

**FACTORS INHIBITING IMPLEMENTATION OF INTEGRATED
MANAGEMENT OF CHILDHOOD ILLNESSES IN PRIMARY HEALTH
CARE FACILITIES IN MAFIKENG SUB-DISTRICT**

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DECLARATION

I, the undersigned declare that “**Factors Inhibiting the Implementation of Integrated Management of Childhood Illness (IMCI) in Primary Health Care(PHC) Facilities in Mafikeng**” is my original work and that all the sources I have used or cited have been indicated and acknowledged by means of complete references.

.....

Name and surname

Signature

Date

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ABSTRACT

Integrated Management of Childhood Illness (IMCI) is a worldwide strategy started by the World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF). The main objective for this IMCI strategy was to reduce child mortality and morbidity which are associated with major childhood illnesses IMCI offers a comprehensive health programme that is directed at the development needs of children under five year of age. This strategy also focuses on good nutrition, health promotion, immunization and preventive measures, the provision of counselling services to mothers or care givers and engenders an appropriate referral system for seriously ill children.

I had been evident that there is poor implementation and application of IMCI and training of professional nurses, to the management of child illness in PHC settings. There is anecdotal evidence based on the researcher's experience as a professional nurse and as clinical preceptor during student accompaniment has revealed that some children eventually die due to poor implementation of IMCI. Despite the training provided and the child booklet that PHC nurses refer to, they tend to diagnose rather than classify children according to the guideline, and furthermore, treatment is wrongly prescribed. When professional nurses attend to sick children, they only focus on the history provided by the mother or care giver other than applying all principles of IMCI as stipulated in the IMCI guidelines. The professional nurses focus on dealing with patients quickly and end up neglecting the IMCI guidelines. There is also a sense in which nurses' take for granted that they can treat sick children from their experience with similar cases, but the reality is that each patient presents a unique case.

The purpose of the study was to explore and describe factors inhibiting implementation of Integrated Management of Childhood Illness in PHC facilities in Mafikeng sub-district and make recommendations on how it can be effectively implemented.

A qualitative exploratory descriptive –contextual was used and the target population of this study was Professional registered nurses working in the community health centres and Primary health care facilities. The professional registered nurse was selected using a non-probability purposive sampling.

The inclusion criterion for the study was professional registered with South African Nursing Council who are trained on IMCI. The sample size was determined by saturation were 15 professional nurses participated and saturation was reached at participant 12. The researcher collected data using an in-depth individual semi structured interviews, USING an audio tape recorder and field notes. Then data transcribed to verbatim. Data was analysed using a software programme called Atlas TI. was used for qualitative analysis of large bodies of textual, audio, graphic and video data.

The researcher first noticed motifs in transcribed data while coding then make codes related to theme. Two phases of analysis were used which are the descriptive and conceptual levels of analysis. The results was discussed bases on following 4 themes and sub-themes: organisational and structural factors inhibiting IMCI implementation its sub themes are Time pressure factor, inadequate human resources, inadequate material resources, poor referral system and work related factors.

Education, training and awareness sub themes under this theme are lack of training/in-service training, lack of education, lack of updates. Behaviour and attitude of nurses towards IMCI

implementation its sub themes are behavioural and altitudinal factors. The last theme caregiver-related factors affecting IMCI implementation the following sub themes emerged, inability to provide adequate information, inaccessibility of facilities, uncooperative patients or clients and lack of care giver awareness. The limitations of the study were also discussed and recommendations were made for nursing practice, nursing education and nursing research.

The study revealed factors inhibiting implementation of IMCI based on themes and subthemes mentioned above. For IMCI to be implemented properly and efficiently, the following should be in place: adequate space for consultation, staffing, and adequate updated chart booklets. PHC facilities should be adequately provided with drugs. Professional nurses need effective support, mentoring and supervision throughout IMCI implementation by the MCWH coordinators. Supportive supervision reduces work-related stress and nurtures a positive attitude towards implementation of IMCI. There is a dire need to ensure capacity building of professional nurses with regard to IMCI. Caregivers and mothers need to know the importance of providing comprehensive child history to professional nurses and therefore they need to be encouraged to disclose all relevant information during IMCI process.

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LIST OF ACRONYMS

AIDS	: Acquired Immunodeficiency Syndrome
ATLAS.ti	: Computer Software used for Qualitative Analysis
CHC	: Community Health Centres
CoMMic	: Committee on Morbidity and Mortality in Children Under 5 Years
DOH	: Department of Health
DOHNCS	: Department of Health National Core Standards
HIV	: Human Immunodeficiency Virus
IMCI	: Integrated Management of Childhood Illness
MCWH	: Maternal, Child and Women's Health
MDG'S	: Millennium Development Goals
NaPeMMCo	: National Perinatal and Neonatal Morbidity and Mortality Committee
NTC	: Notice-Think-Collect
NWP	: North-West Province
ORS	: Oral Rehydration Solution
PHC	: Primary Health Care
SANC	: South African Nursing Council
SSS	: Sugar Salt Solution
UN	: United Nations
UNICEF	: United Nations Children's Fund
WHO	: World Health Organization

CHAPTER ONE

OVERVIEW OF THE STUDY

1.1 BACKGROUND AND RATIONALE

Integrated Management of Childhood Illness (IMCI) is a strategy which was started in 1992 by the World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF). IMCI has been, to date, implemented in more than 100 countries worldwide (WHO, 2007: ix). The main objective for formulating this IMCI strategy was to reduce child mortality and morbidity which are associated with major childhood illnesses. The global implementation of IMCI is coordinated and supported by WHO and UNICEF. IMCI offers a comprehensive health programme that is directed at the development needs of children under five year of age. This strategy also focuses on good nutrition, health promotion, immunization and preventive measures, the provision of counselling services to mothers or care givers and engenders an appropriate referral system for seriously ill children (Horwood, Voce, Vermaak, Rollins & Qazi, 2009b:2).

Child mortality is a worldwide concern, with more than 10 million children in low and middle income countries dying before their fifth birthday. This high mortality rate is due to the following conditions: malaria, pneumonia, diarrhoea, measles, malnutrition and HIV/AIDS (WHO, 2007: ix). The Millennium Development Goals (MDGs) were developed to improve life and MDG 4 aims at reducing the global child mortality rate by 2/3 by 2015 (United Nations (UN), 2000: np). The South African National Department of Health adopted a strategy of reaching this MDG 4 by introducing IMCI, which is aimed to alleviate this problem (WHO, 2007).

IMCI was introduced in Kenya in 1996 and then their first training towards the full implementation was in 2001 in their 4 major districts. Then between 2005 and 2006 the bulk of training took place and covered 16 districts of Kenya (Mullei *et al.*, 2008:16). Mullei *et al.* (2008:69) in their survey showed that there is a low level of IMCI implementation at the facility level in Kenya. IMCI was also adopted and introduced in Botswana in 1997, where health authorities trained Primary health care nurses, doctors and Pharmacists. At the end of this training, the participants were given booklets with all steps to be followed when managing sick children (Nkosi, Botshabelo, Jorosi, Makole, Nkomo & Ruele, 2012:92). Health authorities further identified that Primary health care nurses implemented some of the IMCI guidelines but assessment portions were incomplete and some children who needed urgent referrals had not been referred (Nkosi *et al.*, 2012:100).

In 1997 IMCI was introduced in South Africa and one mission of the Department of Health is that the health care services should be accessible, affordable, and available and there should be equity in the provision of health care services. IMCI strategy addresses the mission statement of the Department of Health that focuses on the provision of service to children. The mission avers that services to children should be available, accessible and affordable. Vhuromu and Davhana-Maselesele (2009:69) also identified that this strategy is cost effective when it is fully and correctly implemented. Horwood *et al.*, (2009c:5) identified that IMCI could improve quality of care for sick children and only an incomplete implementation of IMCI strategy fails to achieve maximum benefits recognised through child survival. Vhuromu and Davhana-Maselesele identified that Professional nurses were not adequately equipped with this skill.

