

**CHALLENGES FACING PRIMARY HEALTH CARE NURSES IN THE
IMPLEMENTATION OF INTEGRATED MANAGEMENT OF CHILDHOOD
ILLNESS: A CASE STUDY OF SELECTED CLINICS IN VHEMBE DISTRICT,
LIMPOPO PROVINCE**

I, Takalani Edith Mutshatshi, the mini-dissertation, for Master of Public Management (MPM) degree at the University of Venda, hereby submitted by me, has not been submitted previously to this or any other university and that this is my own work and that all reference materials contained herein has been duly acknowledged.

by

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A Mini-Dissertation submitted in partial fulfillment of the requirements for the Degree of

MASTER OF PUBLIC MANAGEMENT

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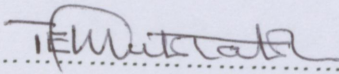
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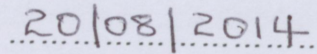
DECLARATION

I Takalani Edith Mutshatshi, hereby declare that the mini-dissertation for Master of Public Management (MPM) degree at the University of Venda, hereby submitted by me, has not been submitted previously to this or any other university and that this is my own work and that all reference materials contained herein has been duly acknowledged.


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.....

DATE

DEDICATION

This mini-dissertation is dedicated to God Almighty who gave me the strength and wisdom to complete this study, my beloved husband Zwidofhelangani Nicholus Mutshatshi, my children Vhuhwavho, Vhuthu and Vhulenda for their unconditional support up to the end of this project.

- All my lecturers who assisted me during my course work.
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- My late father Mr. S. A. Mphahlele who inspired me that everything is possible and believed that I could do it.
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ABSTRACT

The problem that guided this study is that management of childhood illnesses in the clinics is facing many challenges and there is a need to develop strategies to counteract the challenges. The aim of the study is to investigate the challenges facing primary health care nurses in the implementation of the Integrated Management of Childhood Illnesses Strategy in selected clinics in the Vhembe District, Limpopo Province.

Both qualitative and quantitative methodologies were used in the study. The research design which was used was descriptive in nature in the form of a case study. To get a holistic view, a non-probability, purposive sampling method was used to obtain samples from the population. Data was collected from respondents using structured interviews and close-ended questionnaires. Data analysis was done using Tesch's eight steps method of open coding for the qualitative approach. In quantitative approach, collected data was analyzed using the Statistical Package for Social Sciences (SPSS). Ethical issues were taken into consideration throughout the research process.

The main findings of this study are:

- There is shortage of staff to implement Integrated Management of Childhood Illness in the clinics.
- There is shortage of rooms to consult children when implementing Integrated Management of Childhood Illness at the clinics.
- Integrated Management of Childhood Illness implementation is time consuming.
- There are no follow-up visits by facilitators and in-service training for Primary Health Care nurses on Integrated Management of Childhood Illness.

The main recommendations of this study are:

- The Department of Health must ensure there is more staff employed in the clinics so that Primary Health care nurses can be able to cope with the workload of implementing Integrated Management Childhood Illness.

- The department to improve the infrastructure in the clinics so that children can be seen in their designated areas not combined with adults as outlined in the national norms and standards for child care.
- Integrated Management of Childhood Illness training need to be expanded to all categories of nurses up to the level of home based care in the communities in order to can improve patients' waiting period at clinics.
- There must be scheduled professional development plan for in-service training with adequate facilitators who will conduct follow up visits at the clinics.

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INTRODUCTION / **LIST OF ACRONYMS** / THE STUDY

1.1 INTRODUCTION

ANC	African National congress.
DAMMM	Diarrhea, Acute respiratory infection, Measles, Malaria and Malnutrition.
ETAT	Emergency Triage Assessment Treatment
ICAT	Integrated Management of Childhood Illness Computerised Adaptation and Training
IMCI	Integrated Management of Childhood Illness
MDG	Millennium Development Goals
NDOH	National Department of Health.
PHC	Primary Health Care Nurse.
SANC	South African Nursing Council.
SPSS	Statistical Package for Social Science
UNICEF	United Nations Children's Fund.
WHO	World Health Organization

1.2 BACKGROUND TO THE STUDY

The legacy of apartheid in South Africa created discrepancies amongst racial groups in terms of socio-economic, housing, education and health. The disparities in health care system were reflected in the health status where disadvantaged and provision of accessible health care services for the disadvantaged groups was emphasized in the National Health Plan document (African National Congress, 1994:20)

One of the major health care and health care deficit leads to child deaths. Diarrhea, Acute respiratory infections, Measles, Malaria and Malnutrition (DAMMM). These deaths are largely due to

CHAPTER 1

INTRODUCTION AND BACKGROUND OF THE STUDY

1.1 INTRODUCTION

This study is based on the challenges facing primary health care nurses in the implementation of Integrated Management of Childhood Illnesses. The health status of the community is dynamic and not static therefore change in the health status of the community is also accompanied by changes in the management of health problems leading to the adoption of new approaches and strategies. When South Africa achieved its democracy in 1994, health was not exceptional as many changes were brought into the national health department as outlined in the National Health Plan of South Africa. Health and health care like other social services, particularly where they serve women and children are said to have suffered as a result of foreign debt and adjustment programs (African National Congress, 1994:19).

This chapter will outline the background of the study, problem statement, aim of the study, objectives of the study, research questions, significance of the study, delimitations and limitations of the study, referencing technique, definition of operational concepts, brief literature review, and organization of the study.

1.2 BACKGROUND TO THE STUDY

The legacy of apartheid in South Africa created discrepancies amongst racial groups in terms of socio-economics, housing, education and health. Inequalities in health care system were reflected in the health vision where promotion of health and provision of accessible health care services for the vulnerable groups was emphasized in the National Health Plan document (African National Congress, 1994:20).

For children to grow they need essential health care and deficit leads to increased childhood deaths more common in the under-fives due to the five main killer diseases namely, Diarrhea, Acute respiratory infections, Measles, Malaria and Malnutrition (DAMMM). These deaths are largely due to

preventable and treatable diseases. It is estimated 60% of deaths of children under the age of five can be prevented by community health workers through the implementation of community based interventions, health promotion and prevention (Kibel and Wagstaff, 2001:320).

Child mortality remains a common problem in developing countries and childhood deaths can be prevented by two-thirds by using existing tools and interventions (United Nation International Children's Fund, 2009). In 2000, the world set a goal to reduce child deaths by two-thirds and making a commitment to achieve that Millennium Development Goal No 4 (MDG 4). South African children between the ages of one month to five years die each year because of preventable causes. Mortality rate in South Africa is in a position of between 57, 6 to 94, 7 deaths per 1,000 live birth (National Department of Health Strategic Plan, 2011/2012:18).

The World Health Organization (2003:10) reported that the implementation of the adopted strategy like other changes has been accompanied by challenges in other international countries where it was implemented, so, South Africa is not an exceptional to the challenges. To achieve the millennium development goals, primary health care nurses have to change approaches to the management of children by implementing the Integrated Management of Childhood Illness strategy as adopted from the World Health Organization.

The democratic government came along with the recommendation by the Minister of Health in June 1994 of free health care for children under six years of age, pregnant and nursing mothers in all public sectors and the legislation was enacted in 1995. During the apartheid era children were treated in the health sector like the general public and their management in the health sectors was not given any special consideration despite their alarming mortality rates as reflected in the departmental statistics. Of the 37.7 million of the South African population in 1991, 36% of the populations were children between ages 0 and 14, and 46% were less than 19 years whereas 13% were children under the age of four years. In 1991 the infant mortality rate was 54 per live births and the major causes of death were infectious diseases

especially intestinal infections and respiratory diseases (African National Congress, 1994; 29).

The first report of the Committee on Morbidity and Mortality in Children less than five years (CoMMiC) estimated that over 60,000 South African children between the ages of one month to five years die each year because of preventable causes. Successful implementation on the health priorities in health depend on the revitalization of health system through the primary health care approach and the decentralization of management of health services and establishment of district health services (National Department of Health Strategic Plan, 2011/2012:18).

The first declaration of children for the protection of rights was declared in 1959 and was adopted by the United Nations and United Nation International Children's Fund. Since the introduction of children rights, every country is in pressure to ensure it changes its management approach in their treatment and management into a more comprehensive or integrated approach and South Africa having been allowed into the international arena was forced to reevaluate its approaches towards child care in relation to international standards (Kibel and Wagstaff, 2001:323).

A major cause of deaths in children less than five years, both internationally and nationally, is a result of childhood illnesses. Thus, proper management of the diseases is essential to curb mortality from the illnesses. The World Health Organization (WHO) and the United Nations International Children's Fund (UNICEF) came up with the Integrated Management of Childhood Illnesses (IMCI) strategy which was adopted in South Africa and even internationally. The strategy was spread to other developing countries like Brazil and Tanzania. South Africa adopted the IMCI strategy and launched it in the national department in 1998. In Limpopo Province the strategy was launched in 1999 where the first group of nurses was trained in 2001 in the Vhembe District. The IMCI training has been incorporated in nursing education and training (World Health organization, 2003:14).

1.3 PROBLEM STATEMENT

The Constitution of the Republic of South Africa of 1996, Section 27 makes provision for the health care delivery system to provide health for all and under the bill of rights it states that everyone has the right to health services, including reproductive health care. The National Health Care Act, (Act No 61 of 2003), Section 4 focus on range of people who are eligible for free health services which includes women and children and a transformed health care system for the entire people of the Republic of South Africa. Child Care Act, (Act No 74 of 1983 as amended), Section 42 makes provision for the protection of children and their rights.

Despite the provision of the Acts in South Africa, primary health care nurses are still faced with challenges with regard to the implementation of the Integrated Management of Childhood Illnesses at various clinics in Vhembe district, Limpopo Province. The strategy entails the new advanced and comprehensive way of managing childhood illnesses to those children under the age of five years within the public sector but the strategy like any other form of change brought along some challenges with regard to its implementation.

The transformation process in the health system in South Africa brought along many challenges. The following are some challenges which impact negatively on the health care delivery systems of the country, backlog in patient care due to shortage of staff to implement programs, lack of funds to run programs, lack of material resources such as drugs and equipments needed for the provision of patient care (South African Journal for Child Health, 2010:27). This study is then conducted in order to can come up with solution to curb challenges of implementing Integrated Management of Childhood Illnesses in the clinics at Vhembe district.

1.4 AIM OF THE STUDY

The aim of the study is to investigate the challenges facing primary health care nurses in the implementation of Integrated Management of Childhood Illnesses: A case study of selected clinics in Vhembe District, Limpopo Province.

1.5 SPECIFIC OBJECTIVES OF THE STUDY

- To identify challenges facing primary health care nurses in the implementation of the Integrated Management of Childhood Illnesses.
- To describe the importance of implementation of Integrated Management of Childhood Illnesses strategy in the clinics.
- To determine strategies to overcome challenges encountered in the implementation of the Integrated Management of Childhood Illnesses (IMCI) strategy.

1.6 CRITICAL RESEARCH QUESTIONS

- What are the challenges facing primary health care nurses in the implementation of Integrated Management of Childhood Illnesses?
- What is the importance of implementing Integrated Management of Childhood Illnesses?
- What are the strategies to solve problems in the implementation of Integrated Management of Childhood Illnesses?

1.7 SIGNIFICANCE OF THE STUDY

The knowledge obtained from the research may be used to plan in-service education for health care providers at clinics on how to effectively implement IMCI strategy and this will also help the community in the reduction of child morbidity and mortality. Findings of the study may prompt other researchers to explore the concept further and identify gaps in child health services that need to be explored further to improve service delivery of children less than five years. The findings and recommendations of the study may be of use to policy-makers during policy-making process. The research findings will add to the existing body of knowledge in nursing education.

1.8 DELIMITATION OF THE STUDY

This study is based on challenges faced by primary health care nurses in the implementation of IMCI in selected clinics at Vhembe district. The research will be restricted in selected clinics in the Vhembe District, Limpopo Province. The researcher will investigate challenges facing primary health care nurses in the implementation of IMCI strategy and the study will focus directly on those primary health care nurses in the selected clinics.

1.9 LIMITATION OF THE STUDY

There are potential threats to the study because the topic is sensitive and respondents may fear to give true and honest information, funds like travelling expenses, costs for typing, photocopying, proof reading and binding may also pose a threat. The other limitation can be time needed for collecting data in clinics that are very busy may also be another limitation.

1.10 REFERENCE TECHNIQUE

Reference is defined as a direction in a book to another passage or another book where information can be found, mention of it and an illusion of it (Simpson, 1989:93). The researcher will use the Harvard method of referencing in the format as follows, when referencing a paragraph in a book it will be: authors' surname, followed by year of publication and page all in brackets at the end of paragraph. Example, (Mouton, 1996:50). When referencing a paragraph in a book at the beginning of a paragraph it will be author's surname outside the brackets followed by year of the publication and page all in brackets for example: According to Brink (2003:44) a sample is

1.11 DEFINITIONS OF OPERATIONAL CONCEPTS

This section defines the operational definitions of the study which are, child, Integrated Management of Childhood Illnesses, implementation, management and Primary Health Care Nurse.

- **Child**

According to Child Care Act (Act No 74 of 1983 as amended), a child is any person

below the age of 18 years of age. In the study, a child refers to any person below the age of

five years.

- **The Integrated Management of Childhood Illnesses (IMCI) strategy**

This is an integrated approach to child health that focuses on the wellbeing of the whole child. IMCI aims at reducing illness, disability, death and promoting growth and development amongst children less than five years of age (World Health Organization, 2007:1). In the study, Integrated Management of Childhood Illnesses refers to the treatment of illnesses such as measles, malaria, pneumonia, diarrhea and malnutrition affecting children under five years of age.

