identified and amended if clear and feasible guidelines for training were standardized and available [2].

Methodology

Study sites and sample selection

Conducted in Zambia at five sites including two sites from a rural area Chirundu district and three sites in Lusaka urban. Study population comprised of 50 mothers for one-to-one in-depth exit interview and 50 CCGMP leaders for FDG, were both randomly selected. Ten (10) participants from each of the five (5) selected areas, were included giving a total of 50 participants for each of the two (2) qualitative methods that were applied. For FGD 10 leaders of the CCGMPs who participated in providing CCGMPs services in the community were selected during child growth monitoring sessions at each of the five sites using simple random sampling.

Mothers who were selected to participate had to be residents of the study sites whose children had been receiving child health growth monitoring services from CCGMPs for a minimum period of one (1) year. Fifty (50) mothers were randomly recruited by choosing ten (10) mothers from each selected site, using simple random sampling. Ten numbers were randomly picked and those mothers who picked similar numbers were included as participants of the one-to-one exit interview.

Methods

To increase the strength of the study findings, triangulation was applied by engaging two (2) methods and two (2) different sets of participants respectively; one-on-one exit interviews with mothers, and focus group discussions with leaders of CCGMPs. A FGD guide was pre-developed with open ended questions to facilitate discussions whose responses were recorded on tape of which prior consent was sort. FDGs were guided the by asking prior written down questions while listening to and observing the CCGMPs express themselves without losing focus. After collecting data on tape, it was transcribed, grouped in themes and analyzed thematically by applying the 'framework method'.

For in-depth interviews, with the mothers, a check list of services on which mothers indicated which ones they were satisfied with or not. Analysis was conducted by grouping similar responses indicating using N-VIVO statistical package to code the responses and manual interpretation was conducted to determine mothers' satisfaction.

Results

This study discovered challenges in the implementation of vital child survival programs of child monitoring by volunteers. These could contribute to incompetent services provided by CCGMPs consequently leading to mothers' dissatisfaction of services. This was coupled by lack of regular and timely refresher courses and their implementation programs suffered unaddressed challenges like; lack of supervision form professionally qualified staff, equipment, protective clothing, no remuneration among many others.

FDG Results

Most key informants during FDGs expressed the fact that problems started from their training duration which was not enough particularly the practical experience as expressed by one key informant; "We learn these skills on our own as we work with our friends. The trainers do not follow us up in the practical sites to ensure that we are learning the skills correctly."(P1). Most of the skills were learnt during GMP sessions and orientation session before the child health week.

The felt that there was urgent need for regular and timely refresher courses since despite guidelines for the CCGMP implementation program being frequently reviewed and updated the CCGMPs who are the major program implementers were not being updated. This was expressed by most participants as cited by one who said; "We are now faced with this challenge of children who are exposed to HIV positive mothers, we have not learnt how to handle them or how to refer them." (P2).

Mothers'

Table 2 presents results of the social demographic attributes of mothers who participated in the in-depth interview. All the women who participated in this study had been to school though none of them went up to tertiary education. The Highest level of education attained and majority of them were those who went up to secondary school (72%) and those that went only up to primary school were (28%). Almost all of these women were married (96.0%), while only (4.0%) were widowed. Majority of the women (92%) were economically depended on their husband for their livelihood and to provide for the home, while only (8%) were selling some vegetables in order to be able to provide for them and their children's basic needs.