Training and implementation of this IMCI strategy in North West Province was started in 1998. The IMCI strategy is meant for the first level facilities, which are Primary Health Care (PHC)

facilities. Generally, training for IMCI takes 2 weeks; it has the practical aspect and a flow chart to follow when attending to sick children. The updated IMCI guidelines include HIV/AIDS management of children (IMCI Guidelines, 2014:8). Even though IMCI training is offered to professional nurses and most of newly qualified nurses come trained from their nursing education institutions, IMCI implementation is still a major challenge in North West Province (South Africa). The opinions of professional nurse on IMCI implementation in SA are not explored and described. In addition, there are also few research studies that have been done on the implementation of this IMCI initiative, particularly focusing on exploring the opinions of nurses regarding IMCI implementation in the North West province. This study therefore seeks to fill the gap in the evaluation of how IMCI has been implemented by exploring and describing factors inhibiting IMCI implementation in Mafikeng, which is in the Ngaka Modiri Molema district of the North West province in South Africa.

1.2. PROBLEM STATEMENT

Professional nurses are trained on the proper implementation of IMCI. There is anecdotal evidence based on the researcher's experience as a professional nurse and as clinical preceptor during student accompaniment has revealed that some children eventually die due to poor implementation of IMCI. Despite the training provided and the child booklet that PHC nurses refer to, they tend to diagnose rather than classify children according to the guideline, and furthermore, treatment is wrongly prescribed. As far as IMCI is concerned, the researcher has identified omissions in the strategy such as Oral Rehydration Corner. In addition to the omissions identified, some clinics do not have the child booklets or these booklets are limited. When professional nurses attend to sick children, they only focus on the history provided by the mother or care giver other than applying all principles of IMCI as stipulated in the IMCI

guidelines. The professional nurses focus on dealing with patients quickly and end up neglecting the IMCI guidelines. There is also a sense in which nurses' take for granted that they can treat sick children from their experience with similar cases, but the reality is that each patient presents a unique case. Therefore the researcher found it important to explore and describe factors inhibiting successful implementation of IMCI in Mafikeng sub-district.

1.3 RESEARCH QUESTIONS

The following research questions emerged from the above introduction, background and problem statement:

- What are the factors inhibiting successful implementation of IMCI in PHC facilities in Mafikeng sub district?
- What strategies could be deployed such that IMCI strategy would be effectively implemented?

1.4 RESEARCH PURPOSE

The purpose of this study is to explore and describe factors inhibiting implementation of Integrated Management of Childhood Illnesses in PHC facilities in Mafikeng sub district and recommendations for effective implementation.

1.5 RESEARCH OBJECTIVES

This study seeks:

- To explore and describe factors inhibiting implementation of IMCI in PHC facilities Mafikeng sub-district.

- To classify and describe strategies how IMCI could be effectively implemented in PHC facilities in Mafikeng sub-district

1.6 DEFINITION OF CONCEPTS

1.6.1 Integrated Management of Childhood Illness (IMCI)

It is a major strategy for child survival, health, growth and development based on combined essential interventions at community level and health facilities level. Maleshane (2012:13) defines it as an integrated approach to child health that aims to reduce morbidity and mortality rates to promote improved growth and development of children under 5 years. In this study IMCI will be a strategy that professional nurses use to attend children under 5.

1.6.2 Professional Nurse

A person who is qualified and competent to independently practice comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice (Nursing Act No.33, 2005:34). In this study professional nurse will be one that works in the health care facilities with children, and one who follows the IMCI strategy.

1.6.3 Primary Registered health care

Hattingh, Dreyer and Roos (2013:70) define primary health care as essential health care which is made accessible to individuals and families in the community, through their full participation. Primary health care is also the first element in the continuing health care process.

1.7 SIGNIFICANCE OF THE STUDY

The researcher expects that the outcomes of this study might contribute in closing gaps in health care services and reduce child mortality and morbidity rate. It is anticipated that this study could assist the government of SA to improve child health care services for under-five children and assist in reaching the MDG 4. Outcomes of this study could assist training institutions to incorporate IMCI in the nursing curriculum. This is directed at facilitating the readiness of newly qualified nurses to implement IMCI fully. In-service nursing education on IMCI is anticipated to improve from the evaluations submitted in this study as the Department of Health could review this policy or strategy. The study strives also to stimulate further research on IMCI.

1.8 RESEARCH DESIGN AND METHODS

1.8.1 Research Design

Qualitative approach was used in this study to explore and describe factors inhibiting IMCI implementation. The explorative-descriptive and contextual designs were used in this study. Explorative researcher move from the unknown to known and descriptive researcher look for the in-depth details of professional nurse's opinions. And this study was conducted in the health care facilities in Mafikeng sub district and the researcher did not go beyond this area.

1.8.2 Research Setting

The research setting for this study was South Africa, North West Province, Ngaka Modiri Molema district in the Mafikeng sub-district. The researcher conducted the study at Primary health care facilities under this sub-district.

1.8.3 Population and Sampling

Population of this study included professional nurse working in health care facilities in Mafikeng sub-district. This sub district has 16 health facilities with 86 professional nurses. Purposive sampling was used to sample participants. All professional nurses registered with South African nursing council, working in Primary health care facilities and who are IMCI trained were included in the study.

1.8.4 Data Collection

Data was collected using semi-structured individual interviews in order to reach the purpose of the study after appointments were made with the research participants before data was collected. On the appointment day, the purpose of the study was outlined to participants. The following questions guided the researcher:

- What are factors inhibiting the successful implementation of IMCI?
- How can IMCI be effectively implemented in Mafikeng?

The researcher used audio tape after permission was granted by participants and field notes to record gestures and other observable information.

1.8.5 Data analysis

Data was transcribed verbatim, organised, prepared and arranged into different types then compared recorded and transcribed data to avoid omitting information (Creswell, 2009:185). Atlas TI was used to analyse data following the Notice-Collect-Think analysis where two phases of analysis were used which are the descriptive and conceptual levels of analysis.

1.8.6 Measures to Ensure Trustworthiness

The researcher followed and applied the following measures to ensure trustworthiness, namely, credibility, transferability, dependability, Conformability and transferability.

1.9 CHAPTER OUTLINE

Chapter One	Overview of the Study
Chapter two	Research Methods
Chapter three	Research Findings
Chapter Four	Discussion of Findings
Chapter Five	Limitations, Conclusion and Recommendations

1.10 SUMMARY

In this chapter the research topic was introduced as factors inhibiting implementation of IMCI in the Mafikeng sub district. The background and rationale, research questions, research purpose and research objectives were also outlined. The dominant concepts in this study were defined. Research design and method, which included population, sampling method, data collection data analysis and trustworthiness, were described as well as the ethical considerations. Chapters of this study were outlined. The next chapter, which is Chapter 2, focuses on details of the research design and methods.

CHAPTER TWO

RESEARCH METHODS

2.1 INTRODUCTION

In this chapter research methods that were used are discussed, including how data collection was done and analysed. Issues of trustworthiness and ethical consideration in this study also are discussed.

2.2. RESEARCH DESIGN

Research design is an overall plan for the study and this includes the order of activities, their duration and the purposes for which information was sought. Research designs are blueprint for conducting a study. Polit and Beck (2010:222) establish that research design encompasses basic strategies that a researcher utilises to answer a research question about the study. In this study, qualitative exploratory descriptive-contextual approach was followed.