- **Implementation**

Marsh and Morris (1991:25) define implementation, as what happens in the health care facilities at the service delivery level. This means implementation is what health care providers are doing in the health care centers. From the public policy perspective, Parson (1985:23) defines implementation as a delivery end of policy. Implementation also refers to actions initiated to accomplish defined goals and objectives and it also means putting into effect according to or by means of a definite plan or procedure (Random House Dictionary, 1966:224). In this study, implementation means what primary health care nurses are practically doing in the clinics in rendering nursing care to children less than five years of age.

- **Management**

Management is defined as the planning, organization; leading and controlling of the work of the organization using all the available resources to reach organizational goals (Stoner and Freeman, 1992:4). In the study, management

means the ability to effectively render child health services comprehensively using available resources.

● **Primary Health Care Nurse (PHCN)** and interpretation

A primary health care nurse is a nurse registered with the South African Nursing Council (SANC), who holds a certificate in Primary health care, diagnosis and treatment (SANC, 1985: No R48 as amended). In this study, it refers to a registered nurse who is trained to implement the Integrated Management of Childhood Illnesses strategy in the clinics.

1.12 ORGANIZATION OF THE STUDY definitions and conclusion

In this section the researcher will focus on the organization of the study which includes introduction and background, literature review, research methodology and design, data collection and data analysis.

Chapter one: Introduction and background of the study

This chapter focuses on the overview and background of the study and introduces important aspects of the research such as the problem statement, aims of the study, hypothesis, and significance of the study, research questions, delimitations and limitations, literature review and research methodology as well as organization of the study.

Chapter two: Literature review

This chapter focuses mainly on a brief literature review and includes the introduction and background of Integrated Management of Childhood Illnesses, legislative framework governing health in South Africa, policy making in Integrated Management of Childhood illnesses, policy implementation in in Integrated Management of Childhood illnesses.

Chapter three: Research design and methodology

This chapter presents the research design and the methodology to be used to conduct the research. This is divided into the following sub-headings : the population, sample, sampling and sampling method, sample size, data

collection method, data collection instrument, data analysis as well as framework for analysis.

Chapter four: Data presentation, analysis and interpretation

In this chapter, the researcher gives research results based on the facts and analysis on the findings obtained from the respondents using the methodology which will be discussed in chapter three. The collected data will be analyzed using SPSS for quantitative approach and Tesch's eight steps of data analysis for qualitative research.

Chapter five: Findings, recommendations and conclusion

The researcher concludes the investigations by giving the findings which will be found in the research and the recommendations for possible gaps and areas of improvement and also the conclusions of the study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter will review the literature which is relevant to the challenges facing primary health care nurses in the implementation of Integrated Management of Childhood Illnesses. The chapter will also highlight the legislative framework for child care, theoretical framework of Integrated Management of Childhood Illnesses, the challenges facing primary health care nurses in the implementation of Integrated Management of Childhood Illnesses, the background history of Integrated Management of Childhood Illnesses, the importance of implementing Integrated Management of Childhood Illnesses, implementation of Integrated Management of Childhood Illnesses in South Africa, the broad analysis of the strategy internationally, policy making process, policy implementation process, and strategies to improve the implementation of Integrate Management of Childhood Illnesses.

2.2 LEGISLATIVE FRAMEWORK OF INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES

This section focuses on legal aspects pertaining to care and management of childhood illnesses. The legislative framework on child health includes the Constitution of the Republic of South Africa, National Health Act, Nursing Act, Child Care Act, South African Nursing Council Rules and Regulations, White Paper on Transformation of Health Services and World Health Organization Right charter for children.

2.2.1 The Constitution of the Republic of South Africa, 1996

The Constitution of the Republic of South Africa of 1996 is the supreme rule of the country and Section 27 makes provision for free access to health care by all citizens of the Republic of South Africa including children. This provision also ensures that every child under the age of six years have access to free and quality health care with no discrimination based on gender, race, ethnic origin and religious affiliation. This means that children should be raised in an

environment which is conducive to quality health care, growth and development.

2.2.2 The National Health Care Act, 2003

The National Health Act, 2003 (Act No 61 of 2003), Section 4 provides for a transformed health system for the entire Republic of South Africa. The National Health Act, 2003 (Act No 61 of 2003) provides a framework for a structured uniform health system within the Republic of South Africa, taking into account the obligations imposed in the Constitution and other laws on the national, provincial and local government with regard to health services. The Act also focuses on provision of health care at national, provincial and local or district level. The national level in the ministry of health is responsible for providing leadership, formulation of national policies building the capacities of provinces, municipalities, non-governmental organizations involved with health issues, private providers by ensuring equity and that certain services are cost-effective and providing regulations of the public and private health sectors (Young, Van Niekerk and Mogotlane, 2007:26)

2.2.3 The Nursing Act, 2005

The Nursing Act, 2005 (Act No 33 of 2005) provides for the regulation of the nursing profession and provides for other matters connected thereof. The act consolidates and amends laws relating to the professions of registered or enrolled nurses, nursing auxiliaries and midwives and provides for matters incidental thereto (Nursing Act, Act No 33 of 2005). According to Young, Van Niekerk & Mogotlane, 2007:42), the objectives of the Nursing act are to control the nursing profession through legislation in the hands of nurses who by the same token, also exercise control over the delivery of an ethical, competent nursing service to the community, to ensure all nurses who practice for gain are registered or enrolled with the South African Nursing Council there by preventing non-nurses from practicing, provide peer group control in the form of South African Nursing Council, establish co-operation between nursing profession and other health professions and to provide for training of properly qualified nurses who will make contribution to the development of health services and provide safe nursing care to the public.

2.2.4 Child Care Act, 1983 as amended

The Child Care Act, 1983 (Act No 74 of 1983 as amended) makes provision for the protection of children and their rights. The Child Care Act, 1983 (Act No 74 of 1983 as amended) provides for the establishment of children's courts and the appointment of commissioners of child welfare for the protection of children. It also provides for the establishment of certain institutions for reception and for treatment of children. The Act also set conditions for placing children who are being abused to be taken to place of safety pending investigations. The Act also focuses on the procedures that are followed in the process of adoption and also deals with issues that prohibit sexual exploitation of children (Child Care Act, Act No 74 of 1983 as amended).

2.2.5 The South African Nursing Council (SANC) Rules and Regulations R2598

South African Nursing Council makes provision for the scope of practice of various categories of nurses, registered nurses, midwives, enrolled nurses and enrolled nursing auxiliaries. According to the rules and regulation (R2598) of the South African Nursing Council of 30th November as amended, the scope of practice of a professional nurse includes the following:- the diagnosing of a health need and the prescribing, provision and execution of a nursing regimen to meet the need of a patient or a group of patients, or where necessary by referral to a registered person. Regulation No R2598 also ensures for the supervision of and maintenance of fluids, electrolytes and acid base balance of the patients, facilitation of and maintenance of supply of oxygen to the patient, facilitation and maintenance of nutrition of a patient, co-ordination of health care regimen provided for the patient by other categories of health personnel.

2.2.6 The White Paper on Transformation of Health Services in South Africa

The public sector was functioning according to the White Paper on Transformation of Health Services in South Africa until the envisaged act has been promulgated. In 1994, South Africa adopted a Convention of the rights

of children which puts children first and commits itself to the “first call for children”. The National Department of Health committed itself to rendering the highest quality of child health care delivery. This legislative framework describes the way that the health department should function and provide the directives for how health institutions should render child health services to the community. The white paper favors the primary health care approach which is aimed at basic health needs of all people of South Africa and is aimed at correcting historic imbalances. (African National Congress, 1994:19).

The White Paper for the Transformation of the Health System, released in 1997 accentuated the need to:- decentralize management of health services; establish the District Health System to facilitate implementation of Primary Health Care, increase access to services for citizens, ensure the availability of good quality essential drugs in health facilities, strengthen disease prevention and health promotion in areas such as Human Immune Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), maternal, child and women’s health, implement the Integrated Nutrition Programme to focus more on sustainable food security for the needy, and rationalize health financing through budget reprioritization (National Department of Health Strategic Plan of South Africa ,2012/13:4).

2.2.6 The World Health Organization

The World Health Organization in its objectives made provision for all children and adolescents to have all the means and opportunity to develop to full potential. The World Health Organization further regard life, survival, full or maximum development, access to health and access to health services as not just basic needs for children but declare this a fundamental rights. The United Nation Convention on Children s Rights reflects international consensus on standards of ensuring overall well-being of children and young people up to the age of 18 years. The Children s Right Charter also advocates and gives practical support for child and adolescent health (World Health Organization, 2003:2).

2.3 THEORETICAL FRAMEWORK OF INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES

Theories are a set of interrelated phenomenon of observable vents that are explanatory and predictive in nature. In nursing a theory is an organized and systemic participation of set of statement related to questions in the discipline of nursing. The aim of theories is to focus on patient as individual with nursing needs not just medical needs (Whelamis, 2003:26).

2.3.1 The Health Believe Model

The study will be guided by Health Believe Model which was developed in the 1950s by a group of social psychologists and was aimed at identifying failure of people to participate in programs to decrease and prevent diseases. The model emphasizes the health behavior which is determined by personal perception and beliefs and also strategies available to decrease the occurrence of diseases. Personal perception is also influenced by a wide range of intra personal factors affecting behavior. This model provides guidelines for programs to be developed and addresses reasons for non-compliance. The model is important in health as it focuses on aspects that might influence implementation of nursing programs either positively or negatively (Glanz, Lewis and Rimer, 2003:3). According to Glanz et al (2003:34) the health model further focuses on factors like demographic issues and socio-psychological factors that influence preventive actions.

2.4 CHALLENGES IN THE IMPLEMENTATION OF INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES

This section will outline the factors which contribute to challenges faced by primary health care nurses in the implementation of the Integrated Management of Childhood Illnesses. The following factors impact negatively on the health care delivery system at a primary health care level and they includes lack of material resources such as medicines and equipments, lack human resources, political factors, economic factors, social factors, educational factors and lack of proper supervision. The South African health system was characterized by imbalances of the past apartheid regime were

even health care facilities were unfairly distributed. With the dawn of democracy, the government decided to put health at top priority in order to can provide health to all South Africans (South African Journal of Child Health, 2010:28) .

The department from national, provincial and local levels formulated policy guidelines to can run the health services in the public sector. Priorities were directed to women and children and improvement of service delivery to the previously disadvantaged groups. Major challenges have been scale up Integrate Management of Childhood Illnesses implementation to tackle the millions of preventable deaths of under-fives that occurs each year in poor countries and there by reach the fourth Millennium Development Goal of reducing these deaths by two thirds in 2015. The introduction and implementation of IMCI strategy in both pre service and continuing in-service has always been problematic as there are shortage of trainers, inadequate supply of training materials, poor follow-up and support and frequent attrition of trained staff. Other practical difficulties of IMCI training in Southern Africa includes family responsibilities of participants, releasing of staff for for-site training ,salary, travel and accommodation costs (South African Journal of Child Health,2010:28) . People resist change from fear of losing comfort of the familiar, no matter how inadequate it is (Booyens, 1998:438).

2.4.1 Lack of material resources

Material resources refers to aspects which include equipments, medications, stationery, physical resources like buildings, information technology systems, education and communication materials which are necessary for rendering quality child care services at the clinics. In a study conducted in Makuduthamaga municipality, Limpopo province the findings indicates that resources for rendering child health care are so limited in such a way that the care giver is not capable of providing support for children under the age five years. Children are referred to facilities like clinics and resources like information, education and communication materials beneficial in providing information are limited especially for rendering community Integrated Management of Childhood Illnesses. There are no community awarenesses

programs specially conducted that focus on children health (Maule &Lebese, 2011:280).

Implementation of Integrated Management of Childhood Illnesses needs material resources which include medicines, monitoring devices and medical equipment to simplify and fasten assessments in order to can make proper diagnosis and treatment of a child in need of care. Successful implementation of IMCI in the community depends on training and sustained supply of essential medications and medical equipments. In another study conducted in Vhembe district , the findings shows that there is lack of adequate rooms for consulting children as they also has right to privacy. The results further reveals that there is a challenge of shortage of medication necessary for effective implementation of Integrated Management of Childhood Illnesses Integrated Management of Childhood Illnesses (Vhuromu and Davhana-Maselesele, 2009:65).

Financial resources in health is still geared to the needs of minority thus most primary health care facilities especially in rural areas lacks funds to can purchase equipment adequate to can provide quality services (African National Conress,1994:32). The Integrated Management of Childhood Illnesses guidelines requires a primary health care nurse when assessing every child from malaria declared area to be able to test and exclude for malaria using a malaria kit and the child to be weighed with a baby scale. All the procedures become difficult with inadequate funding to can purchase proper material resources like medical equipments to can manage the child comprehensively (WHO and UNICEF, 2002b:56).

2.4.2 Lack of human resources

This refers to manpower needed to implement the programs which basically focus on trained Integrated Management of Childhood Illnesses primary health care nurses providing quality health services. Adequate staffing if considered is seen as a way of enabling nurses to can implement health interventions and health programs effectively .Improved interpersonal relationships amongst staff also allows for more open discussion and

exploration of feelings which contributes to increased productivity (African National Congress 1994:78).

Comprehensive assessment of a child using Integrated Management of Childhood Illnesses approach is more time consuming and thus require more nurses if it is to be done according to the outlined as in the guidelines. In those disadvantaged areas before standards democracy, clinics were under staffed with almost two professional nurses running the clinic at a 24 hour basis. Shortage of staff was accompanied by shortage of material and financial resources that aggravated increased mortality and morbidity rate which was more prevalent in children. The government then initiated strategies to redress the challenges of the past but this advanced strategies fell in the health care delivery system which is undergoing transformation in all angles .Although South Africa having large number of skilled health workers much of their training is inappropriate and they are poorly distributed in relation to health and health care needs (African National Congress 1994:79).

