ABSTRACT

This study on growth monitoring was a descriptive study of a representative sample of 851 children born during the period 01.01.87 to 31.03.89 living in the area administered by the Regional Director of Health Services Gampaha.

The main objectives of the study were to make a quantitative and qualitative assessment of the performance of activities involved in growth monitoring and to determine the factors influencing; to assess the knowledge of mothers on growth monitoring and to determine the factors influencing.

The study consisting of three components viz. community study, clinic study and the Public Health Midwife study was carried out during the period 01.04.89 to 30.10.89. The main instrument used was the structured pre-coded questionnaire. Appropriate techniques were used to collect the data for the different sections of the questionnaire viz. interviewing, self administration of questionnaire, direct observations of activities and perusal of routine records. Data entry and analysis were done using the computer.

The study revealed that the quantitative coverage of certain activities required for growth monitoring were satisfactory. 99.2% of the children had access to a CHDR. 85.7% of children were visited by a public health midwife at home. 96.5% were registered by a public health midwife(PHM).

However the qualitative coverage was less satisfactory. Only three fourths of the children were registered at the home of the baby. Less than half were registered within 7 days of birth. 11.2% of the registered children were not visited even once at home by PHM. Only one third of children were visited once a month by the PHM. Home visiting was not targetted towards the vulnerable families with poor income and less education. In turn the utilisation of services was less among these groups. Less children of first birth order have been visited by the public health midwife at home.

The study revealed that the programme was well accepted by the mothers. Only 1.5% of the CHDRR were lost. 83.8% of the children visited the field clinic at least once. 84% of the children visiting the clinic were weighed at least once. However the sustained compliance of the mothers was less satisfactory. Only one third of the children were brought to the clinics for weighing more than 50% of the specified number of times appropriate to age.

Home visiting was shown to motivate the mothers to attend clinics. Recording the date of appointment for next clinic visit in the card was found to have much influence on the frequency of visiting. Clinic accessibility was not shown to have a significant influence on the frequency of weighing. Knowledge of the mothers on growth monitoring had significant effect on frequency of weighing. Only 12.6% of the mothers however had high level of knowledge on growth monitoring. The poor motivation of the mothers, over-crowding of clinics,long duration of stay and poor services in the clinics were shown to discourage the mothers from attending clinics regularly.

It was encouraging however to note that the activities were improving with time. It was also shown that the activities were poor in Negombo AGA area which came under the administration of the Municipal Council.

The study revealed that the knowledge of the mothers on growth monitoring was dependent on her educational level and income. Home visiting and frequency of attending clinics for weighing had a significant effect on the mothers' knowledge on growth monitoring. Mothers visiting general practitioners had higher level of knowledge compared to the mothers visiting the field MCH clinics. Only one fourth of the mothers had learnt about growth monitoring from PHM at home or in clinics.

The study revealed that only 40 (39.2%) of the PHMM had high level of knowledge on growth monitoring. Activities more specific to growth monitoring requiring better knowledge, attitudes and skills were performed less satisfactorily by the PHMM. Though the identification details were completely and accurately recorded, recording of birth weight, plotting the birth weight, completion of the calendar, identification of reasons for special care and writing the date of appointment for next clinic visit in the CHDR were not completely and accurately recorded. Likewise the procedure in use of scales, accuracy and precision of weighing, interpretation of growth curves, recording history of important events were not carried out adequately in the clinics. As a result the utilisation of the CHDR for intervention purposes was minimal. Individual counselling of mothers on nutrition and child care, explanation of the growth curve, provision of Thriposha, antihelminthics & vitamins for children according to the needs were unsatisfactory.

Though the availability of vitamins and antihelminthics were good in the clinics, Thriposha was not available in one third of the clinics. Only 58% of the clinics had both types of scales in use. Supervision and physical facilities in the clinic seem to influence performance of activities in the clinics.

Hence it is recommended that,

1) political commitment and better health administration is provided towards growth monitoring;
2) action is taken to motivate the mothers, the PHMM and supervisors on growth monitoring by increasing the knowledge, attitudes and skills.
3) action is taken to improve the existing clinic facilities and supervision of growth monitoring activities.