2.2.1 Qualitative Approach

Qualitative approach is defined as an investigative approach that is used to answer a complex question or situation about phenomena which could be experiences, situations and behaviours (De Vos *et al.* 2011:64). Intentions in using a qualitative approach are to have an in-depth understanding of the research questions from the selected sample. Qualitative approaches intend to understand the phenomenon in depth rather than specific concepts and also to analyse a narrative data in an organized way (Brink, van der Walt & van Rensburg, 2013:11). In Grove *et al.* (2013: 705) qualitative research is defined as an approach that is systematic, interactive, subjective and it is used to describe life experiences and give a meaning of it .The investigation will be through the collection of rich narrative materials

2.2.2 Exploratory-Descriptive

The exploratory descriptive studies intend to address an issue, gain insight into a situation and also understand the nature of the phenomenon. This helps the researcher find a tentative solution to the problem under investigation (Grove, Burns & Gray, 2013:66). It is explained by Polit and Beck (2012:18) that exploratory research it's when the full nature of the phenomenon is investigated fully and the factors related to it. Descriptive research study it's an intense examination of the phenomena and its deep meaning that will lead to thicker description (De Vos et al., 2011:96) In this study the researcher explored and described factors inhibiting implementation of IMCI from the professional registered nurses, as they are the professional on the coal-face of implementing this strategy

2.2.3 Contextual

The context of this study was Mafikeng sub-district. It is in North West province in Ngaka Modiri Molema. Mafikeng sub-district has 4 community health centres (CHC) and 12 Primary health care (PHC) facilities. Most of these facilities are in rural areas with only few in urban areas. Participants were recruited from selected CHC and PHC facilities until data saturation was reached.

2.3 RESEARCH SETTING

Research setting refers to specific location where the study is conducted and there are three common settings for conducting research in nursing: natural, partially controlled and highly controlled (Grove *et al.*, 2013:373).

The research setting for this study is natural and it is in a real life situation therefore not controlled. The research setting was chosen by the participants and it was in a conducive and comfortable room with no disturbances. The setting was in health facilities in the Mafikeng sub-

district which is within Ngaka Modiri Molema district in North West province, South Africa. The sub district has 16 health facilities. The facilities are far apart with 4 CHC operating 24 hours 7 days a week and 12 PHC facilities which operate 24 hour 7 days a week and those which only operates five days a week for eight hours. The researcher went to different facilities of each of the categories, PHC (6) and CHC (3).

2.4. POPULATION

Grove *et al.* (2013:44), defines population as all individuals that meet an inclusion criterion for the study and the researcher needs to determine which population is easily accessible and that can be represented by the study sample.

The population of this study included all professional/registered nurses in Mafikeng sub-district. The target population was all professional nurses in the CHC and PHC facilities. Accessible ones were those who were on day duty. A sample is a subgroup of the population that is selected for the study (Grove *et al.*, 2013:44).

2.5 Sampling

Sampling is the process of selecting a subgroup of people with which to conduct a study and this can either be a probability or non-probability sampling.

Non-probability, purposive sampling approach was used in this study to select participants meeting the inclusion criteria because the researcher found it more convenient. Purposive sampling is a sampling that is based on a judgment of a researcher regarding participants who are knowledgeable about the phenomenon (Brink *et al.*, 2013:141). Purposive sampling one of its general goals is to find examples that represent a group on some dimensions of interest (Polit *et al.*, 2012:517). The nature of qualitative study requires a sample from the population with first-hand knowledge and experience in implementing IMCI strategy. The researcher did not

know in advance how many participants were needed for the study as the sample size was determined by data saturation. In this study professional/registered nurses working in CHC and PHC facilities who are knowledgeable about IMCI were purposively selected.

2.5.1 Sampling criteria

Sampling criteria includes a list of important aspects for a participant to be included in the study and justification of this selection from the entire population. Polit *et al.*; (2012:519) defines sampling criteria as selecting cases that meet the predetermined criteria of the study.

The researcher was guided by the inclusion criteria to select the sample for the study which are characteristics of the participants that made them a part of the study.

Inclusion criteria in this research entailed that a participant had to be:

- Professional nurse registered with South African Nursing Council (SANC),
- Working in CHC or PHC facilities,
- IMCI trained, and
- Professional nurses who voluntarily wished to participate

Professional nurses who are not IMCI trained and working at the hospital were excluded from the study

2.5.2 Sample size

Sample size of the study was determined by data saturation where the researcher was no longer getting new information from any anticipated or additional sample. Data saturation is reached where the researcher is no longer getting new information during data collection (Polit *et al.*,

2012:521). In this study, based on the purposive nature of the investigation, 15 professional nurses participated and data saturation was reached at participant 12.

2.6 DATA COLLECTION

The researcher was guided by the following important questions: What, How, Who, When and Where (Brink, 2012:147). Appointments were made with the research participants before data was collected. On the appointment day the purpose of the study was outlined to these participants.

Data was collected using semi-structured individual interviews in order to reach the purpose of the study. Interviews were done face-to-face, considering the fact that interview is an interaction between the researcher and the participant where questions are asked. It involves verbal communication whereby the participant provides information that the researcher seeks to track in a bid to provide answers to a specific research question (Grove *et al.*, 2009:403). An audio tape was used to record the voices and participants were made aware of its use. They also gave consent to have their views recorded. The issue of confidentiality was addressed and the duration was outlined before the interview started. Data was collected during working hours from 15 professional nurses. Questions were not asked right away, rather some rapport was built first as the nurses were made comfortable.

English language was used during interviews because the participants were fluent in English, understand and speak in English by virtue of their academic qualifications. The researcher and participants also used Setswana where there was a need for better expression because the researcher sought in-depth information from the participants. Data collection was done by the researcher in a setting selected by the research participants.

The following questions guided the researcher:

- What are factors inhibiting the successful implementation of IMCI?
- How can IMCI be effectively implemented in Mafikeng?

The interview session took between 30 minutes and an hour depending on the openness of each participant. During the interview session, interviewing skills such as probing, silence, clarification and paraphrasing and listening were intentionally used. Questions asked did not lead the participants towards specific nor pre-set notions. Other sources of data collection in qualitative research such as fields notes was used, where the behaviour of the participants and activities during interview were recorded (Creswell, 2009:181).

2.7 DATA ANALYSIS

Data analysis is a process of interpreting, reducing and giving meaning to data in order to gain understanding of the research issues (Grove *et al.*, 2013:279). In this study the researcher started by organizing and preparing data for analysis through listening to the audio tape, transcribing interviews verbatim, typing field notes and arranging data into different themes. Thereafter the researcher compared recoded and transcribed data to ensure that all information reflected what had transpired in the interviews (Creswell, 2009:185).

Then data was analysed using a software program called ATLAS.ti used for qualitative analysis of large bodies of textual, audio, graphic and video data. In this study the textual and audio data was analysed. ATLAS.ti helped to explore the complex phenomena hidden in the data collected. The basic data collection steps of notice-collect-think (NCT) were followed in this study (Friese, 2012:228). The researcher firstly noticed recurrent motifs in the transcribed data while coding then apportioned codes related to each theme. There are two phases of data analysis; the descriptive and conceptual levels of analysis.

2.7.1 PHASES OF ANALYSIS

2.7.1.1 Descriptive-level analysis

The main aim of descriptive level analysis was to explore the data, to read through the data and notice recurrent motifs and themes in the first stage (Friese, 2012:229). Descriptive level analysis has two stages which are:

- **First stage- coding**

This is where the researcher started listening to audio recordings, transcribing and reading through field notes. This stage ends when the researcher no longer notices new things.

- **Second stage-coding**

In the second stage of coding the researcher continued to code and validates the code list. This phase comes after initial coding has been done and it serves as to validate the code list (Friese, 2012:233).

2.7.1.2 Conceptual-level analysis

The researcher looked deeper at details and began to understand how it all fitted together. Categories and themes were developed. The researcher dug deeper into the codes and established details that contribute towards understanding the relationship of developed themes. (Friese, 2012:234).