A number of prominent problems in human resource development include the emigration of highly trained personnel and insufficient personnel to with necessary training or skills to manage change in accordance with the primary health care approach. The transformation of the health system thus requires reorientation of existing personnel and in-service training and acquisition of new skills to can lay a more effective role in promoting, maintaining and restoring health. There need to be development of new categories of health personnel to support the aims of the National Health System which focus on serving the underserved communities. The policy of the National Health System focuses on the following:-Improvement in the planning system for evaluation of health personnel and their distribution, reviews of the numbers and categories of health personnel required, establishment of data base for existing numbers and their distribution, the development and reestablishment of new programs and curricular for health personnel education (African National Congress, 1994:79).

The implementation of Integrated Management of Childhood Illnesses needs material resources to ease and hasten the assessment in order to make

proper diagnosis and treatment of the child effectively. Without necessary material resources it is difficult for primary health care nurses to implement Integrated Management of Childhood Illnesses Integrated Management of Childhood Illnesses strategy. The implementation of the Integrated Management of Childhood Illnesses needs adequate rooms where children can be assessed taking into account their right to privacy as outlined in the basic human rights (Vhuromu and Davhana-Maselesele, 2009:61).

2.4.3 Political factors

The post-apartheid government that came into power in 1994 in South Africa was faced with many challenges and one of those challenges was a transformation of highly fragmented health system in terms of design and legislation into equitable, comprehensive, and non-racial and integrated national health system that will in collaboration with other social systems, redress the social and economic injustice of the past (Young, Van Niekerk and Mogotlane, 2007:26).

According to Fullan (1992:76) the Political factors like misdistribution of resources inherited from the past political regime brought along the political will to improve the quality of life of all the people but the change process is still slow .Most comprehensive programs are politically influenced and hence lacks consistency since monitoring and evaluation is still lacking. Poorly thought implementation strategies, inadequate preparations are seen as based on political pressure for visible changes. Fullan (1992:76) again views this issue of political pressures as factors which brings about symbolic changes that are not real.

In the study conducted in Vhembe district, lack of political support is also an issue in the implementation of IMCI thus primary health care nurses must get support from stakeholders if IMCI is to be successful. The findings shows that politicians always respond negatively and went straight to media without investigating a case in situations where a primary health care nurse implementing such programs are convicted of wrong-doing and as such this encourages community to look down upon nurses and nursing as a whole (Vhuromu and Davhana-Maselesele,2009:67)

2.4.4 Economic factors

The laws and policies of the previous apartheid dispensation had negatively impacted on health of millions of mostly blacks of South Africa. Although the country has undergone dramatic change in socio-political transition in the past decade many distortions introduced in the former political dispensation continue to reproduce poverty and inequalities in health and health care status of the people of South Africa. Child health services and services of other vulnerable groups like pregnant women continues to suffer because children in most health care settings are still assessed mixed with adults despite the call by the national norms and standards which expect children to be assessed in areas designated for them only (Van Rensburg, 2004:205).

Economic constraints existed which also prevent the democratic government from rectifying social and economic imbalances within a short space of time (Joubert and Ehrlich, 2007:57). According to African National Congress (1994:77), the long term goal is to ensure all citizen, including the unemployed are covered by the National Health Insurance system. Effective implementation of Integrated Management of Childhood Illnesses is reliant on a well-functioning health system Poor countries and regions are generally more likely to have poorly functioning health systems and therefore less successful in implementing Integrated Management of Childhood Illnesses. Efforts to improve Integrated Management of Childhood Illnesses should priorities strengthening of poorly functioning health system but health worker training has training costs as a barrier.

2.4.5 Social factors

As a new strategy Integrated Management of Childhood Illnesses Integrated Management of Childhood Illnesses was designed to serve the needs of all people of South Africa. Community involvement is crucial for effective service delivery and the Education and Training Unit for Democracy and Development includes the following factors: - Community involvement enhances better understanding of strategies and government plans, Enhances more efficient and better implementation through increased understanding and commitment The primary health care approach focus on community development, and is

based on full community participation in the planning, provision, and control and monitoring of services especially in rural areas and pre-deprived communities (African National Congress, 1994:19).

According to World Health Organization (1978:3) the people are said to have the right and duty to participate individually and collectively in the planning and implementation of their health care. The National Department of Health in its strategic plan for 2012/2013 focused on the decentralization of health services to the district and the formation of district specialized teams to ensure effective implementation of programs. Thus one of the most important reasons for introducing a district health system was to allow people to design and improve their services (Harrison, 1997:9).

Participatory health care through community involvement implies a two way process where community members can make contributions to health care system and thus on the other hand health services must reach the community by way of consulting stake holders on programs, launching of campaigns conducting information workshops and initiating community based care services Van Rensburg (2004:145). According to the White Paper for transformation of health services (National Department of Health, 1994:14) the objectives of restructuring health system included fostering of community awareness and participation across various aspects of planning implementation and provision of health care services.

2.4.6 Educational factors.

According to a study result on experiences of nurses who are implementing Integrated Management of Childhood Illnesses, the training is adequate but the period of training which is 11 days makes nurse not to acquire skill. Integrated Management of Childhood Illnesses is has shown to improve health but there are some constrains in achieving sufficient coverage.to improve child survival, give counseling. The strategy is conducted over a period of 11 days and the course combines both classroom and clinical practice and variety techniques are used, supported by comprehensive Integrated Management of Childhood Illnesses material and detailed instructions for facilitators. The training time is too short to can acquire both

knowledge and skills in all areas of IMCI and for effective implementation it needs follow up to can improve its implementation (Horwood, Vermaak, Rollins, Haskins, Nkosi and Quazi, 2009: 5)

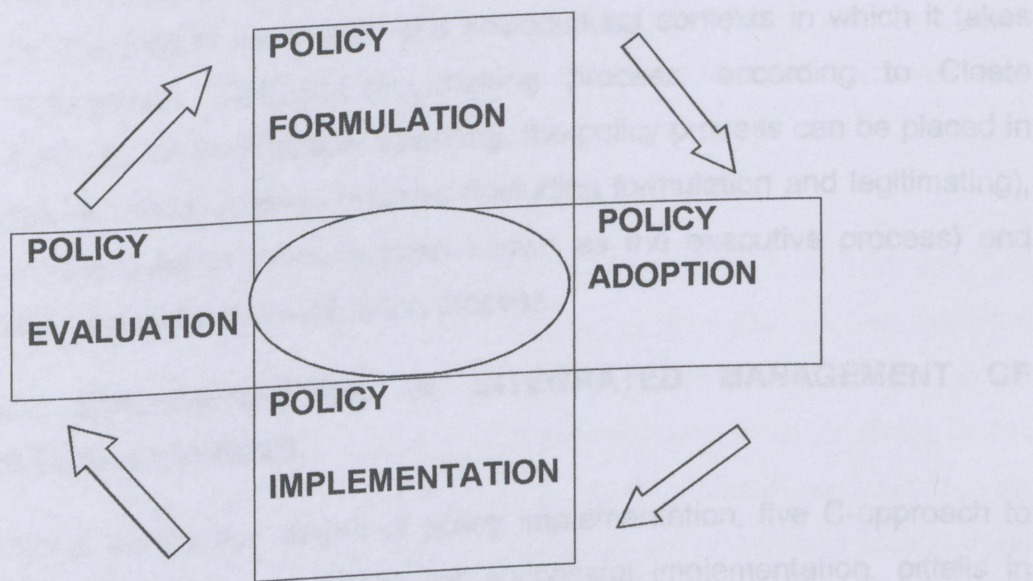
2.4.7 Lack of supervision.

According to Meyer, Naude, Shangase and Van Niekerk (2009:224), supervision is the process of directing, guiding and influencing the outcome of an individual's performance. There are two types of supervision which are direct supervision and indirect supervision. There is on-site supervision where the supervisor is physically present or immediately available while the individual performs an activity. The supervisor gives direction through various means, for example written, verbal, and through electronic communication. The unit manager must be available to ensure the unit objectives are met as supervision is a continuous process and supervision must be done focusing on the scope of practice of the nurse being supervised. The supervisor must possess integrity, good interpersonal skills, mutual respect and a sense of loyalty to ensure effectiveness of supervision. The main objective of supervision is to improve quality of patient care and to develop the nurses.

Supervision is important for proper implementation of programs and this also applies to implementation of the Integrated Management of Childhood Illnesses in the primary health care setting. According to research findings the supervisors who conduct training are equipped with knowledge which enables them to carry a systemic and supportive follow-up to observe case management, reinforce skills and solve problems associated with implementation and this is regarded as a support visit to IMCI trained nurses. According to results of studies conducted about implementation, supervision needs to be strengthened and a proper monitoring tool needs to be in place to check effectiveness of implementation. The findings also show that there is lack of supervision on issues related to Integrated Management of Childhood Illnesses and support by supervisors in most primary health settings and even if there it is very poor and this lowers productivity (Chaudhary, Mohanty and Sharma, 2005:737).

2.5 POLICY MAKING PROCESS IN INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES

The following is a schematic illustration of policy making process by McLennan (2003:10).



(Source: McLennan, 2003:10)

Various authors' analyses the policy making process in terms of the stages through which the policy issues pass. According to McLennan (2003:10), policy process starts with policy formulation, then policy adoption, policy implementation and finally policy evaluation. In policy making process implementation is the third step in the whole process and thus McLennan continues to argue that implementation occurs after policy adoption and that implementation is a complex and political phenomenon just as the policy formulation process. Failure in policy implementation is thus believed to be due to series of factors in the implementation process which has to be readjusted to keep implementation on track. Policy implementation is seen as the third stage in the policy making process.

The IMCI as a new policy document for the management of childhood illness in South Africa has to undergo various stages that a policy passes through

namely, policy formulation, policy adoption, policy implementation and evaluation and review. Policy implementation is also understood as part of the policy process which follows its adoption. This stage of the policy process is thus more relevant in this study as the main point of departure is the investigation of challenges faced by the Department of Health in the implementation of IMCI strategy. The approach adopted in the research is that policy implementation is both a political and an institutional process which is mediated by political, economic and sociocultural contexts in which it takes place (McLennan, 2003:9). Policy-making process, according to Cloete (1994:102), claims that broadly speaking, the policy process can be placed in three groups: Policy making process (including formulation and legitimating), policy implementation process (also known as the executive process) and lastly policy analysis and evaluation process.

2.6 POLICY IMPLEMENTATION IN INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES.

This section entails the stages of policy implementation, five C-approach to policy implementation, conditions for successful implementation, pitfalls in policy implementation and the core variables for effective implementation. The concept of implementation inevitably takes different shapes and forms in different cultures and institutional settings and this is important particularly in era where the process of government has been seen as being transformed into those of governance (Hill and Hupe, 2002:1).

In nursing, implementation is the doing phase which encompasses nursing intervention and rationale for doing that effective implementation of nursing care which leads to improved quality of patient care and stimulate the construction of theoretical and scientific based on best clinical practice ,aiming at collecting information to improve the nursing care currently provided. Implementation is the application of knowledge to perform interventions and involves the carrying out and documentation of planned nursing intervention (Berman and Snyder, 2012:181).

There are many challenges in policy implementation and the way in which policy implementation problems are perceived and what one might do about

them is dependent upon the perspective being used. In case of vertical perspective implementation means that authorized decisions at the top coincide with outcomes at the bottom. The assumption that much of the writing is based focus on the fact that policy process is best understood as the formulation of goals by policy makers, the selection of instruments to achieve them and the assessment of the outcomes. This reflects constitutional models of government and instrumental models of organization and that those elected are able to place their policies into action. In horizontal dimension implementation is an exercise in collective negotiation and the emphasis is on desired outcome to the process and the people through which it can be accomplished (Linder and Peters, 1987:465).

According to McLennan (2003:9) policy implementation is a complex and political process like policy formulation and thus policy failure in this view is a consequence of a multiple factors in the implementation system which requires to be renegotiated to keep the implementation in track. Thus in this study policy implementation is regarded as a political as well as an institutional process which is mediated by political, economic and sociocultural context. Implementation thus needs a wide range of organizational and individual skills and capabilities relating to leadership and change.

Authors such as De Coning (2004:183) and Hannekom (1987:60) distinguished three interdepartmental stages of policy implementation namely :- development of implementation guidelines which includes the priority in determining budget ,translation of executive policy into administrative policies which involves issues like human resources, work procedures, and organizational arrangements and lastly overseeing of implementation. This implies that for the IMCI approach to be effective such stages of policy implementation have to be considered by the health department. In this case McLennan (2003:10) continues to argue that implementation occurs after adoption of policy and that implementation is as complex and political as the policy formulation process and failure is believed to be due to a series of factors in the implementation process which have to be readjusted to keep implementation on track.

According to Dye (1995:311-312), implementation of a policy is seen as the continuation of politics by other means and thus does not end with the passing of the relevant drawing up of contracts laws. It involves activities designed to carry out the policies. Above all the activities include the creation of new organizations, departments, agencies or the assignment of new responsibilities to existing organizations. There must be hiring of personnel, , spending of money by performing activities.

Cloete (1994:108) further explains that policy implementation requires performance of full spectrum activities, consulting public administration, namely, generic administrative, auxiliary and instrumental activities as well as functional activities. According to Hannekom (1987:550), policy-making and policy implementation are two different concepts which are just interrelated of which separating them is very difficult if not impractical. Policies are not self-implementing; thus, they need public officials to implement and evaluate them and in this era, government has a responsibility to ensure policies are implemented effectively and efficiently.

Khosa (2003:49) notes in "Closing the gap between policy and implementation in South Africa," that, the discrepancies between policy and implementation are largely caused by unrealistic policies and a lack of managerial expertise. Another key finding is that policy implementation has suffered from the absence of people driven process. Insufficient coordination of policy implementation is cited in virtually all sectors, and has significantly hampered the implementation of policies. In addition, insufficient staffing and capability of all three spheres of government, as well as the linkages between them, have largely worked against the successful implementation of policies.

2.6.1 5-C approach to policy implementation

McLennan (2003:11) indicates that there is a **5-c approach** to policy implementation which includes the following:-

- **The content of the policy**

This refers to the fact whether the policy is distributive, regulatory or redistributive and this has impact on implementation. This is because policy

content defines the problem which has been identified, its solutions or goals and method of resolution.