Theme	Sub-Theme	Resp. code	Respondents' Statements
Training inadequacies (Competency)	Initial Training (Both theory and practical)	1: P1	"We were trained by different organisations who conducted different programs; Nutrition promoters were trained by JICA, CHW by DHMT, TBA and HBC givers by the church and so many more. So our trainings were different in terms of content covered under GMP, methods used and most of all the duration varied from 2 to 6weeks or more of both theoretical and practical experience."
		3: P6	"Some of us were trained within a very short period of time as a result we did not learn most of the things during training. We learnt to perform most of the tasks as we provided services to the children."
	In-Service training (Mainly practical)	4: P2	"We are now faced with this challenge of children who are exposed to HIV positive mothers; we have not learnt how to handle them or how to refer them. We also need to train more on how to educate the mothers on good nutrition for the children especially for children who are malnourished."
		2: P8	"I was neither trained nor supervised by nurses during practical training. And ever since I was trained 7 years ago by JICA and since they have gone, I've never been called for any refresher course"
Challenges of practice (Context)	Lack of Government recognition	1: P5	"We feel that we do not belong to any Ministry and yet we contribute a lot to the Ministry of Health, as we work extremely hard to provide different health care services in our communities, we also tally all the GMP activities and provide most of the information that the health workers at the clinic use to write their reports. Without us working in the communities and submitting the information they cannot write reports to higher offices, and yet our work is never recognised let alone acknowledged."
		5: P9	"Some qualified health workers really demoralise us. They say that after all we are not recognised by the government and are just volunteers, not on government pay role, therefore we should not claim or complain about anything like conditions of service etc…"
		2: P2	"We are not answerable to anybody and so whether we work or not, or even when we stop to work as some of our colleagues have done, nobody seems to care as no one asks us or even follows us up once we drop out. The needs in the community are what drives the few of us who continue to work hard for the children so they can grow up healthy and better citizens of our country"
	Lack of logistics	1: P4	"There is no transport what so ever, we carry the entire requirements for conducting GMP sessions in our hands and walk to and from the health centres to collect as well as take back; scales, tally sheets, Vitamin A and deworming tablets since they are in short supplies and other zones have to use them as well. If a child gets very sick we escort the mother with the child on foot to the clinic."
		4: P9	We are never provided with any stationery, no referral forms, pens to write with, papers to record important things, sometimes there are no registers, no tally sheets not even the under-5 cards let alone medical surgical supplies like vaccines, gloves, thermometers… Even scales are not enough so sometimes we are forced to cancel the GMP sessions at the expense of the children whose growth needs to be monitored and they need to be immunised."
	No protective clothing or identification	3: P1	"We have to on our own look for protective clothing or even beg from nurses for an old apron. Once we see a faded apron on a nurse, we follow her and beg that she may kindly give us the finished apron so that we can use it as we work"
		5: P1	"Sometimes we deal with well-to-do women who do not allow us to touch their children unless they see some sort of identification. An identity card will go a long way to help us be identified as CCGMPs."
	Work Overload	2: P7	"We are overwhelmed with the large number of children so that sometimes we cannot cope with the work. On very busy days, we even return some children back home unattended as there is too much to do since we conduct GMP only once per month in each area, regardless of the numbers of children"
		4: P8	"Due to too much work, we do not have time to counsel mothers who come with children that have nutritional problems because we have to weigh all the children and sometime we have up to 300-400 children. We work all day from 7 to 16 hours on the day for GMP session, and yet the government does even recognise us."
	No remuneration	1: P3	"We spend the whole day working from 7 hours to 16 hours and are given nothing not even water or a drink. After that we go back home tired, hungry and with nothing at the end of the month."
		4: P3	"But surely even a volunteer needs to eat, bath and put on clean clothes, especially with the huge work load that we have to perform. Sometimes the children are not securely dressed and we are splashed with urine or stool on our clothes. Our spouses even wonder when we get back home because we are usually so dirty, since we have no protective clothing."
		5: P2	"Long ago, in the 1990s, some NGOs like JICA, had awarded hard working volunteers with bails of second hand clothes and that used to motivate us to continue doing our work,".
The plight of volunteers	Incentives or/ and motivation	2: P4	"Since the government has no money to pay us and we are considered to be volunteers, we request to please be exempted from Hospital user fees and queues especially when we or our children or dependents are sick and they need the services of a big Hospital like UTH. This would motivate us. Despite providing free services to others they we are not exempted from paying user fees and queuing at big hospitals."
		5: P2	"Even if we are not considered for a small salary or an allowance, probably just a bag of mealie-meal per month can be considered just so that we can supplement towards feeding our families since we spend so much time doing voluntary work."
		4: P1	"When there is a job opportunity that does not need any special qualification and we can perform very well due to our experience, we just get shock to see totally new, young and inexperienced people being employed. Sometimes we are even the ones who teach them what to do. But we are usually not considered even if we apply and so we remain volunteers forever."

Table 1: Themes from key Statements from CCGMPs during FGD.

	Category	n (%)
Age of mothers	> 30 years old	17 (34)
	20 – 30 years old	33 (66)
Highest level of education	Secondary	36 (72)
	Primary	14 (28)
Marital status	Married	48 (96)
	Widowed	2 (4)

Table 2: Demographics of participating mothers.

Table 3 presents results of mothers' satisfaction with the services being provided by the CCGMPs. Responses indicated that majority (64%) were not satisfied with 80% of the services provided by CCGMPs, while only (36 %) rated the services as very satisfactory.

Satisfaction of mother with services provided by CCGPM	Very satisfied (80-100%)	18 (36)
	Somehow satisfied/Not sure	32 (64)

Table 3: Satisfaction (Contentment) of mothers with CCGMPs services.

One of the mothers expressed herself that: "We are not happy with most of the services provided by the community volunteers. They are usually in a hurry to just finish the queue so that they can go back to doing their own work. Sometimes they don't finish the queue as we mothers are too many. As a result, our children sometimes miss out on the vaccines, since they are the ones who refer our children to the qualified nurses for immunizations." (M1)

Conclusion

This study discovered challenges implementation of the three key players of child health programs namely: competency, context and contentment. Though there was was an encouraging finding that despite minimal support in implementing child survival programs, CCGMPs continued to enthusiastically deliver services to the community as volunteers. However, challenges faced by CCGMPs call for combined effort of all the stakeholders involved in ensuring that the programs provide excellent services to yield the best results for the growth monitoring and promotion of our children. Conclusively, this study investigated a combination of three components: context, competency and contentment as essential elements for training and implementation of community-based health program and "triple C index" was coined.

References

1. Charlton KE, Kawana BM, Hendricks MK. An assessment of the effectiveness of growth monitoring and promotion practices in the Lusaka district of Zambia. Nutrition. 2009; 25: 1035-1046.
2. Griffiths M, Rosso J. Growth monitoring and the promotion of healthy young child growth evidence of effectiveness and potential to prevent malnutrition. Washington DC. Manoff Group. 2007; 36.
3. Marriott BP, White A, Hadden L, et al. World Health Organization WHO infant and young child feeding indicators associations with growth measures in 14 low-income countries. Maternal & child nutrition. 2012; 8: 354-370.
4. Morley D, Woodland M. See How They Grow-Monitoring Child Growth For Appropriate Health Care In Developing Countries, Macmillan Press Ltd., 4 Little Essex Street, London Wc2r 3lf. 1979; 265.
5. Msefula D. How Can Growth Monitoring And Special Care Of Underweight Children Be Improved In Zambia? Tropical Doctor. 1993; 23: 107-112.
6. Mumba Zulu J, Michelo C, Kinsman J. et al. 1/3. Hope And Despair: The Community Health Assistant Role In Zambia. British Journal Of Healthcare Assistants. 2015; 9.
7. Zulu JM, Kinsman J, Michelo C. et al. Developing the national community health assistant strategy in Zambia a policy analysis. Health Research Policy and Systems. 2013; 11: 24.

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