2.8 TRUSTWORTHINESS

Qualitative validity ensures accuracy of findings and reliability refers to consistency throughout the study. In qualitative studies, trustworthiness is used to ensure data quality (Brink *et al.*, 2012:172). The researcher ensured trustworthiness by apply the following:

2.8.1 Credibility

The researcher built rapport with research participants to nurture good trust and amiable relationship with the participants. Appointments were set to ensure that the participants were available on the dates and times set. The researcher stayed long in the field until data saturation was reached and also sought peer review of the field data by colleagues and supervisor (Brink *et al.*, 2013:172).

2.8.2 Dependability

An enquiry audit provides evidence that if the study was to be repeated with the same or similar respondents in the same context, its findings would be similar (Babbie *et al.*, 2012:278). The findings of this study are dependable if it was to be repeated in another different context.

2.8.3 Conformability

The researcher ensured that the data of this study reflect the true information provided by participants and reflects the voice of the participants not of the researcher. This was ensured through triangulation to avoid researcher bias (Brink *et al.*, 2013:173). The researcher used a co-coder in the sorting of data.

2.8.4 Transferability

This refers to the extent to which the findings can be applied in other contexts (Babbie *et al.*, 2012:278). The findings of this study are applicable to health care. The findings of this study cannot be generalized even in the health sector because of the spatial extent and limitations of the scope of this investigation.

2.9 ETHICAL CONSIDERATIONS

The study was presented and approved at the Department of Nursing Science, School and Faculty Research committee. The ethical clearance was issued from the Ethics committee of the university. Then permission to conduct this study was issued from the Department of Health. The following principles were adhered to.

The principle of Privacy and Confidentiality: De Vos *et al.*, (2011:119) indicates that every person has a right to privacy and this privacy can be violated by hidden apparatus or equipment. Invasion of privacy is when participant's information is shared without the participant's knowledge (Grove *et al.*, 2013:170). In this study the participants were made aware of the audio tape and its use. Limit to others' access to information was adhered to; the audio tape was kept under lock. Only the researcher and the supervisor had access to it. Participants' views are anonymous and respondents' names are not divulged in this report; codes were used instead. The interviews were conducted in a private room and the participants were assured that whatever was discussed was kept confidential. Confidentiality is when the researcher manages the participant's private information.

Respect for person: The participants should be given a chance to choose what happens to them. The researcher respected the participants throughout the study, and no coercion was used. Their decision was respected if they wished to withdraw from the study (Brink *et al.*, 2013:35). No participant withdraw from this study.

Principle of beneficence: The researcher ensured the wellbeing of the participants throughout the study (Brink *et al.*, 2013:35). During interview no uncomfortable questions were asked, and they were made aware of questions to be asked.

Informed consent: The information sheet was provided and read by the participants, that their participation in the study was entirely voluntary (Brink *et al.*, 2013:39). And the process of the

study was outlined to the participants. The participants were informed that they could withdraw from the study at any time. It was clearly stated that there was no reimbursement for participation in this study. All the participants were given a consent form to sign to show that no coercion was used.

2.10 SUMMARY

This chapter described in detail the research methods chosen for this study, which includes the research design. Data collection and analysis was discussed in full. Trustworthiness and issues of ethical consideration were discussed. The following Chapter 3 discusses the findings of this study.

CHAPTER 3

DESCRIPTION OF FINDINGS

3.1 INTRODUCTION

The purpose of this study was to identify, explore and describe factors inhibiting implementation of IMCI in PHC facilities Mafikeng sub-district. The qualitative design provided the researcher with a greater understanding of nurses' perceptions regarding IMCI implementation that could potentially maximize their physical, emotional, and social impact in the healthcare facilities, rather than what could have been captured with standardized instruments. This chapter first presents a brief description of the participant demographics, followed by the findings of the study which are enriched and buttressed by direct quotations from participants.

3.2 PARTICIPANT DEMOGRAPHIC DATA

Participants included in this study were professional registered nurses (n=15) from the 9 research sites, and these were aged between 25-45 years. The majority of the participants were females (n=13) working in the primary health care facilities and trained on IMCI. The other two were males working at PHCs. Participants' level of qualifications ranged from Diploma (8) in nursing to a Bachelor's degree (7 inclusive of a Master's degree) in nursing. Their nursing experience ranged from 2years and 30years. They are all Setswana-speaking but interviews were in English which they understand.

3.3 RESEARCH FINDINGS

Factors inhibiting the implementation of IMCI in PHC facilities were revealed by nurses through semi-structured individual interviews and the following themes emerged: organizational and

structural factors inhibiting IMCI implementation; education, training and awareness; behaviour and attitude of nurses towards IMCI implementation; and caregiver-related factors towards IMCI implementation. Findings are herein supported with direct quotations from participants including field notes taken during data collection. The outline of themes and sub-themes are indicated in Table 3.1.

Factors inhibiting implementation of integrated management of childhood illness described by participants

Themes	Sub-themes
3.3.1 Organisational and structural factors inhibiting IMCI implementation	<ol style="list-style-type: none"> 1. Time pressure factor 2. Inadequate human resources 3. Inadequate material resources 4. Poor referral system 5. Work related Factors
3.3.2 Education, training and awareness	<ol style="list-style-type: none"> 1. Inadequate training/in-service training 2. Lack of education 3. Lack of updates on IMCI among nurses
3.3.3 Behaviour and attitude of nurses towards IMCI implementation	<ol style="list-style-type: none"> 1. Behavioural factors 2. Attitudinal factors
3.3.4 Caregiver-related factors affecting IMCI implementation	<ol style="list-style-type: none"> 1. Inability to provide adequate information 2. Inaccessibility of facilities 3. Uncooperative patients or clients 4. Lack of caregiver awareness

3.3.1 Theme 1: Organizational and Structural Factors Inhibiting IMCI Implementation

Nurses revealed that they experienced organizational and structural factors that inhibit IMCI implementation. These included the five sub-themes that emerged, namely: time pressure factor, lack of human resources and material resources, work related factors and poor referral system.

3.3.1.1. Time Pressure Factor

Difficulties in implementing IMCI was verbalized and indicated to be related to time. Implementation of IMCI was seen to be time consuming and nurses felt that there is not enough time to implement IMCI. Professional nurses further highlighted that they feel the pressure of implementing IMCI given the short time that they have and the number of patients they are supposed to see per day. Primary health care facilities have a relatively large number of patients seeking health care services and these high numbers result in long patient queues and all need to be assisted within the prescribed waiting time which further increases pressure on the nurses. This was evident in the following direct comments from participants:

“When implementing IMCI one needs you to page through the chart booklet, assess the child holistically and it is time consuming.”

Another nurse further emphasized that:

“The facility is also packed and we still have a lot of recording which takes time because we record on the forms and road to health card.”

It was also evident that nurses are faced with a large number of patients. Given this, it is clear that nurses do not have enough time; therefore less time is given to IMCI implementation in the PHC facilities.

“And the other challenge we face is the facility head count. Our facility head count for a day is more than 300, and within the 300 there are children included. So when seeing so many patients it doesn't give you enough time to implement IMCI. In addition we are using the supermarket approach whereby we see different patients with different needs or complaint. When a mother comes with a baby I won't give the baby time.”

4.3.1.2 Inadequate Human Resources

Nurses indicated that there is a huge shortage of workforce, thus professional nurses, in the PHC facilities find it difficult for them to implement IMCI because this increases the nurse-patient ratio. In many cases a professional nurse is alone in the facility and left with an operational manager that is just there doing the facility administration, so all the clinical work has to be dealt with by the only available professional nurses. This creates an unfavourable condition for the nurses and consequently there is poor implementation of IMCI. This was evidenced when a nurse verbalized that:

“You will be alone in the clinic because it’s only you a professional nurse and the manager; and the manager will be doing administration work. Hence you are going to spend a lot of time helping a patient and as our clinic is so busy sometimes we do fail to implement IMCI because of shortage of staff.”

Another nurse added

“Our clinic operates for 7 days like every day the clinic is open and we are only two sisters and the manager so sometimes the other sister is not on duty.”