- **Institutional context**

This is the context in which the policy implementation takes place which is also critical for its effectiveness. In health context this in the institutions where the policy will be put into action.

- **Commitment to policy**

This is more important in implementation due to the following reasons:-without commitment to all officials at various levels of the system implementation is likely not to take place and commitment is the glue that holds the other components of the model together in a complete web of processes.

- **The capacity of the system to implement the policy**

This refers to issues such as human, financial, material, technological, and other resources as well as levels of commitment and courage. Imbalances in material, human, financial and technological resources impact negatively on implementation of policies. All this has an impact on success of policy implementation.

- **Stakeholders in the form of clients**

This is in the form of clients or coalitions having a stake in the policy and its implementation and the also affects the policy outcomes. Must contain clear and consistent objectives or some criteria for resolving goal conflicts.

2.6.2 Conditions for successful policy implementation

Policy and its statues The policy accurately identifies principal factors and linkages leading to, and influencing policy outcomes, specification of target groups and incentives, Policy implementation is structured to maximize the probability of compliance from implementing agent and target groups. And this includes:-

Assignment of implementation responsibility to a capable and sympathetic agency, integrated implementation structures with minimum veto points and adequate incentives for compliance, supportive decision rules example appropriate authority and procedures, adequate financial resources, access to and participation of supporters, leaders and top managers possess substantial strategic management and political skills and are committed to policy objectives, the policy receives ongoing support from constituency groups and key stakeholders within a neutral legal system as well as socio economic and political conditions are sufficiently supportive and stable for policy not to be undermined by changes in priority conflicts and resource availability for implementation (Kaul, 1997:15-16).

According to Hill and Hupe (2002:75), successful implementation requires compliance with statutes, directives and goals, achievement of specific success indicators, and improvement in the political climate around a program. Besides that success of policy also depends on two broad factors that are the local capacity and the will. The will reflect the implementers assessment of the value of a policy or appropriateness of the strategy.

2.6.3 Some pitfalls in policy implementation

The following are some pitfalls in policy implementation:- Lack of communication and coordination within various elements involved in the programme and thus for perfect implementation to be achieved it is necessary to have a completely unitary administrative system. Thus communication is very crucial in the coordination and implementation in general, tasks may be incorrectly specified in sequence, policy to be implemented based on theory of cause and effect, adequacy of time and availability of resources also hinders implementation a success, and poorly understood objectives (Hill and Hupe: 1997:220).

2.6.4 Core variables for effective implementation

According to Yapeng (2010:3) core variables for effective implementation includes the policy characteristics and the ambiguity of policy goals and objectives and policy content, the use of discretions and monitoring system

and perfect communication, good organizational control and monitoring system and perfect communications, policy instrument, including resources, incentives, legal authority and political, institutional, organizational and technical characteristics of policy content.

Some scholars argue that policy implementation theory could be based on democratic values and a democratic approach or bottom up orientation should be the central focus in future implementation research. A democratic approach to policy implementation would thus include participation in the policy process. The other limitation is an assumption that implementers understand a policy's intended message or that the failure to understand derives from policy content. Implementers' values, knowledge, understanding, or cognitive dimensions in policy implementation is largely neglected (Yapeng, 2010:3).

2.7 THE INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES

This section focus on the goals and objectives of Integrated Management of Childhood Illnesses, importance of implementation of Integrated Management of Childhood Illnesses, international approaches to the implementation of Integrated Management of Childhood Illnesses as well as adoption of Integrated Management of Childhood Illnesses strategy in South Africa.

Integrated Management of Childhood Illnesses is an integrated approach to child health which focuses on the well-being of the whole, aiming at reducing death, illness and disability, and to promote improved growth and development of children under five years of age. And includes both preventive and curative elements that are implemented by families and communities as well as health care facilities (World Health Organization 2010:1)

2.7.1 Background History of Integrated Management of Childhood Illness

The IMCI strategy was established by the World Health Organization (WHO) and the United Nation International Children's Fund (UNICEF) in the 1990s as an integrated approach combining both curative and preventive methods towards child care. At the global level, IMCI started to be implemented in 1995 when a small number of countries expressed interest in the strategy. The first

IMCI pretest was in Arusha in 1995 and the strategy was then spread to other developing countries where it was adopted in 1998. By December 2001, about 40 countries were at different stages of IMCI implementation. The guidelines recommend an 11 days case management training course for frontline health workers and IMCI indicators for monitoring and evaluation were also provided (Red Cross Works, 2003:3 and World Health Organization, 2002:1).

2.7.2 Goals and objectives of Integrated Management of Childhood Illnesses

The aims of IMCI includes ,reduction of infant mortality, reducing incidents and seriousness of illness and health problems that affects children and Improving growth and development during the first five years of life of a child.

2.7.3 Importance of implementing integrated management of childhood illnesses

According to World Health Organization (2007:2) the following are important benefits of implementing IMCI:-

2.7.3.1 Improvement of health worker skills.

This takes the form of health worker training in case management of sick children and case management require one to have well-defined set of knowledge and skills to assess sick children. Case management includes aspects like, assessment of a child by checking at the danger signs, classification of a child s illness using the classification chart provided, identification of specific treatment by developing integrated treatment plan and giving first dose drugs to the child, provision of practical treatment instruction including advising care taker how to give drugs and, identification of drugs or treatment or referral, and if child is due for immunization the child is given such immunizations.

2.7.3.2 Improvement of health system

The Integrated Management of Childhood Illnesses strategy requires strengthening of health system by ensuring availability of essential drugs and supplies, organization of hospital emergency area to support rapid evaluation and management of sick children, training of health worker in Emergency

Triage Assessment Treatment (ETAT), adherence to national policies for standard of care and availing job aide in critical areas.

2.7.3.3 Improving family and community practices.

This third component of IMCI addresses household and community as most of sick children die in the community. If communities and households are taught to observe positive practices many deaths could be prevented and this component is regarded as community Integrated Management of Childhood Illnesses. Community IMCI focuses mainly on the following aspects:-Growth promotion and development, disease prevention, home care management and care seeking and compliance.

According to a multi –country evaluation to evaluate the impact and cost effectiveness of Integrated Management of Childhood Illnesses strategy, the results supports planning and advocacy for child health by ministries of health in developing countries and by national and international partner development. The results indicated that Integrated Management of Childhood Illnesses improves the health worker performance and their quality care, IMCI can reduce under-five mortality and improve nutritional status if implemented in current care, IMCI is worth the investment, as it cost up to six times less per child if implemented correctly, child survival programs require more attention to activities that improve family and community behavior, the implementation of child survival interventions needs to be complemented by strengthened system support, a significant reduction in under-five mortality will not be attained unless large scaling coverage is achieved, strengthening care in hospitals for those children too sick to be treated in and out of the hospital and also helps in developing support mechanism within communities for preventing diseases for care of sick children ,and for getting children to clinics or hospital when need arise (World Health Organisation,2010:2).

2.8 ADOPTION AND IMPLEMENTATION OF INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES IN SOUTH AFRICA

In1994 the government implemented changes for free health services in children less than five years to reduce mortality rate amongst children.

Changes in the primary health care services were introduced when the government adopted the IMCI, which was identified as a national priority since it was adopted in 1997 and implemented in 1998 in various provinces in South Africa. The guidelines were developed by the World Health Organization (WHO) and the United International Children Fund (UNICEF). IMCI is different from the traditional way of caring for sick children and when IMCI is implemented into the district the prescribing patterns of children under five years was changed dramatically as newly trained IMCI practitioner implement the strategy (WHO,2003:16).

According to World Health Organization (1997:1), it was reported that the Republic of South Africa was also experiencing high mortality and morbidity rate amongst children younger than five years of age and thus presenting the country with serious challenge in the management of childhood illnesses. The strategy developed by WHO and UNICEF (2007:1) referred to as IMCI was then introduced in Sedibeng district in Gauteng province in 1998. IMCI was first launched in South Africa in 1998 and has become a compulsory approach to all health workers and has been incorporated into the basic training curriculum so that it is implemented by all health workers at all levels of care.

The IMCI was then seen as a new programme and was funded by WHO and UNICEF as part of third world country in order to combat infant and child mortality and morbidity rates in. The establishment of dedicated programs at national and provincial levels within the directorate of maternal and child health in 1995 was a huge advancement in South Africa. Programs were initiated to improve the delivery of services including baby-friendly hospitals and integrated nutrition programs South Africa adopted the IMCI approach in 1998 and the first training for professional nurses was conducted in Mpumalanga province on the same year with 24 representatives from different provinces (Maternal and Child Health News, 1991:1).

The department of health in South Africa has further defined key objectives to improve child health services in the objectives of the operational plan for the directorate: child and youth health which includes, to implement the national

programs of action for children in South Africa, to decrease the morbidity and mortality rates in infants and children under the age of five due to common childhood illnesses, maintaining and improving the health of children during their schooling years by developing raised school health guidelines and facilitating the provision of health care information for children in difficult circumstances by providing basic health care information guidelines of National Department of Health (World Health Organization, 2002:4).

The implementation of Integrated Management of childhood Illnesses in the Limpopo province included training of first group of nurses which was conducted for the first time in 1999 and in Vhembe district the first group were trained in 2001. The Department of Health and Social Development in South Africa furthermore strengthened IMCI training by even establishing posts at national, provincial and district level to coordinate, oversee the training and implementation of the adopted strategy.

2.9 INTERNATIONAL APPROACH TO IMPLEMENTATION OF INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES

This section will focus on the international implementation of the Integrated Management of childhood Illnesses strategy globally in developed countries like Brazil and also implementation of the strategy in the Sub-Saharan or African countries like Tanzania which are still developing.

Pneumonia, Malaria, diarrhea, measles and malnutrition cause more than 70% of the deaths of children fewer than five years, particularly in developing countries. Projections based on the 1996 analysis by Murray and Lopez (1996:7-9) shows that these conditions will continue to be major contributions to child deaths globally through the year 2020, unless significantly greater efforts are made to control them. Globally the Integrated Management of childhood Illnesses, a strategy initiated in 1995 at Arusha was spread to other developing countries.

2.9.1 The Implementation of IMCI Brazil

In Brazil common child health problems included respiratory diseases ,nutritional disturbances such as gaining insufficient weight ,anemia ,and obesity and thus students were evaluating those problems when assessing children using IMCI guidelines The results of studies on Integrated Management of childhood illnesses implementation in Brazil shows that care provided to children in Brazil has significantly improved especially to those who received care from IMCI trained health workers compared to those who are not trained on IMCI. The study also showed that IMCI also improves health worker performance in North East of Brazil (Amaral, Leite, Victoria and Cunha, 2005:141).

Example of change in the management of childhood illnesses was introduced in Brazil where IMCI was incorporated into the basic nursing education program throughout the country s nursing training institutions. In Brazil the IMCI was incorporated in 1997 and the IMCI guidelines integrated into the basic child health nursing curriculum where students learned basic concepts of child health promotion and management of common childhood illnesses, incorporating the strategies outlined in the IMCI program. Students in Brazil incorporated the guidelines in their clinical experiences in primary care services, schools, hospitals, day care centers and other community settings. Students also make use of home visits to assess the parent-child relationship and to evaluate the child and family (Amaral, Leite, Victoria and Cunha, 2005:142).

2.9.2. Implementation of IMCI in Tanzania

Of every 1 000 children born in Tanzania and Kenya 115 die before they reach their fifth birthday due to five major killer diseases , diarrhea, pneumonia, measles, malaria and malnutrition. All those diseases can be effectively managed at a primary health care facility like a clinic. To try and reduce deaths for the under-fives Tanzania adopted IMCI in 1998 .IMCI was integrated into the health system of Tanzania and all of the 114 district council has received training and by 2005 83% of district was at least trained. Exploration of IMCI implementation reveals a decrease in mortality rate of

under-fives but continues to be faced with some challenges (World Health Organization, 2003:14).

The findings reveals that both countries has made rolling progress out of IMCI strategy despite the fact that implementation which was inadequate due to low training profiles, failure of IMCI trained personnel implement IMCI protocols and barriers to access for community members .It was recommended that here need to be improved IMCI supervision and case management and also addressing of issues of understaffing. Shortage of essential drugs also aids in the ineffective implementation of the strategy. During planning meeting held in Tanzania in June 2002 members from various countries came together to share challenges and achievements in the implementation of change in the management of childhood illnesses and to prepare a monitoring and evaluation program (Armstrong, Schellenberg, Bryce, Savigny, Mbuya and Mgalula, 2004:1-16).

2.10 STRATEGIES WHICH CAN BE USED TO IMPROVE CHALLENGES IN THE IMPLEMENTATION OF INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES

According to Itah (2005:20) strategies are conceptualized as specific major actions or patterns for attainment of objectives .Strategies could also be seen as set s of actions plan mapped out to achieve specific objectives by guiding the behavior of participants towards the attainment of objectives. The following are strategies to improve implementation of

2.10.1 Strengthening quality service and human resource

Strengthening health systems is one of the three key elements of the IMCI strategy to ensure universal access to services of high quality. IMCI packages essential interventions and strengthens service delivery in primary care settings with a focus on conditions of significant public health importance. Common barriers to improving coverage, access, quality and demand for child health interventions include: gaps in capacity to coordinate and manage child health at national and subnational levels. The inadequate human resources and high staff turnover, including capacity-building for clinical skills is also

another factor contributing to poor service delivery (World Health Organisation & United Nation International Children's Fund, 2009: 1).

The quantity and distribution of skilled human resources remains an important challenge, with imbalances towards the private sector and urban areas. Difficulties remain in attracting and retaining qualified staff in the public health sector. The department must come with strategies to attract more nurses into the public sector to ensure all primary health clinics are well staffed. The strategy will minimise burnout experienced by primary health care nurses which contribute to poor service delivery in the primary health care institutions. The department's approach which focus on reengineering of primary health care services is seen as a mechanism based on improving health service delivery in the clinics as more nurses will be needed for the approach to be successful (National Department of Health Strategic Plan Document, 2012-2013:7).