This shortage of staff leads professional nurses who are always in the facilities to become overburdened with the work load to the extent that they only focus on pushing numbers or rather just routinely serving the patients. Nurses indicated that

“Due to the shortage of nurses we experience we end up feeling exhausted and not needing anything but we just want to knockoff and go rest.”

Another nurse emphasized:

“Being the only sister in the facility is what becomes a burden to us and prevent us from providing proper IMCI services.”

3.3.1.3 Inadequate Material Resources

Many health care facilities are facing challenges regarding shortage of material resources that makes IMCI implementation difficult to achieve. Shortage of material resources, such as shortage of consulting rooms, shortage of medication, unavailability and shortage of chart booklets, lack of computers and internet were evidently identified by nurses to be militating against proper IMCI implementation. There is also lack of proper recording forms and reports on IMCI because the present recording and reporting documentation seems not to cater for IMCI. Nurses felt that there is no point of assessing a child when they know exactly that the facility’s medication is out stock. This has a negative impact on the community that has also lost confidence in health care system or facility because they do not get full services when they need. It was clearly indicated by a nurse that:

“We face a challenge of unavailability of medication whereby the nurses become lazy to carry out the assessment of the child knowing that the medication is out of stock.”

Another one added

“It becomes a problem to assess a child knowing that medication is out of stock for IMCI in the facility.”

It was also further emphasized that some of the IMCI drugs are always unavailable within the facility and this on its own prevents proper implementation of IMCI. Hence nurses apparently choose not to use the chart booklet as most of the recommended drugs are not even in the facility. A nurse observed that:

“Something I’ve noticed on the IMICI booklet, they say we should give certain drugs for certain classification in the facility however these drugs are unavailable in the facility and it’s something that frightens me so at the end of the day I don’t use the chart booklet because there are no drugs available and there’s the one I am familiar with. However the point is treatment for IMCI is not always available in the facility.”

Lack of supplementary feeds was also identified as a challenge that affects the implementation of IMCI. Nurses indicated that they face a lot of malnourished children due to poor provision of supplementary feeds, a nurse verbalized that:

“Even for malnutrition we don’t have the supplementary feeds for example the Phelani, babies suffer and end up with severe malnutrition like kwashiorkor because of the shortage of supplementary feeds.”

Furthermore nurses indicated that there are not enough consultation rooms to assess patients. At some facilities, especially those that open 5 days a week, there are a lot of programmes in place and there is no space to attend to children. This situation compromises patient privacy, with the nurses consequently having to deal with two or more clients at the same time.

“Even the clinic structure at times we have to squeeze children into this room tomorrow in that room we cannot say we have a stable room.”

Another nurse added:

“Especially 5 day operating clinics we only have two consulting rooms. You would be seeing chronic patients, primary health care patients and IMCI too. There are not enough consulting room.”

It was also emphasized that:

“Then again given the number of consulting rooms even if nurses are there to work in our facilities, there are no consulting rooms because we can’t consult two patients in one consulting room, privacy is needed.”

There was an outcry by nurses regarding the difficulties they face while having to use old chart booklets because some of them do not have the revised version of the latest chart booklets. Even though nurses are aware of the availability of the chart booklets at the provincial offices, they cannot get them delivered due to logistical constraints. Chart booklets are not enough for the facilities and often 24 hour CHC facilities have only one chart booklet, and this makes it difficult for nurses to implement IMCI using one chart booklet. This also includes the assessment forms, where there are no facilities or equipment to print or photocopy the necessary assessment forms. A nurse revealed that:

“We are still using the old IMCI chart booklet while there is a new one that started somewhere last year, if not 2014 and I think we only know or heard about it but we’ve never seen it. We don’t have it, we using an old chart booklet.”

Another one added:

“And also provision of chart booklets, we will be using just one chart booklet the whole facility.”

The need for assessment forms was also verbalized:

“First challenge is the assessment forms. There are assessment forms we use to record child information, classify and treat the child and are also useful when we do follow-ups. You find that they are not available in the clinic. When you are supposed to make copies, there is no cartridge.”

Nurses stated that working conditions in the PHC facilities regarding lack of resources are getting worse. Salt and sugar was unavailable in the facility and this impact negatively on the Oral Rehydration (ORS) or Sugar-Salt Solution (SSS) corner which is severely compromised.

This is what nurses indicated:

“Eish! The working conditions are not good at all because there’s a shortage of resources; we do not even have sugar and salt to make ORS and it’s getting worse since last year. We tired of buying sugar and salt for the facilities, we had compromised it’s enough, the department should intervene.”

3.3.1.4 Poor Referral System

Referral system of children from PHC/CHC to hospital was revealed as one of the factors affecting IMCI implementation. Nurses indicated that they even go to an extent of using their own cars to take children to the hospital because they would have requested an ambulance and then wait in vain. On the other hand, children wait for a longer time to be taken to the hospital because the ambulance service is unreliable. This challenge demoralizes nurses in correct implementation of IMCI as their efforts end up not benefiting the child. This was said by one of the nurses:

“One other challenge is that the transport for the children delays and you are waiting with a seriously ill child. Sometimes we end up sacrificing [to drive] our cars taking them to then hospital. This in turn makes us demoralized and not to follow IMCI guidelines correctly with regard to implementation of IMCI, but send the child and the care giver straight to the hospital without any delays.”

3.3.1.5 Work-related Factors

Nurses who work in a 24 hours health care centre also highlighted experiencing long working hours. Nurses end up working overtime due to increased workload and this in its entirety can inhibit the proper implementation of IMCI, as nurses work incessantly until they knockoff. A nurse verbalised that:

“The knockoff time is a challenge whereby instead of knocking off at 16h00 you will be knocking off at 19h00 still finishing(Sic) [dealing with] patients and these prevent us from implementing IMCI correctly.”

Sometimes nurses do not really avoid implementing IMCI: they observe the number of patients remaining in the queues and start thinking about knockoff time hence they resort to pushing or helping the patients faster in order to finish before the knockoff time. However, in the process of doing this, it is the quality of health care provided that is negatively affected. A nurse verbalized that:

“Ok, other challenges are that we tend to look at the line and forgetting the quality of work, you will be the only nurse versus your workload here. I have to do ANC (Antenatal clinic), IMCI etc., so we tend not to implement it due to timeframe so you will be saying if I start with IMCI, what time am I going to finish with the next patient.”

Lack of support by programme coordinators was also identified as inhibiting the implementation of IMCI. Nurses stated that they are not supported, especially by programme coordinators and emphasized that when coordinators visit the facilities they only look for mistakes and never provide them with positive criticism. This was said to increase nurses' work related stress among those not supported. Nurses mentioned difficulty and not coping at all. They stated that

the workload is ever-increasing with many programmes that finally coerce them not implementing IMCI. It is evident when a nurse said:

“You can hardly see the programme coordinators coming for support visit. Mainly they will only come anytime and during their visit they will be looking for mistakes only. This normally happens when you are working alone in the consulting rooms and they never assist with patients so it’s very difficult on our side and we end up being stressed and not coping with the workload and this prevents us from proper implementation of IMCI.”

3.3.2. Theme 2: Education, Training and Awareness Regarding IMCI

Nurses revealed that for proper implementation of IMCI they need to be properly trained and updated on IMCI implementation. Nurses find it difficult to use the chart booklet if they are not trained or in-serviced and updated on IMCI implementation. The following subthemes were expressed in terms education, training and awareness regarding IMCI, namely: lack of in-service training, lack of education, lack of caregiver awareness and lack of updates on IMCI among nurses.

3.3.2.1 Inadequate Training /In-Service Training

Lack of training among professional nurses was identified as affecting the implementation of IMCI. The participants expressed that there is little if any in-service training for professional nurses who are working in the PHC/CHC which really affects the implementation of IMCI as practising nurses have a problem in properly implementing IMCI. One nurse stated that:

“Most of nurses are not IMCI trained in this facility. Some of them find it difficult using and reading the chart booklet. This affects the provision of IMCI in this facility.”