Improving capacity of primary health care worker has shown that primary health nurses are the frontline in the implementation of public health programs and as such they need training to update their knowledge and skills. . Good progress has been associated with improving coverage of trained IMCI nurses because frequent personnel turn over in some areas at primary health care facilities remains a major challenge. Strategies to motivate nurses include making placement in remote areas as part of service agreements and providing incentives for working in remote areas (Kebede, 2007:2).

2.10.2 Integration of Integrated Management of childhood illnesses into the teaching curriculum

One of the strategies to improve IMCI implementation is through the introduction of a program in the training and education of nurses. Students learn best when content and methods are included in into the text of other relevant child and community health topics. Teaching and learning must focus on clinical practice through supervision. During community service of newly qualified nurses, the allocation to primary health care services needed to be

compulsory to can get more practical experience in IMCI skills which will improve its implementation (WHO, 2007:4).

2.10.3 Making Integrated Management of childhood illnesses as part of licensure examination for health staff

Another strategy in improving IMCI implementation is the collaboration with other professional bodies in some countries so that IMCI is included in licensure examinations. This will benefit the strategy by motivation students to completing training to learn more, understand and practice IMCI skills in order for them to be licenced. Another advantage is that it will ensure that newly qualified nurses will be more skilled to implement the program effectively (WHO, 2007:6).

2.10.4 Support by political leaders

Primary health care workers needs to get support from political office bearers so than implementation of introduced policies can be well communicated from the policy makers to implementers harmoniously. Policy makers at provincial and local levels must have support visits to can identify challenges experienced by implementations o policies so that they can intervene on early. The role of political office bearers must be for support and not fault finders and the positive attitude will then promote good working relationships. (Vhuromu and Davhana - Maselesele, 2009:67).

2.10.5 The use of s Computerised Adaptation and Training (ICAT)

This is a computerised IMCI training tool used during training and can be used to conduct computer based group classes for those who have their training with clinical practice and it allows them local updates of integrated management of childhood illness guidelines to can be added easily and modification of training material to suit local requirement. This strategy is more effective when dealing with majority of the workforce which are more technologically advice for example; audio-visual material and practice exercises are easily added. The advancement in technology in developing countries where computer is used necessitates the use of computerised training to enhance effectiveness on training and also implementation of

Integrated Management of Childhood Illnesses. The strategy was used effectively in Western Pacific Region in yielded good results (Rowe, 2008:5).

2.10.6 Improving follow-up and in-service training

The standard for Integrated Management of childhood Illnesses course recommend that training facilitators conduct follow-up visits with participants one month after training and this is mostly not effectively followed. The visits are intended to assess the IMCI nurse in the clinical area to reinforce and suggest measures to improve case management. The visits also give trainers a chance to identify barriers to implementation of IMCI and coming up with strategies to overcome them. Follow-up can be in the form of observation of nurse assessing patients, interviewing patients, reinforcing acquired, encouraging appropriate counselling. The visits are both supportive and focus on problem solving. Even though this has proven difficult to follow but he visits remains important to ensure nurses use IMCI approach effectively (World Health Organisation, 2008:7).

2.10.7 Leadership and governance

This strategy improves implementation because in all countries which has progress in Integrated Management of childhood Illnesses implementation, improving policy by policy makers has been the point of departure as this increase both geographical and financial access to essential child health interventions and services. Strong leadership on child survival is needed amongst the government and collaborating partners to improve implementation of child health programs towards achieving a universal coverage. Leadership and governance are also responsible for health financing system. Continued advocacy for IMCI is also seen as an integral part of the national leadership to can obtain increased resource allocation for the support of IMCI implementation (WHO and UNICEF, 2009:3).

2.11 CONCLUSION

The chapter discussed the legislations used in Integrated Management of Childhood Illness, the theoretical framework guiding the study, challenges facing primary health care nurses in the implementation of Integrated

Management Childhood Illnesses. The challenges discussed include lack of resources, political factors, economic factors, social factors, educational factors and lack of supervision. The chapter also focused on the implementation of Integrated Management of Childhood Illness, approaches to policy implementation, conditions for successful policy implementation, some pitfalls in policy implementation, and core variables for effective implementation. Goals of implementing IMCI and the importance were discussed. The chapter also highlighted the international approaches and the strategies to improve challenges of IMCI implementation.

3.2 RESEARCH DESIGN

According to Brink (2006:92), research design is the set of logical steps taken by researcher to answer the research problem. The research design is defined as a set of guidelines and instructions to be followed in addressing the research problem (Mouton, 2009:107). In this study the design to be followed by the researcher will be descriptive in nature.

Descriptive studies are defined as a way of discovering new meaning, describing what exist, determining the frequency with which something occurs and categorizing information (Burns and Grove, 2005:26). According to Botma, Greeff, Mulaudzi and Wright (2010:110) a descriptive design is a non-experimental design used if the researcher wants to describe the variable of interest as it naturally occurs. In this study the descriptive design was used because more information is needed about this phenomenon that is being studied as it occurs naturally. The design was also appropriate because the challenges in the implementation of Integrated Management of Childhood illnesses are a current problem in practice which may get answers by using a descriptive design.

3.3 RESEARCH METHODOLOGIES

According to McMillan and Schumacher (1993:45) research methodology refers to section where the researcher indicates the subjects, instruments and procedures used in the study. Research methodology refers to the rules and procedures that specify how the researcher must investigate what the researcher believes must be known (Botma, Greeff, Mulaudzi and Wright,

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter focused on the research design and methodologies that were followed when conducting this study. This section also outlined study area, population of the study, sample, sampling methods, sample size, data collection, data analysis and ethical considerations.

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2010:41). This study followed mixed methodologies that are quantitative and qualitative methodology in order to examine challenges faced by primary health care nurses in the implementation of IMCI.

Quantitative research refers to methodology where data is symbolized by numerical symbols (Rubin and Babbie, 1993:90). According to Brink (2006:10), a quantitative research is based on logical positivism behavior and focus on measurable human behavior. The quantitative research approach was used in this study because it used procedures and formal instruments and collects information under conditions of control.

Qualitative research method refers to methodology where data is produced in the form of words related to a specific phenomenon (Botma, Greef, Mulaudzi and Wright, 2010:182). Qualitative research refers to a broad range of research designs and methods used to study phenomena of social action and which we do not have an understanding (Brink, Van Der Walt and Rensburg, 2012:121). Qualitative approach was used in this study because the method enabled the researcher to explore meanings and get in-depth knowledge and understanding of human lived experiences.

3.4 The Study Area

Study area is the areas where the study was conducted and the criteria for choosing the study area or site were based on its accessibility and suitability (Neuman, 2000:198). Vhembe District is one of the five districts in Limpopo Province. The selected clinics under study are serviced by Thulamela Municipality and there are nine (9) fixed clinics namely: Thondo-Tshivhase, Vhufuli-Tshitereke, Gonden, William Eddie, Mukula, Sterkstroom, Makonde, Tshiombo and Damani.

3.5 Population of the Study

According to De Vos (2005:98), a population is defined as individuals who possess specific characteristics and set boundaries on the unit. A population is defined as a complete set of persons or subjects that have some common characteristics that is of interest to the researcher (Brink et al, 2012:216). The study population was all primary health care nurses who are working in the

nine selected clinics in the Vhembe District, Limpopo Province. All primary health care nurses working in both shifts were taken to be the study population. The total population was 140 primary health care nurses in the selected clinics.

3.6 Sample

A sample is part of a fraction of a whole or subset of a large set selected by the researcher to participate in the research study (Brink, 2006:124). A sample is also defined as a subset of the population that is selected to represent the population (Brink et al, 2012:217). In this study the sample group was primary health operational managers and primary health care nurses.

3.6.1 Sampling Method

The sampling method used in the study was the non-probability sampling and its sub type. The sub type which was used was purposive sampling method. This is also referred as the judgmental sampling or theoretical sampling. This technique is based on the judgment made by the researcher regarding subjects or objects that are typical or representative of the study population or who are knowledgeable or experts about the question at hand (Brink, 2006:133).

Purposive sampling method was used because the method allows the researcher to select a sample based on knowledge of the phenomenon at hand. In the study, the researcher sampled only those IMCI trained professional nurses based on the fact that they are knowledgeable as they are implementing the strategy on daily basis, and thus are regarded as having expert knowledge on the issue in question.

3.6.2 Sample Size

The sample size for this study was 5 primary health care operational managers and 45 primary healthcare nurses who are trained on Integrated Management of Childhood Illnesses, making a total of 50 respondents from the nine selected clinics in Vhembe District, Limpopo Province.

3.7 DATA COLLECTION

According to Mouton (2001:45), data collection focuses on gathering of information for a research project through a variety of data resources. Data collection is a process of collecting information during a research study (Brink et al, 2012:21). For the purpose of the study, the questionnaires and an interview as data collecting instruments were used.

A questionnaire is a data collecting instrument where the respondent answers questions printed on a document (Brink et al, 2012:154). A questionnaire is an instrument to collect data which may contain fixed or open ended questions which are answered by the respondents (Botma et al, 2010:134). Open ended questionnaires were used to collect data from the respondents. Questionnaires were hand distributed to respondents in various clinics by the researcher. The respondents were given time to complete the questionnaires individually. The completed questionnaires were then be collected for analysis.

An interview is a method of data collection where the interviewer obtains responses from a participant in a face to face encounter (Brink, 2010:157). According to Gay (1996:23), a typical qualitative interview is one session in which the researcher asks a series of questions. The interview was semi-structured in nature. There were open ended questions which were being asked to all respondents which were followed by probing questions based on the response of the participants. Each individual was then interviewed separately to allow participants to speak freely while the researcher was taking field notes. The researcher visited the respondents in their respective clinics and a scheduled appointment for the interview was secured. Data was collected until data saturation was achieved.

3.8 DATA ANALYSIS

Data analysis is defined as the breaking down of data and searching for codes and categories which are then reassembled to form themes (Leedy, 1997:108). Data analysis is also defined as a mechanism for reducing and organizing data to provide findings that require interpretation by the

researcher (Burns and Grove, 2003:479). There are two types of data analysis methods which will be used to analyze data.

Data collected through questionnaires was analyzed using the Statistical Package for Social Sciences (SPSS) which is regarded as a widely used package which is very useful for routine management and analysis of surveyed data (Allan and Skinner, 1991:245). The analysis was done after the questionnaires have been completed and data was then be analyzed and interpreted using frequency tables and percentages

The analysis of data collected through interviews was analyzed using thematic analysis and the analysis was done after the interviews were completed using Tesch's eight steps of data analysis which guided the development of main categories, categories and sub categories and direct quotes were extracted from transcriptions. The following were Tesch's eight steps of data analysis described by (Creswell 2009:204).

- Reading through transcriptions and writing ideas to get a sense of the whole interview.
- Starting with the most interesting and shortest interview, thinking about the underlying meaning of information while writing thoughts in the margins
- Making a list of all topics, similar topics clustered together and topics will be used to form columns that will be arranged in major and unique topics.
- Taking the list back to data, abbreviate the topics as codes, writing the codes next to the appropriate segment of the text, which will help the researcher to see whether new categories and codes emerged.
- Identifying the most descriptive wording for the topics and turn them into categories.
- Making abbreviations for each category and arrange the codes alphabetically.
- Making preliminary analysis by assembling the data material belonging to each category in one place and lastly
- Recording the existing data.

Field notes were also be analyzed to develop their relationship with the interviews and categories (Wilson, 1989:380).

3.9 ETHICAL CONSIDERATIONS

Ethics refers to the quality of research procedure with respect to their adherence to professional, social and legal aspects to research subjects (Polit and Hungler, 1996:64). According to Albertse (2007:16), ethics is defined as a set of moral principles that concerns human conditions. The researcher was well conversant with ethical principles of conducting research in human beings and this was adhered to in order to and was ensure by the following:-

3.9.1 Permission to conduct research

The researcher applied for permission to undertake the research. Permission was obtained from the Research Ethical Review Committee of the University of Venda for Science and Technology, Limpopo Provincial Ethical Research Committee, Vhembe district, from the area managers of the William Eddie local area and from clinic managers.

3.9.2 Informed consent

An informed consent refers to a situation where a participant voluntarily agrees to participate in a research study with full understanding of the study before the study begins (Botma at al 2010:213). According to (Burns & Grove, 2009:201) an informed consent entails that adequate information on the goal of the investigation ,procedures to be followed during the investigation, advantages, disadvantages to which respondents will be exposed as well as the credibility of the researcher, was explained to respondents before the participant gave a verbal consent. Respondents were legally and psychologically competent to give consent and were informed that they were at liberty to withdraw from the investigations at any time .In this study the respondents were requested to give a verbal consent before completing the questionnaire and engaging in an interview session.

3.9.3 Voluntary participation

Participants were allowed to withdraw from participating at any time if they feel they cannot continue without fear of being victimized. In the study, participation was voluntary and participants were informed before engaging in the study. There were no rewards for participating in the study. (Polit and Beck, 2008:176).

3.9.4 Confidentiality and anonymity

Respondents were reassured about confidentiality and anonymity as no real names were to be used instead codes were to be used. Confidentiality means that individuals' identity of subjects were not be linked to the information they have provided and will not be publicly divulged (Wood and Harb, 2002:273). Participation is voluntary and there were no payments for participating. Respondents are allowed to withdraw from the study if they so wish without any fear of intimidation.

3.9.5 Privacy

Participants' privacy was ensured throughout the study. According to Burns and Groove (2009: 173), participants have rights to determine the time, extent and general circumstances under which personal information will be shared or withheld from others. In this study, the right to privacy was maintained by making sure that data collected was handled by the researcher, supervisor and other people involved in the processes of the research.