Another nurse added:

“Those nurses who are not trained in IMCI they’ve got a problem of implementing IMCI.”

3.3.2.2 Lack of education

Nurses detailed that most of them still lack skills and knowledge on how to assess and classify a child using IMCI approach. Some professional nurses are not exposed to clinical practice on IMCI in PHC facilities. Nurses felt that there is a strong need for IMCI clinical learning and education; and the need to increase the knowledge of nurses so that they can implement without difficulties. Clinical exposure is also vital as the majority of nurses are said to be theoretically knowledgeable but lacking in practical exposure. This is evident from a nurse who voiced the following:

“We are having a serious problem about implementation of IMCI, first and foremost the problem is that not all of us are trained that is the first problem. There are Professional nurses who are having the theoretical part of IMCI but they are not exposed to clinic set up.”

3.3.2.3 Lack of Caregiver Awareness

Nurses attested to the fact that there is not enough health education provided to caregivers and mothers in the community and this has a negative impact on the implementation of IMCI. They further felt that nurses need to provide proper health education that assists them to care for the children at home so as to decrease the influx at clinic with children coming for conditions that could be dealt with at home. A long-serving nurse indicated the following:

“We (Nurses) are failing to implement IMCI by not educating the mothers or caregivers on health matters.”

Another nurse emphasized that:

“If we can just try health educating them and enforcing health education provided on the chart booklet, it will be the best way of also reducing the influx in the facility due to conditions that will need home remedies.”

3.3.2.4 Lack of Update on IMCI among Nurses

It was clearly verbalized that nurses felt that they do not get updates with regard to IMCI implementation. It is possible for nurses to only see a new chart booklet in the facility without knowing that there is a new chart booklet. Some get information that there is a new chart booklet but they have never seen it and it is not available in their facility. Furthermore, the contents of the new chart booklets suggest that nurses are not updated. They find out for themselves when they go through the chart booklet and one nurse voiced that:

“MCHW (Maternal Child and Women’s Health) coordinator will just come and drop the chart booklets and then you will see what to do with the booklets and that’s it. And you will find that, hey! There is initiation of ART in this booklet. You will find it for yourself no one will tell you.”

Another nurse indicated the following:

“There are new changes on the guidelines; however people had been trained long time ago so things are changing now and again. I’ve seen they’ve brought a new chart booklet, the new child booklet for 2014 or so... the new one but we have been trained with the old one so what is added in[this] new one we don’t know.”

3.3.3. Theme 3: Behaviour and Attitude of Nurses towards IMCI Implementation

Nurses expressed different behaviours and attitudes towards IMCI implementation. These were described under behavioural factors and attitudinal factors inhibiting the implementation of IMCI.

3.3.3.1 Behavioural factors

Lack of interest towards IMCI implementation was identified as pervasive among nurses and it was evident that they had poor confidence with regard to assessing, classifying and treating a child. Given this they end up shifting responsibility, and projecting signs of laziness, some nurses would not bother if the chart booklet is not on their table to go and look for it. They will just do what they think it is right for the child at that point. Some do not use the chart booklet even if it is on their table. Ignorance was also revealed by nurses whereby a nurse will not monitor the weight of a child. This was indicated by one of the nurses:

“Some nurses likes shifting responsibility or maybe they are not having that self-confidence of treating children according to guideline of IMCI, which I think is straight forward.”

Another added that:

“Sometimes we overlook other things we don’t go according to the steps of IMCI maybe I will be concentrating only to the problem the baby was brought for in the clinic that specific day. To be honest I have never seen any nurse who is very serious with IMCI.”(sic)

Another nurse reported that:

“Most of the nurses are lazy to even follow the chart booklet if it is not in their consulting room. They won’t even refer to the chart booklet when treating the child. So regardless of the chart booklet nurses are just lazy and this impact negatively on the IMCI implementation.”

It was clear that some of these behaviours are attributed to other factors such as time and physical feelings. One nurse indicated that:

“I am not going to take out the chart booklet to manage the child correctly because I will be looking at the time and at the same time I am exhausted.”

3.3.3.2 Attitudinal Factors

Nurses displayed some negative attitude towards mothers and so did mothers towards nurses. These attitudes are said to be due to increased workload and long working hours and it was evident that they just attend to children for the sake of reaching a certain head count without following the IMCI strategy. Caregivers were also said to display negative attitudes towards professional nurses when they refer to the chart booklet because they feel that the professional nurses ask a lot of personal and seemingly irrelevant questions. A nurse elaborated that:

“Maybe I can say nurses needs to debrief maybe twice a year because for example we are working long shifts and when a child comes at around 4pm you are tired, then you are just going to assess the child normally and turn him/her back without implementing IMCI.”

Another nurse added that:

“Sometimes I will be reluctant to ask questions because if you ask the mother or caregiver questions in relation to IMCI booklet, the mother or caregiver will ask you

as to ‘why are you asking so much questions, am just asking for Panado (Paracetamol)?’

3.3.4 Theme 4: Caregiver-related factors affecting IMCI implementation

Most children are brought to the PHC facilities by their caregivers because mothers would have gone to school, work or other more pressing matters and left them under the care of a caregiver. Nurses indicated that it is difficult to implement IMCI because most of the time the caregiver provides inadequate information about the child’s history or illness. Inaccessible facilities also contribute because caregivers are unable to reach facilities due to the distance between their home and the facilities. Some of them do not have money for transport.

3.3.4.1 Inability to Provide Adequate Information

Caregivers are usually unable to provide nurses with relevant or proper history of the child’s illness. However, when mothers are requested to bring the child themselves for follow-up they do not come. Other factors are connected to language barriers, especially looking at caregivers who are not local citizens from neighbouring countries. A nurse indicated that:

“Akere according to the booklet we have to ask all those questions even if the child is not complaining about. The child is complaining of cough you will ask how long? Is there TB contact at home, then there will be a question on HIV/AIDS and there will be a problem there. She won’t want to answer that ever.”

Another nurse added that:

“One other challenge is the cross border clients, the issue of language because here in our clinic we see clients from Malawi. We don’t know their language so communication is a problem.”

One other nurse added that:

“You are managing childhood illness, when the parent or guardian doesn’t give appropriate information about the child you can end up mismanaging that child, yah.”

3.3.4.2 Inaccessibility of Facilities

Nurses also revealed that caregivers or mothers are unable to come to the facilities due to distance and sometimes they do not have money for transport which is really a stumbling block for IMCI implementation. A nurse suggested that:

“Children are brought by caregivers or mothers from very far community to this clinic and sometimes they cannot afford to be here because they do not have money for transport hence we do not blame them but the IMCI processes are affected.”

3.3.4.3 Uncooperative patients or clients

Nurses indicated that they deal with difficult patients or clients who do not understand the ways in which the PHC facilities run. Even when a professional nurse is not supposed to give antibiotics, a patient would demand them and while they are in the queue they also disturb the professional nurse by knocking on the door demanding to be attended to first. It was further indicated that when another patient takes longer in the consulting room, they think that the professional nurse is into a social conversation with that client and they make negative comments. This was elaborated upon by a nurse saying that:

“Our patient their problem is they don’t want to wait on the line, when you busy with another patient maybe you taking more than the normal time because you dealing with something problematic for example, they will be shouting at you saying bad

things about you 'that patient have been there for a long time.' They will be knocking on the door saying 'are you not done with that patient'."

Another nurse indicated that:

"Mostly patients don't like to tell you what [is] wrong with the child rather they come and prescribe 'no my child was having fever can I just have Panado' then when you try sit with them with that questionnaire of IMCI booklet they would be telling, you are wasting their time they have to get back to work and their child is getting restless. And say why not give Panado like previous sisters normally do. So they will be giving you attitude when you trying to implement."