3.10 CONCLUSION

This chapter highlighted the research design which is descriptive in nature, research methodologies which is both qualitative and quantitative, the study area, population of the study, sample, sampling method and sample size. The chapter also discussed the data collection methods, data analysis and ethical considerations followed in the study

CHAPTER 4

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

This chapter discussed data presentation, analysis and interpretation. The responses to the questionnaires items are presented graphically in tabular form and the responses to the interview items are presented in narrative form and are followed by a brief synthesis of the findings for the item and the detailed findings are discussed in chapter 5.

4.2 ANALYSIS OF DATA COLLECTED THROUGH QUESTIONNAIRE

In this section, the researcher presents the data collected through questionnaire.

4.2.1 Section A: Biographical Information of Respondents

In this section the researcher presents the biographical information of the respondents in this study. The information is presented in tabular form and followed by a synthesis of the findings.

Table 4.1 Gender of respondents

	Response	Frequencies	Percentage
1	Male	11	24%
2	Female	34	76%
	TOTAL	45	100%

Table 4.1 presents the biographical information of the respondents in terms of gender. A total of 45 respondents took part in this study, of the 45 respondents, 11 (24%) were males whereas 34 (76%) were females. All targeted 45 respondents managed to return the questionnaires, and all the questionnaires were analysed. There were more female respondents than male.

Table 4.2 Age of respondents

	Response	Frequencies	Percentage
1	21 – 30 years	03	7%
2	31 – 40 years	13	29
3	41 – 50 years	22	49%
4	51 – 60 Years	07	16%
5	61 and above	0	0%
	TOTAL	45	100%

Most of the respondents, 22 (49%) who took part in this study were aged between 41 and 50 years. Thirteen 13 (29%) of the respondents were aged between 31 and 40, and 7 (16%) were between 51 and 60 years. Few respondent at 03 (7%) were youth aged 21 to 30 years and there was no respondent from 61 and above who took part in the study. It can therefore be concluded that in this study, there has been a relatively better representation of the population in terms of age distribution of respondents.

Table 4.3 Highest professional qualification

	Response	Frequencies	Percentage
1	Diploma/Degree	27	60%
2	Post Basic Diploma/Honours	18	40%
3	Masters	0	0%
4	Doctoral Degree	0	0%
	TOTAL	45	100%

Most of the population at 27 (60%) who took part in this study were having a diploma, who at the same time formed an integral part of the study. Eighteen 18 (40%) of the respondents were having a post basic diploma/honours. For masters and doctoral degree there was no respondent. Majority of the respondent who took part in the study were having only a diploma, meaning that there is a need for people to enrol for honours, masters and doctoral degrees.

Table 4.4 Period of employment into the post

	Response	Frequencies	Percentage
1	2 to 4 Years	04	09%
2	5 to 9 Years	14	31%
3	10 to 19 Years	17	38%
4	20 to 29 Years	09	20%
5	30 to 39 Years	0	0%
6	40 Years and Above	01	2%
	TOTAL	45	100%

Table 4.4 indicated that majority of respondents in this study at 17 (38%) were having 10 to 19 years. 09 (20) of the respondents were having 20 to 29 years working experience, while 14 (31%) were having 5 to 9 years. Four 04 (9%) were having 2 to 4 years working experience, while on the other hand 01 (2%) of the respondents were from 40 years and above. There was no respondent who was having 30 to 39 working experience. Majority of respondents who took part in the study were having 10 to 19 years working experience.

Table 4.5 Period of implementing IMCI

	Response	Frequencies	Percentage
1	2 to 4 Years	18	40%
2	5 to 7 Years	17	38%
3	8 to 10 Years	06	13%
4	11 to 13 Years	04	9%
	TOTAL	45	100%

Table 4.5 indicated that majority of respondents in this study at 18 (40%) were having 2 to 4 years on implementing the Integrated Management of Childhood Illness (IMCI). 17 (38%) of the respondents were having 5 to 7 years of implementing IMCI, while 06 (13%) were having 8 to 10 years. Four 04 (9%) were having 11 to 13 years of implementing IMCI. Majority of respondents

who took part in the study were having 2 to 4 years on implementing the Integrated Management of Childhood Illness.

4.2.2 Section B: The implementation of Integrated Management of Childhood Illness

In this sub-section, data is analysed using graphical statistics which is further divided into three themes which arose from the survey questionnaire respondents. The three themes are challenges facing primary health care nurses in the Implementation of Integrated Management of Childhood Illness; the importance of implementing IMCI strategy in the clinics; and the strategies to improve IMCI implementation at the clinics.

4.2.2.1 Challenges facing primary health care nurses in the implementation of IMCI

This sub-section presents data regarding the challenges facing primary health care nurses in the Implementation of Integrated Management of Childhood Illness. The data is presented in the form of tables followed by brief interpretation.

Table 4.6 There is enough staff to implement IMCI in the clinics

	Response	Frequencies	Percentage
1	Strongly agree	03	7%
2	Agree	07	16%
3	Not sure	01	2%
4	Disagree	26	58%
5	Strongly disagree	04	18%
	TOTAL	45	100%

Twenty-six (58%) of the respondents disagreed with the idea that there is enough staff to implement IMCI in the clinics, 07 (16%) respondents agreed. On the other hand, 04 (18%) strongly disagreed and on 03 (7%) strongly agreed with that there is enough staff to implement IMCI in the clinics. One 01

(2%) respondent was not sure whether there is enough staff to implement IMCI in the clinics or not. The statistics shows that there is no enough staff to implement IMCI in the clinics. However, there is a need to ensure that the clinics must have enough staff to implement the IMCI, because of 30 (76%) respondents who revealed that the clinics does not have enough staff for the implementation of IMCI.

Table 4.7 There is enough equipment to use when implementing IMCI in the clinics

	Response	Frequencies	Percentage
1	Strongly agree	05	11%
2	Agree	17	38%
3	Not Sure	03	7%
4	Disagree	13	29%
5	Strongly disagree	07	16%
	TOTAL	45	100%

Table 4.7 indicated that many respondents at 17 (38%) agreed with the idea that there is enough equipment to use when implementing IMCI in the clinics, while 13 (29%) disagreed. Seven 07 (16%) of the respondents strongly disagreed with the statement while 05 (11%) strongly agreed that there is enough equipment to use when implementing IMCI in the clinics. Three 03 (7%) of the respondents revealed that they were not sure whether there is enough equipment to use when implementing IMCI in the clinics or not. Conclusion can be made that respondents in the study revealed that there is enough equipment to use when implementing IMCI in the clinics.

Table 4.8 PHC nurses get support from politicians when implementing IMCI

	Response	Frequencies	Percentage
1	Strongly agree	02	4%
2	Agree	11	24%
3	Not Sure	12	27%
4	Disagree	11	24%
5	Strongly disagree	09	20%
	TOTAL	45	100%

Nine 9 (20%) respondents strongly disagreed that PHC nurses get support from politicians when implementing IMCI whereas only two (4%) respondents strongly agreed. Eleven 11 (24%) respondents were having similar views as both agreed and disagreed equally that PHC nurses get support from politicians. 12 (27%) respondents were not sure whether PHC nurses get support from politicians. From the above statistics, the respondents 20 (44%) indicate that PHC nurses do not get support from politicians when implementing IMCI.

Table 4.9 The communities served by clinics are well informed about IMCI

	Response	Frequencies	Percentage
1	Strongly agree	2	4%
2	Agree	21	47%
3	Not Sure	09	20%
4	Disagree	09	20%
5	Strongly disagree	04	9%
	TOTAL	45	100%

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5	Strongly disagree	04	9%
	TOTAL	45	100%

Table 4.9 indicated that most of the respondents 21 (47%) agreed that the communities served by clinics are well informed about IMCI and only 09 (20%) disagreed. Two 02 (4%) of the respondents strongly agreed that the communities served by clinics are well informed about IMCI and four 04 (9%) strongly disagreed. Nine 09 (20%) of the respondents who participated in the study were not sure whether the communities served by clinics are well informed about IMCI or not. It can be concluded that of the 23 (51%) respondents, the statistics reveals that they agreed that the communities served by clinics are well informed about IMCI

Table 4.10 The period of IMCI training is adequate to equip PHC nurses

	Response	Frequencies	Percentage
1	Strongly agree	05	11%
2	Agree	17	38%
3	Not Sure	02	4%
4	Disagree	17	38%
5	Strongly disagree	04	9%
	TOTAL	45	100%

Five 05 (11%) of the respondents strongly agreed that the period of IMCI training is adequate to equip PHC nurses with enough skills whereas only four 04 (9%) strongly disagreed. Only two 02 (4%) of the respondents were not sure of the fact that the period of IMCI training is adequate to equip PHC nurses with enough skills. Seventeen 17 (38%) of the respondents revealed that they equally agreed and disagreed that the period of IMCI training is adequate to equip PHC nurses with enough skills. From the above statistics it can be concluded that the respondents of 22 (49%) shows that he period of IMCI training is adequate to equip PHC nurses with enough skills.

Table 4.11 The IMCI facilitators conduct follow-up visits for reinforcement of skills

	Response	Frequencies	Percentage
1	Strongly agree	1	2%
2	Agree	7	16%
3	Not Sure	3	7%
4	Disagree	17	38%
5	Strongly disagree	17	38%
	TOTAL	45	100%

Seventeen 17 (38%) of the respondents indicated that the IMCI facilitators do not conduct follow-up visits for reinforcement of skills compared to only seven 07 (16%) respondents who disagreed. Most respondents 17 (38%) reveals that the IMCI facilitators do not conduct follow-up visits for reinforcement of skills whereas only one 01 (2%) strongly agreed to that. There appears to be a need for facilitators to conduct follow-up visits because majority of respondents 34 (76%) reveals that the IMCI facilitators do not conduct follow-up visits for reinforcement of skills.

Table 4.12 There is adequate supervision by clinics management on IMCI

	Response	Frequencies	Percentage
1	Strongly agree	11	24%
2	Agree	17	38%
3	Not Sure	01	2%
4	Disagree	12	27%
5	Strongly disagree	04	9%
	TOTAL	45	100%

Tale 4.12 showed that seventeen 17 (38%) respondents, agreed with the fact that there is adequate supervision by clinics management on IMCI in contrast with twelve 12 (27%) of respondents who disagreed with that. Most respondent 11 (24%) strongly agreed that there is adequate supervision by clinics management on IMCI whereas only 04 (9%) strongly disagree. Very few respondents one 01 (2%) was not sure whether there is adequate supervision by clinics management on IMCI or not. Based on the statistics above it can be concluded respondents 28 (62%) agreed that there is adequate supervision by clinics management of IMCI.

4.2.2.2 The importance of implementing IMCI strategy in the clinics

This portion presented the importance of implementing IMCI strategy in the clinics. It also provides an understanding of the importance of implementing IMCI strategy in the clinics. The information in this section are presented in graphical and tabular forms and followed by a discussion of the findings.

Table 4.13 IMCI improves PHC nurses performance

	Response	Frequencies	Percentage
1	Strongly agree	18	40%
2	Agree	18	40%
3	Not Sure	03	7%
4	Disagree	05	11%
5	Strongly disagree	01	2%
	TOTAL	45	100%

Table 4.13 revealed that 18 (40%) of respondents agreed that IMCI improves PHC nurses performance and only five 05 (11%) disagreed to that. Respondent 18 (38%) also indicated that they strongly agreed IMCI improves PHC nurses performance compared to only 01 (2%) who strongly disagreed. Only 03(7%) were not sure if IMCI improves PHC nurses performance.

A conclusion can be made based on the statistics that 36 (80%) of respondents agreed that IMCI improves PHC nurses performance

Table 4.14 The implementation of IMCI reduces mortality in children

	Response	Frequencies	Percentage
1	Strongly agree	26	58%
2	Agree	17	38%
3	Not Sure	01	2%
4	Disagree	01	2%
5	Strongly disagree	0	0%
	TOTAL	45	100%

Seventeen 17 (38) respondents agreed that the implementation of IMCI reduces mortality in children but only 01 (2%) disagreed. Twenty six 26 (58%) of respondents strongly agreed that the implementation of IMCI reduces mortality in children whereas nobody disagreed with the idea .Only one 01 (2%) respondent was not sure if the implementation of IMCI reduces mortality in children or not. A conclusion can be made that 43 (96%) of respondents agreed implementation of IMCI reduces child mortality.

Table 4.15 IMCI improve community practices on child care

	Response	Frequencies	Percentage
1	Strongly agree	16	36%
2	Agree	22	49%
3	Not Sure	05	11%
4	Disagree	02	4%
5	Strongly disagree	0	0%
	TOTAL	45	100%

Table 4.15 indicate that many of respondents 22 (49%) agree that the implementation of IMCI reduces mortality in children in contrast with only two

02 (4%) of respondents who disagreed with the idea. Only 05 (11%) respondents were not sure whether the implementation of IMCI reduces mortality in children or not. On the other hand 16 (36%) respondents strongly agreed and no respondent strongly disagreed with the fact that the implementation of IMCI reduces mortality in children. Base on the above statistics it can be concluded that majority of respondents 38 (85%) agreed IMCI improves community practices on child care.

Table 4.16 The quality of care for children is improved by implementation of IMCI

	Response	Frequencies	Percentage
1	Strongly agree	23	51%
2	Agree	20	44%
3	Not Sure	01	2%
4	Disagree	01	2%
5	Strongly disagree	0	0%
	TOTAL	45	100%

IMCI but only 05 (11%) respondents agreed. Twenty three 23 (51%) Twenty 20 (44%) of respondents indicate that they agreed and only one 01 (2%) disagreed that the quality of care for children is improved by implementation of IMCI. Many respondents 23 (51%) indicate that they strongly agreed that the quality of care for children is improved by implementation of IMCI and no respondent strongly disagreed to that. Only one 01 (2%) respondent was not sure if the quality of care for children is improved by implementation of IMCI. It can therefore be concluded that 43 (96%) of respondents agreed that quality of care for children is improved by implementing IMCI.

4.2.2.3 The strategies to improve IMCI implementation at the clinics

This section provide a description of motivation which influences the performance of PHC nurses, and the information in this section are presented in graphical and tabular forms and followed by discussions.

Table 4.17 There is continuous in-service training for PHC nurses who implement IMCI

	Response	Frequencies	Percentage
1	Strongly agree	01	2%
2	Agree	05	11%
3	Not Sure	02	4%
4	Disagree	14	31%
5	Strongly disagree	23	51%
	TOTAL	45	100%

Table 4.17 reveals that 14 (31%) of the respondents disagreed with the idea that there is continuous in-service training for PHC nurses who implement IMCI but only 05 (11%) respondents agreed. Twenty three 23 (51%) respondents strongly disagreed that there is continuous in-service training for PHC nurses who implement IMCI, only one respondent strongly agreed to that. In conclusion it can be shown that 37 (82%) of respondents revealed that they disagreed that there is continuous in-service training for PHC nurses who implement IMCI

Table 4.18 The clinics are well equipped with skilled PHC nurses

	Response	Frequencies	Percentage
1	Strongly agree	13	29%
2	Agree	14	31%
3	Not Sure	03	7%
4	Disagree	11	24%
5	Strongly disagree	04	9%
	TOTAL	45	100%

Table 4.18 indicate that some of the respondents 14 (31%) agree the clinics are well equipped with skilled PHC nurses and only 11(24%) disagreed. Most of the respondents 13 (29%) also agreed strongly that the clinics are well equipped with skilled PHC nurses in contrast to only 04 (9%) who disagreed. Only very few respondents three 03 (7%) were not sure but majority of respondents 27 (60%) agree the clinics are well equipped with skilled PHC nurses. From the above statistics it can be concluded that majority of respondents 27 (60%) revealed that the clinics are well equipped with skilled PHC nurses to implement IMCI.

Table 4.19 IMCI has been integrated into nursing curriculum

	Response	Frequencies	Percentage
1	Strongly agree	15	33%
2	Agree	16	36%
3	Not Sure	11	24%
4	Disagree	02	4%
5	Strongly disagree	01	2%
	TOTAL	45	100%

Table 4.19 shows that 16 (36%) respondents agreed that IMCI has been integrated into nursing curriculum and only 02 (4%) disagreed. Fifteen 15

(33%) respondent strongly agreed indicating that IMCI has been integrated into nursing curriculum and only one 01 (2%) strongly disagreed to that. Eleven 11 (24%) were not sure whether IMCI has been integrated into nursing curriculum or not. It can be concluded that IMCI has been integrated into nursing curriculum because most respondents 31 (69%) agree.

Table 4.20 The use of technology in IMCI is practiced in the clinics

	Response	Frequencies	Percentage
1	Strongly agree	01	2%
2	Agree	05	11%
3	Not Sure	04	9%
4	Disagree	06	13%
5	Strongly disagree	28	62%
	TOTAL		100%

Table 4.20 indicate that 28 (62%) of the respondents strongly disagreed that the use of technology in IMCI is practiced in the clinics whereas only one 01 respondent (2%) strongly agreed to that. Six 06 (13%) disagreed and 05 (11%) agree that the use of technology in IMCI is practiced in the clinics. Only 04 (9%) of the respondents were not sure if the use of technology in IMCI is practiced in the clinics. The clinics must have technology in the form of computes in order to improve IMCI implementation because 34 (75%) respondents are suggestive of a conclusion that PCH nurses disagreed that the use of technology in IMCI is practiced in the clinics.

Table 4.21 IMCI forms part of licensure examinations in nursing staff

	Response	Frequencies	Percentage
1	Strongly agree	14	31%
2	Agree	17	38%
3	Not Sure	12	27%
4	Disagree	02	4%
5	Strongly disagree	0	0%
	TOTAL	45	100%

Seventeen 17 (38%) respondents agreed that IMCI forms part of licensure examinations in nursing staff and only two 02 (4%) of the respondents disagreed on that matter. The respondents who were not sure whether or not IMCI forms part of licensure examinations in nursing staff were 12 (27%). From the above statistics a conclusion can be drawn that majority of respondents 31 (69%) agreed that IMCI forms part of licensure examinations in nursing staff.

Table 4.22 There is adequate leadership on child health issues.

	Response	Frequencies	Percentage
1	Strongly agree	07	16%
2	Agree	10	22%
3	Not Sure	07	16%
4	Disagree	12	27%
5	Strongly disagree	09	20%
	TOTAL	45	100%

Table 2.22 reveals that 09 (20%) of respondents strongly disagreed that there is adequate leadership on child health issues and 07 (16%) strongly agreed. Twelve 12 (27%) respondent disagreed while ten 10 (22%) disagreed that there is adequate leadership on child health issues. Only seven 07 (16%) of

the respondents were not sure if there is adequate leadership on child health issues or not. Leadership on child health issues need to be improved because from the statistics it is revealed that twenty one 21 (47%) of the respondents disagreed that there is adequate leadership on child health issues in the clinics.

4.3 ANALYSIS OF DATA COLLECTED THROUGH INTERVIEW

This section entails the analysis of data which was collected through face to face interviews. Data analysis for the interviews were done using Tesch's eights steps of data analysis where themes, categories and sub-categories were developed.

4.3.1 Question 1: What are the challenges that you are facing as a primary health care nurses with regard to implementation of Integrated Management of Childhood Illnesses (IMCI)?

Respondent 1:

In this question the first respondent replied that there is shortage of medicines at the clinic and there is also shortage of staff to render Integrated Management of Childhood Illnesses. The respondent also said that there are complaints from the community that they are not given medicines during consultation at the clinic because Integrated Management of Childhood Illnesses approach does not give medicines for minor ailments. The respondent also replied that there is long time spent on attending to one child as IMCI takes about 45 minutes.

Respondent 2:

The second respondent replied that Integrated Management of Childhood Illnesses is time consuming and that patients are always complaining. The respondent also indicated that there is shortage of staff and shortage of cubicles to check paediatric patients. The respondent also indicated that there are no in-service trainings conducted for primary health care nurses who are implementing Integrated Management of Childhood Illness

Respondent 3:

The third respondent replied that there is shortage of staff at the clinic to implement Integrated Management of Childhood Illnesses and this is also followed by shortage of medicines for emergency dose. The clinic has shortage of cubicles to care for children and mostly the community complains when no medicines are given to children on consultation because they do not understand Integrated Management of Childhood Illnesses.

Respondent 4:

The respondent indicated that there are no follow-up visits at clinic on Integrated Management of Childhood Illnesses implementation by facilitators and that there is no in-service training conducted. The respondent also replied that there is no update on Integrated Management of Childhood Illnesses issues and no supervision by coordinators at district level.

Respondent 5:

The fifth respondent verbalised that there is no in-service training to update nurses in Integrated Management of Childhood Illnesses and that the staff is not adequate to implement IMCI. The respondent again replied that there is shortage of equipment's like scales for weighing children and that IMCI takes more time in attending to one patient.

4.3.2 Question 2: What is the importance of implementing Integrated Management of Childhood Illnesses (IMCI)?

Respondent 1:

The first respondent replied that Integrated Management of Childhood Illness helps nurses to assess and diagnose children correctly and that the child can be attended in all areas in one consultation.

Respondent 2:

The respondent indicated that Integrated Management of Childhood Illness lead nurses to correct diagnosis and that child is checked holistically and helps nurse to assess other problems not known by the client caregiver. The

respondent also replied that there is proper management of children and this is easy because there are guidelines to follow.

Respondent 3:

The respondent replied that children are assessed and diagnosed correctly and that the mother can also be given health education about what to do at home when taking care of the child.

Respondent 4:

The respondent replied that it is easy to treat a child using Integrated Management of Childhood Illness approach.

Respondent 5:

The respondent replied that the department want nurses to use Integrated Management of Childhood Illness to reduce deaths of children under five.

4.3.3 Question 3: What are the strategies which can be used to solve problems in the implementation of Integrated Management of Childhood Illnesses (IMCI)?

Respondent 1:

The first respondent indicated that there must be teaching of the community about Integrated Management of Childhood Illness with regard to medications and that the mother is also checked for other problems that the mother is having. There must be more nurses to implement Integrated Management of Childhood Illness at the clinics.

Respondent 2:

The respondent indicated that there must be enough staff and enough cubicles to assess children at clinics. The respondent also replied that all nurses must be trained on Integrated Management of Childhood Illness including the junior categories.

Respondent 3:

The respondent replied that more staff I needed at the clinic and that community awareness on Integrated Management of Childhood Illness strategy is needed. The respondent further replied that more supervision from the district level on child health issues is needed.

Respondent 4:

The respondent verbalises that in-service training is needed and that there must be improvement in coordination of Integrated Management of Childhood Illness from the district and provincially. The respondent further replied that there must be community awareness on issues related to Integrated Management of Childhood Illness.

Respondent 5:

The respondent replied that there must be more nurses at clinics to implement IMCI and that those nurses many years back must be given in-service training to update them on new IMCI issues. The respondent also replied that nurses at clinics must be given extra incentives for implementing Integrated Management of Childhood Illness because the clinics are too busy.

4.4 CONCLUSION

This chapter highlighted presentation, analysis and interpretation of data collected through questionnaires and interviews. Data which was collected through questionnaires was analysed and represented using frequency and percentage tables. Data which was collected through one to one interview was analysed using narrative form.

FINDINGS, RECOMMENDATIONS AND CONCLUSION

5.1 INTRODUCTION

The main purpose of the study was to investigate challenges facing primary health care nurses in the implementation of Integrated Management of Childhood Illness. The study followed both quantitative and qualitative *research methodology*. A qualitative questionnaire and a qualitative interview were used to collect data. Data was analysed and interpreted. This chapter will focus on the findings and also recommendations and conclusion based on the findings.

5.2 MAJOR FINDINGS OF THE STUDY

The major findings of the study arose from the three specific objectives of the study which are; to identify challenges facing primary health care nurses in the implementation of the Integrated Management of Childhood Illnesses; to describe the importance of implementation of Integrated Management of Childhood Illnesses strategy in the clinics; and to determine strategies to overcome challenges encountered in the implementation of the Integrated Management of Childhood Illnesses (IMCI) strategy. The respondents who participated by answering the questionnaire were 45 and those who answered the verbal interview were five.

5.2.1 Findings on the challenges facing primary health care nurses in the implementation of the Integrated Management of Childhood Illnesses

The first specific objective of the study sought to identify challenges facing primary health care nurses in the implementation of the Integrated Management of Childhood Illnesses and the researcher found out that majority of the respondents at 30 (76%) disagreed with the idea that there is enough staff to implement IMCI in the clinics, while few of the respondents agreed. The researcher found out that majority of the respondents at 22 (49%) agreed with the idea that there is enough equipment to use when implementing IMCI in the clinics. Majority of respondents 20 (40%) disagree that there is no support of PHC nurses by politicians and very few agreed on

that. The idea that community served by the clinics is well informed about IMCI has majority of respondents 23 (51%) agreeing on that than those who disagreed. Most of the respondents 22 (49%) agreed that period of IMCI training period is adequate but 21 (47%) disagreed. Majority of respondents 34 (76%) confirmed that there is no follow-up visits by IMCI facilitators and that supervision by clinic management is adequate as verbalised by 28 (62%) of the respondents.

The study found out that the challenges facing primary health care nurses in the implementation of the IMCI are; shortage of medicines for emergency dose at the clinic and there is also shortage of staff to render Integrated Management of Childhood Illnesses. The respondents also verbalised that there are complaints from the community that they are not given medicines during consultation at the clinic because Integrated Management of Childhood Illnesses approach does not give medicines for minor ailments and lack of knowledge by community to understand IMCI issues. The respondent also revealed that there is long time spent on attending to one child as IMCI takes about 45 minutes per child. The respondents also indicated that there is shortage of cubicles to check paediatric patients. The respondents also indicated that there are no in-service trainings and up-dates conducted for primary health care nurses who are implementing IMCI and there are no follow-up at clinics on IMCI implementation by IMCI facilitators. The respondents also highlighted that there are no supervision by coordinators at district level. Respondents in some clinics verbalised that there are shortage of equipment like scales to weigh children.

5.2.2 Findings on the importance of implementation of Integrated Management of Childhood Illnesses strategy in the clinics

The second objective aims at describing the importance of implementing IMCI in child care and the study identified that majority of respondents 36 (80%) support that IMCI improves primary health care performance and very few disagreed with the idea. The highest majority 43 (96%) confirms that implementation of IMCI reduces child mortality. Thirty eight 38 (85%) of the respondents also supported the fact that IMCI improves community practices

on child care and very few respondents of the respondent disagreed with the idea. Overall majority of the respondents 43 (95%) agreed that quality of children is improved by implementation of IMCI and only few disagreed.

The researcher also identified that respondents revealed that Integrated Management of Childhood Illness helps nurses to assess and diagnose children correctly and that the child can be attended in all areas in one consultation. The respondents further indicated that IMCI helps the nurse to assess other problems not known by the client caregiver and that there is proper management of children as utilisation of the approach makes it easy because there are guidelines to follow. The respondents further outlined that the mother can also be given health education about what to do at home when taking care of the child. The respondents also confirm that the department want nurses to use Integrated Management of Childhood Illness strategy in order to reduce deaths of children below five years of age.