3.4 SUMMARY

This chapter has provided a narrative description of research findings. The research findings here show four major themes. These themes and sub-themes were discussed in detail and supported with direct quotations from participants. The quotations are in italics in order to make them stand out. The next chapter focuses on a discussion, analysis and conceptualization of research findings.

CHAPTER 4

DISCUSSION OF FINDINGS

4.1 INTRODUCTION

This chapter provides the discussion of findings and literature control. The findings revealed factors inhibiting implementation of integrated management of childhood illness as submitted by nurses providing IMCI services in PHC and CHC facilities. The following factors are discussed, namely: organisational and structural factors inhibiting IMCI implementation; education, training and awareness; behaviour and attitudes of nurses towards IMCI implementation; and caregiver-related factors to deficient IMCI implementation.

4.2 CONCEPTUALISATION

Conceptualisation is process whereby data is labelled and categorised so that the presentation suggests thematic and conceptual coherence. It also identifies similarities and differences of perception over a particular research problem such that clarity is provided (De Vos *et al.*, 2011:30). This has been achieved by making inferences based on the data gathered in this study.

4.3 ORGANISATIONAL AND STRUCTURAL FACTORS INHIBITING IMCI IMPLEMENTATION

Organisational and structural factors were identified as inhibiting the successful implementation of IMCI through the following constraints: time pressure factor, inadequate human resources, inadequate material resources, poor referral system and work-related factors.

4.3.1 Time pressure factor

Time was identified as an enormous challenge because nurses need enough time to perform and execute IMCI strategy within the PHC/CHC facility. Difficulty in implementing IMCI due to time has been shown to be a constraining factor and furthermore IMCI in its entirety was said to be time consuming when professional nurses attend to sick children. This is so given the time taken by professional nurses to assess, classify, treat and provide health education to the mothers or caregivers. In this regard, professional nurses are faced with many patients to attend, not forgetting the recording needed thereof. Maleshane (2012:25) indicates that to manage a child comprehensively, a professional nurses requires enough time since they are also recording patient history in different records. It was also clearly elaborated by Adekanye and Odetola (2014:33) that professional nurses find it difficult to implement IMCI as it requires a lot of time. Furthermore, for better assessment, management of a sick child and caregiver counselling through the IMCI strategy calls for adequate time. This is also supported by Horwood *et al.* (2009b:2) who indicates that IMCI consultation time seems to be one of the major barriers for IMCI implementation thus contributing to improper IMCI implementation and some of the important aspects such as caregiver counselling end up being neglected. Hamid *et al.* (2013:189) indicates that mothers/caregivers become upset from overcrowding which makes them wait longer as IMCI consultation and examination is perceived as lengthy. This constraint results in perceived pressure placed on professional nurses who then skip other steps of IMCI such as counselling of caregivers or if this is done, the counselling is not professionally done. It was further indicated that caregivers are normally dissatisfied with long waiting and overcrowding. Consultation time of IMCI is always more given that the professional nurses are assessing the sick child thoroughly.

Long queues at PHC seem to be another factor hindering full IMCI implementation. This is true when professional nurses implement IMCI as this procedure takes more than 15 minutes, meanwhile there are other patients in the queue. Maleshane (2012:47) and Mugela (2010:3-6) indicated that paging through the chart booklets takes a lot of time, especially when a professional nurse is supposed to see many patients and the PHC is faced with shortage of staff. This puts professional nurses under immense pressure when they are now supposed to spend longer time with a child. It was further indicated that professional nurses highlighted that the HIV algorithms on IMCI is very detailed and it takes more time to record such patient history (Mugela, 2010:3-6). The implementation of IMCI takes more time compared to when the professional nurse is not using IMCI strategy in attending to a sick child (Mupara, 2013:82). However, this is in contrast with the South African national core standards domain 1, which intends to reduce delays in care and patient waiting period time. The standards here must be managed to make sure patients are satisfied (National core standards 2011:19). This undertaking has a serious impact on the quality of care provided, given also the lack of human and material resources.

4.3.2 Inadequate human resources

Lack of human resources poses a huge challenge in the implementation of IMCI. Proper and effective implementation of IMCI relies on the availability of adequate professional nurses who would intensively provide efficient IMCI services. It should be emphasized that health care professionals are important in health care service delivery and their work is intensive. Though the Department of Health has developed a workforce strategy plan with the purpose of retaining and increasing health care professionals, human resources for health, South Africa 2030 (2011:22) has shown that the number of professional nurses has aggravated the situation. This has been worsened by the closure of many nursing colleges countrywide, and resulted in

shortage of staff. Furthermore, professional nurse migration was also found to be a massive contributory factor to shortage of professional nurses.

The shortage of nurses affects the quality of service delivery due to the fact that short staffed nurses' experience increased workload which ultimately impacts negatively on the implementation of IMCI. According to Titaley, Ariawan and Weber (2014:164) this shortage of staff is a challenge and it leads to increased workload. Furthermore, Mugela *et.al* (2010:6) concur that shortage of staff in PHC facilities is a challenge that also contributes to sick children not receiving quality care. Kiplagat *et al.* (2014:6) highlights that shortage of nurses contributes to IMCI not being fully implemented due to the large number of children who need to be assessed. There is a need for an increase of nurses in different PHC/CHC facilities for IMCI to be properly implemented (Adekanye & Odetola, 2014:33). The number of staff is important as it reduces overcrowding of patients and long waiting periods (Hamid *et al.*, 2013:189). The need for increased nurses does go hand in glove with the availability of material resources.

4.3.3 Inadequate material resources

Implementation of IMCI requires the availability of a variety of resources such as infrastructure (consulting rooms); medication; recording and reporting forms; and chart booklets. All facilities should be well furnished with adequate consulting rooms in order to provide privacy and adequate space for IMCI assessment, treatment and caregivers counselling. Inadequate space also has an inhibitive impact on implementation of IMCI; it is a challenge for professional nurses when attending to sick children because of inadequate space. This leads to professional nurses sharing consultation rooms and privacy is consequently compromised. In small clinics, professional nurses cannot provide privacy to sick children and it is also a challenge pertaining to issues of HIV counselling and testing of children with HIV-related symptoms (Vhuromu &

Davhana-Maselesele, 2009:64). It is also clear in the patient's right charter that a patient has a right to privacy and confidentiality and this is also one of the national core standards.

Shortage and unavailability of medication in the PHC facilities has been identified as another factor inhibiting effective IMCI implementation. These demoralises professional nurses as they see no point in using IMCI chart booklets to assess, classify and treat the child when there are no appropriate drugs in the facility. According to the Department of Health national core standards (2011:26), clinical support services domain, medication should be available in all health care facilities. This domain further stipulates that there ought to be reliable delivery of medicine and assurance that stock levels are optimal. Maleshane (2012:40-46) indicates that IMCI uses specific medication stipulated in the chart booklet and most of the time these drugs are not available in the PHC/CHC facilities, and consequently children are then referred to a pharmacy. Vhuromu and Davhana-Maselesele (2009:65) concur that shortage of medication hampers the implementation of IMCI and patients become aware of this shortage. According to Adekanye and Odetola (2014:33) IMCI treatment in facilities is a challenge and shortage of drugs in particular make it very difficult for nurses to implement IMCI efficiently.

Furthermore the supermarket approach seems to be having an impact on the basics of immunisation where, whenever a child comes for immunisation, these must be immunised regardless. Hence, it had been viewed as a waste to open one vial of measles then later discard it whereas children can come on a specific day for immunisation and share that vial given the context of this study. Shortage of essential drugs for treating pneumonia, diarrhoea (Oral Rehydration Solution & Zinc Sulphate) and malaria have been detailed as a major challenge in IMCI implementation (Kiplagat *et al.*, 2014:10; Titaley *et al.*, 2014:165). It is of paramount importance that the material resources are put in place then adequate human resources would effectively implement IMCI.