5.2.3 Findings on the strategies to overcome challenges encountered in the implementation of the Integrated Management of Childhood Illnesses (IMCI) strategy

The third objective focus on determining strategies which can be used to overcome challenges encountered during implementation of IMCI. The researcher found out that majority of respondents 37 (87%) disagree with the idea that there is continuous in- service training on IMCI for PHC nurses who implement IMCI in contrast to very few respondents who agreed. Most of the respondents 27 (60%) agreed that clinics are well equipped with PHC nurses who has skills to implement IMCI and very few 15 (33%) disagreed to the idea. Apart from few respondents who disagreed that IMCI has been integrated into the nursing curriculum, most of the respondents 31 (69%) agreed that IMCI has been integrated into the nursing curriculum. The use of technology in IMCI at clinics has been disagreed upon by majority of the respondents 34 (75%) and only 6 (13%) agreed on that. Majority of respondents 31 (69%) agreed that IMCI forms part of licensure examination to nursing staff and very few respondents disagreed to the issue. Most of the respondents disagreed that there is adequate leadership on child health

issues in contrast with few respondents 17 (38%) who agreed that leadership on child health issues is adequate.

The study revealed that there must be teaching of the community about Integrated Management of Childhood Illness with regard to medications and that the mother is also checked for other problems that the mother is having. There must be more nurses to implement Integrated Management of Childhood Illness at the clinics and that those nurses who were trained many years back must be given in-service training to update them on new IMCI issues. The issue ensuring enough cubicles to assess children at clinics was also an area of concern for effective implementation of IMCI. The respondent also verbalised that all nurses must be trained on Integrated Management of Childhood Illness including the junior categories and that community awareness on Integrated Management of Childhood Illness strategy is needed. The respondent further indicated that more supervision from the district level on child health issues is needed. The respondent verbalises that in-service training is needed and that there must be improvement in coordination of Integrated Management of Childhood Illness from the district and provincially. The respondents also felt that nurses at clinics must be given extra incentives for implementing Integrated Management of Childhood Illness because the clinics are too busy.

5.3 RECOMMENDATIONS OF THE STUDY

The following are recommendations that are made based on the findings of the study:

5.3.1 Recommendations on the challenges facing primary health care nurses in the implementation of the Integrated Management of Childhood Illnesses

From the study it was identified that due to shortage of cubicles to assess children when implementing IMCI which pose a challenge to the PHC nurse, it is therefore recommended that the department improve the infrastructure in the clinics so that children can be seen in their designated areas not

combined with adults as outlined in the national norms and standards for child care.

The findings of the study revealed that there is shortage of staff which is also together with lengthy time for attending an individual child during consultation. The researcher therefore recommends that more staff is employed in the clinics PHC nurses to can be able to cope with the workload of implementing Integrated Management Childhood Illness.

Based on the findings of the study there is inadequate follow-up of PHC nurses who have been trained on IMCI and are implementing the strategy. The researcher therefore recommends that there be adequate facilitators who follow-up on IMCI implementation at clinics and offer support visits and mentoring. A child health directorate basically focusing on children issues to be established to strengthen child health services.

5.3.2 Recommendations on the importance of implementation of Integrated Management of Childhood Illnesses strategy in the clinics

The findings of the study shows that implementation of IMCI reduces deaths of children below the age of five years and the researcher recommends that IMCI training be expanded to all categories of nurses up to the level of home based care in the communities.

The study findings also reveals that the performance of PHC nurses has improved with the implementation of IMCI strategy in child care and the researcher recommend for compulsory quarterly inspections in clinics with the aim of motivating staff and awards given to best clinic .

5.3.3 Recommendations on the strategies to overcome challenges encountered in the implementation of the Integrated Management of Childhood Illnesses (IMCI) strategy

The findings of the study reveal that there is no in-service training to PHC nurses and even updates. The researcher recommends for a scheduled professional development plan for the year where such workshops are

conducted to keep PHC nurses abreast with latest development on Integrated Management of Childhood Illness and child health issues.

The findings of the study also shows lack of technological advancement in child health issues including IMCI, the researcher therefore recommend for supply of computers to the clinics to upgrade the current situation where there is no utilization of computers in IMCI at the clinics.

5.4 RECOMMENDATIONS FOR FUTURE STUDY

The study investigated challenges facing primary health care nurses in the implementation of integrated management of childhood illness. During the research process the researcher realized that the study did not explore on other areas with regards to factors affecting IMCI implementation. The findings may also prompt other researcher to explore more on IMCI issues. Based on the assessment of the researcher when conducting this study the researcher identified that there appears to be lack of interest amongst some PHC nurses with regard to child health issues and therefore this may prompt other researchers to explore more on attitudes of nurses towards child health programs at the clinics.

5.5 CONCLUSION

The study focused on challenges faced by primary health care nurses in implementation of integrated management of childhood illness at selected clinics in Vhembe district. The objectives of the study were to identify challenges facing primary health care nurses in the implementation of the Integrated Management of Childhood Illnesses, to describe the importance of implementation of Integrated Management of Childhood Illnesses strategy in the clinics and to determine strategies to overcome challenges encountered in the implementation of the Integrated Management of Childhood Illnesses (IMCI) strategy. Review of existing literature was done to obtain any available information on IMCI. Literature review covered the legal framework in South Africa, implementation of IMCI in other countries like Brazil and Tanzania. Literature reveals that factors like shortage of resource human and material resources, economic factors, educational factors, political factors impact

negatively on the in implementation of IMCI. Literature review also outlined that IMCI improves worker performance, reduce child mortality and improves community care on children.

The study was conducted using both qualitative and quantitative approaches where data was collected through two instruments. The data collecting instrument used was a structured questionnaire with two sections, namely biographic data and the implementation of IMCI part. Another data collecting instrument was a semi structured interview with several questions was respondents were expected to answer through a one to one encounter. The respondents were primary health care nurses working at various clinics in Vhembe district that were chosen based on that they are knowledgeable about IMCI. A sample of 50 respondents were selected purposively form a population of 140 primary health care nurses who were believed to possess information that was relevant to the study. From the findings of the study it was concluded that there is shortage of staff, lack of follow-up visit by facilitators, lack of adequate infrastructure, and lack of in-service training to PHC nurses implementing IMCI. The researcher managed to come up with recommendation for issues identified in the study and also recommendations for other future researchers who might wish to research on similar topic. The study complied with all ethical issues for research.

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November

[Faint, illegible text from a document, possibly a letter or report, with some visible words like 'Dear Sir', 'I am writing to you', and 'Yours faithfully']

UNIVERSITY OF VENDA

SCHOOL OF MANAGEMENT SCIENCES
OFFICE OF THE DEAN

7 May 2014

The District Executive Manager
Department of Health
VHEMBE DISTRICT MUNICIPALITY

Dear Sir/Madam


REQUEST FOR PERMISSION TO COLLECT INFORMATION FOR STUDIES (MASTER OF PUBLIC MANAGEMENT: MUTSHATSHI T.E (STUDENT NO.: 11606763).

The above matter refers.

We hereby wish to confirm that Mutshatshi T.E is a registered Master of Public Management student at the University of Venda. She is researching on the following topic: "Challenges facing primary healthcare nurses in the implementation of integrated management of childhood illness: A case study of selected clinics in Vhembe District, Limpopo Province, South Africa

In order for her to complete her studies, we request your hospital to provide her with the information that she might need for her study project. As an institution of higher learning, we believe that the research she is undertaking will yield the results that might also assist your hospital. We for this reason encourage your hospital to provide her with the necessary information that will be collected through structured questionnaire and interviews from your department. We undertake that whatever information will be provided to her will be solely used for her studies.

We hope that you will find this to be in order and therefore, anticipate your assistance.



Professor M.P. Khwashaba
Deputy Dean: School of Management Sciences



University of Venda

SCHOOL OF MANAGEMENT SCIENCES
PO BOX 340, VENDA CAMPUS, 0950,
LIMPOPO PROVINCE, SOUTH AFRICA
TEL: 053 942 8660 / 053 942 8760
FAX: 053 942 8760

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Ms TE Mutshatshi

Student No: 11606763

PROJECT TITLE: Challenges facing primary health care nurses in the implementation of integrated management of childhood illness: A case study of selected clinics in, Vhembe District, Limpopo Province, South Africa.

PROJECT NO: SMS/14/PDN/02/2803

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof MP Khwashaba	University of Venda	Supervisor
Mr E Mahole	University of Venda	Co-supervisor
Ms TE Mutshatshi	University of Venda	Investigator - Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: April 2014

Decision by Ethical Clearance Committee Granted

Signature of Chairperson of the Committee:

Name of the Chairperson of the Committee: Prof. G.E. Ekosse



University of Venda

PRIVATE BAG X5050, TSOHOYANDOU, 0950, LIMPOPO PROVINCE, SOUTH AFRICA
TELEPHONE (015) 962 8504/8484 /8313 FAX (015) 962 8439

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LIMPOPO

PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH: VHEMBE DISTRICT

Enquiries: Makhwanya T E

Contact details: 084 690 0606 or Makhwanyate@gmail.com or fax no 086 266 2117

Date: 23rd June 2014.

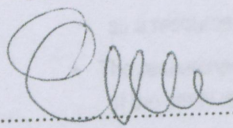
To: Sub-district Manager: PHC
William Eadie Local Area

RE: APPROVAL TO CONDUCT THE STUDY: MUTSHATSHI T E.

This is to confirm that the above-mentioned student has been accepted by the District to conduct the research study as approved by both the Ethics Committee of the University and the Department of Health (See attached approvals).

William Eadie Local Area PHC Facilities are hereby requested to give her the necessary support as the study is likely to benefit profoundly the District in terms of service delivery.

Thanking you in advance for your support.


.....
ACTING-DISTRICT EXECUTIVE MANAGER

23/6/2014
.....
DATE



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Latif Shamila

Ref:4/2/2

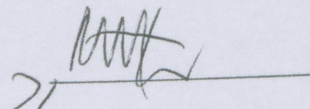
Mutshatshi TE
University of Venda
Private Bag X5050
Thohoyandho
0950

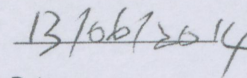
Greetings,

Re: Challenges facing primary health care nurses in the implementation of integrated management of childhood illnesses: A case study of selected clinics in, Vhembe District, Limpopo Province, South Africa.

1. The above matter refers.
2. Permission to conduct the above mentioned study is hereby granted.
3. Kindly be informed that:-
 - Further arrangement should be made with the targeted institutions.
 - In the course of your study there should be no action that disrupts the services.
 - After completion of the study, a copy should be submitted to the Department to serve as a resource.
 - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.

Your cooperation will be highly appreciated.


Head of Department


Date

18 College Street, Polokwane, 0700, Private Bag x9302, POLOLKWANE, 0700
Tel: (015) 293 6000, Fax: (015) 293 6211/20 Website: <http://www.limpopo.gov.za>

The heartland of Southern Africa – *development is about people*

ANNEXURE E

P.O.Box 409
VHUFULI
0971
08 March 2014

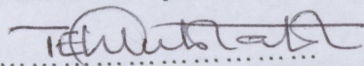
Dear Sir/Madam

I Mutshatshi Takalani Edith a registered student at the University of Venda doing Master of Public Management, conducting a study on: **'Challenges facing primary health care nurses in the implementation of Integrated Management of Childhood Illnesses'**

This is the opportunity for you to be part of the study and I therefore request for your permission to participate in the study.

Your cooperation will be highly appreciated.

Yours faithfully



Mutshatshi T.E (Mrs)

Student number: 11606763

Cell No: 083 689 0587

QUESTIONNAIRE

CHALLENGES FACING PRIMARY HEALTH CARE NURSES IN THE IMPLEMENTATION OF INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS.

INSTRUCTION: Indicate your answer by making a cross (X) in the appropriate space provided.

SECTION A: BIOGRAPHICAL DETAILS

1. Gender

Male		
Female		

2. Age

21 to 30 Years		
31 to 40 Years		
41 to 50 Years		
51 to 60 Years		
61 and above		

3. Highest professional qualification

Diploma /Degree		
Post basic diploma/Honours		
Masters		
Doctoral		

4. Period of employment into the post

2 to 4 Years		
5 to 9 Years		
10 to 19 Years		
20 to 29 Years		
30 to 39 Years		
40 Years and above		

5. Period of implementing Integrated Management of Childhood Illnesses (IMCI)

2 to 4 Years		
5 to 7 Years		
8 to 10 Years		
11 to 13 Years		

SECTION B: THE IMPLEMENTATION OF INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES

ITEMS	Challenges facing primary health care nurses in the implementation of Integrated Management of Childhood Illnesses	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
6	There is enough staff to implement IMCI in the clinics.					
7	There is enough equipments to use when implementing IMCI in the clinics.					
8	Primary health care nurses get support from politicians when implementing IMCI in the clinics.					
9	The community served by the clinic are well informed about the IMCI strategy.					
10	The period for IMCI training is adequate to equip primary health care nurses with skills to can implement IMCI.					
11	The IMCI facilitators conduct follow-up visits for reinforcement of skills.					
12	There is adequate supervision by clinic management on IMCI implementation.					

ITEMS	The importance of implementing IMCI strategy in the clinics	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
13	IMCI improves primary health nurse's performance.					
14	The implementation of IMCI reduces mortality in children less than five years.					
15	IMCI improve community practices on child care					
16	The quality of care for children is improved by the implementation of IMCI.					

ITEMS	Strategies to improve IMCI implementation at the clinics	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
17	There is continuous in-service training for primary health care nurse who implement IMCI.					
18	The clinics are well equipped with skilled primary health care nurses to implement IMCI.					
19	IMCI has been integrated into the nursing curriculum					
20	The use of technology in IMCI is practised in the clinics.					
21	IMCI forms part of licensure examinations in nursing staff.					
22	There is adequate leadership on child health issues.					

THANK YOU

INTERVIEW SCHEDULE

CHALLENGES FACING PRIMARY HEALTH CARE NURSES IN THE IMPLEMENTATION OF INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES.

1. What are the challenges that you are facing as a primary health care nurses with regard to implementation of Integrated Management of Childhood Illnesses (IMCI)?

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.....
.....
.....

2. What is the importance of implementing Integrated Management of Childhood Illnesses (IMCI)?

.....
.....
.....
.....

3. What are the strategies which can be used to solve problems in the implementation of Integrated Management of Childhood Illnesses (IMCI)?

.....
.....
.....
.....

THANK YOU