Lack of access to assessment forms and chart booklets also has an effect on the implementation of IMCI. Thus professional nurses need to be able to access latest IMCI information, guidelines, recommendations and updates. Vhuromu and Davhana-Maselesele (2009:65) state that PHC facilities do not have computers where professional nurses could use these computers for IMCI computerized adaptation. Computers could also sharpen the professional nurses' skills for reference, recording and reporting. A software application in support of the implementation of WHO/UNICEF strategy (IMCI) was developed and these can facilitate relevant updates and there would not be any need for health care workers to leave the facilities and to go for training. And National core standards (2011:40) support that staff must have adequate IT hardware and that computerized systems must be functional and available.

The aim of chart booklet is to assist health care professionals when managing sick children. Kiplagat *et al.* (2014:7) states that adequate supply of updated chart booklets could improve implementation of IMCI. Professional nurses mentioned that they do not have the courage to use IMCI chart booklets as the only available one is out-dated (Pillay, 2012:87).

4.3.4 Poor Referral System

There are a number of discrepancies around the referral systems hence professional nurses' even use their cars to transport children to the nearest higher level of care because of increased waiting time for ambulances. There is a strong need for proper and rapid referral systems to be in place so as to facilitate proper transfer of children from PHC/CHC to hospitals. Horwood *et al.* (2009b:6) indicates that an ambulance service is a challenge when it comes to referrals of patients from PHC/CHCs to hospitals. Delays in referrals contribute heavily towards high mortality of children less than five years. According to the South African National Core Standards (SANCS) (2011:19) it is clear and recommended that when a patient requires to be referred to the next level of care necessary support must be provided and there should not be any

form of delay in the process. Findings in this study suggest a sore lack of such facilitation as ambulances are either booked fully or simply not available in the Mafikeng sub-district.

4.3.5 Work Related Factors

It is indicated by Kiplagat *et al.* (2014:10) on site mentoring and supportive supervision needs strengthening in many districts in South Africa as this is important in IMCI implementation. Professional nurses lack support from supervisors and other stakeholders and this contributes to them having burnout (Vhuromu & Davhana-Maselesele, 2009:66). In view of the working conditions, professional nurses find themselves under high emotional strain, low levels of job satisfaction and stressful working environments that have a potential to lead to burnout. It was also indicated by Makhado and Davhana-Maselesele (2016:7) that nurses experience high workload and this subjects them to job-related stress as they feel emotionally exhausted with less personal accomplishment at the end of the day. Work-related stress generally has a negative impact on psychosocial wellbeing of professional nurses (Khamisa, Peltzer & Oldenburg, 2013:2215; Makhado & Davhana-Maselesele, 2016:7). It was also highlighted by Horwood *et al.* (2009b:2) that professional nurses' performance improves when there is supportive supervision and mentoring. As identified in this study, IMCI trained professional nurses also gain support from the non-trained professional nurses.

Supervisory support has the potential to promote job satisfaction. Professional nurses may not be receiving supportive supervision due to budgetary constraints. This study revealed that supervisors and operational managers rarely provide support towards IMCI implementation and this has been highlighted as contributing to lack of mentoring on IMCI (Kiplagat *et al.*, 2014:7). Similarly professional nurses in Indonesia also complained of lack of supervision and indicated that they never received any support (Titaley *et al.*, 2014:165). Contrary to this, Mugela *et al.* (2010:3) indicated that 90% of professional nurses reported that they received at least some

supervisory support after their IMCI training and only 10% did not receive any supervisory support. Professional nurses see supervisory support as beneficial to them when they encounter difficulties in managing any sick child or if there is a misconception on IMCI which could be clarified by experts in the field (Mugela *et al.*, 2010:3). Furthermore, professional nurses highlighted that regular supervision improves their skills in managing sick children and eventually improves patient care (Pillay, 2012:87).

4.4 EDUCATION, TRAINING AND AWARENESS

Professional growth and development are essential components of professional nurses in terms of health care skills and knowledge. Continuous nursing education, training and awareness are of paramount importance as guidelines keep on changing to suit the needs of the children less than five years of age. For professional nurses to render quality health care, in-service training on IMCI updates and continuous education needs to be in place. Mothers and caregivers also need to be provided with awareness around many issues regarding primary health care services in order to heighten awareness of possible manifestations of specific diseases.

4.4.1 Education and Training Factors

For professional nurses to effectively implement IMCI, they would need to be well educated and knowledgeable about the IMCI strategy and its implementation processes. Training of professional nurses could promote the implementation of IMCI as this would increase their knowledge, skills and ultimately their interest regarding IMCI. According to Horwood *et al.* (2009b:3) professional nurses who are trained indicated that IMCI training is interesting, informative and empowering and training improves their knowledge and skills. It was also indicated by Caesar, Victoria, Adam & Bryce (2005:1178) that in order to improve skills of professional nurses, sufficient and up-to-date training is required. A well-educated and trained

professional nurse working on the set goals of IMCI is likely to demonstrate interest in managing child illness and would be in a position to conduct thoroughly the process of assessing, classifying, treating and providing counselling to mothers or caregivers. Education and training are the vital tools with regards preventive, curative health and health promotion among professional nurses. Preventive health can be offered to caregivers through the provision of counselling or health education.

There is a high concern in this current study that other professional nurses were never trained on IMCI and this opens a gap in the facility as they tend not to implement IMCI. This was further emphasized by Adekanye and Odetola (2014:33) stating that since some of the professional nurses were not sent for IMCI training they did not see the need to implement IMCI. Abdel Kader (2013:187) state that implementation of IMCI after training is very important for IMCI to be successful since the IMCI strategy has to be maintained at all time and integrated into the PHC package. The National Perinatal and Neonatal Morbidity and Mortality Committee (NaPeMMCo) of 2008 (2012:17) recommended that improving quality of care training of health care professionals should be paramount to both pre-service and in-service training. According to the Department of Health National Core Standards, there is a programme for staff training and professional development in place and staff must receive on-going in-service education (NCS, 2011:38). Furthermore, in accordance to National Health Act of 61 (2004:30), the National Department of Health must adhere to the norms and standards of professional training of human resources for health.

According to IMCI strategy, skills are of paramount importance, as these involve looking (Observation), asking (Communication), feeling (Sensation) and listening (Communication), then classification of the disease and finally treating, referral, counselling and follow up (IMCI Handbook; 2005:3). Horwood *et al.* (2009c:1) emphasize that IMCI training helps professional

nurses to acquire skills to improve IMCI implementation. As well as delay in follow up or supervisory support has an effect on professional nurses losing their skills. Pariyo *et al.* (2005:162) indicate that trained professional nurses possess the necessary skills to perform better on IMCI implementation than those who are not trained.

Keeping professional nurses updated on new developments regarding IMCI is a necessity. It is also critical to provide them with all relevant information regarding all changes effected in the IMCI implementation processes. Horwood *et al.* (2009b:7) indicates that there is a strong need for updates on IMCI as this has an impact on implementation of IMCI. Prosper and Borghi (2008:32) indicate that professional nurses that received training give other staff members' feedback with the chart booklet and road to health booklet but this practice is inconsistent. Kiplagat *et al.* (2014:6) further highlights that there is no provision of refresher courses rendered for IMCI especially for those with more than five years training. This is a serious omission, given that the majority of nurses were trained way back when the IMCI strategy was introduced, and there is a vast need for these nurses to be acclimatised with the latest development regarding IMCI implementation.

4.4.2 Caregiver Awareness

Caregivers or mothers awareness regarding IMCI implementation could promote the implementation of IMCI as they would be involved as well. According to the IMCI Handbook (2005:3) it is important that families be taught how and when to seek professional help. This is part of IMCI case management. The intention is to make the community aware of mild, moderate and severe symptoms and signs of the child illnesses. There are three components of IMCI and one of them is to improve family and community practices, whereby professional nurses do community awareness on their roles in development and health of their children. Abdel Kader (2013:189) highlights that communication between professional nurse and care

givers is important in improving IMCI case management. According to Department of Health National Core Standards, the importance of health promotion and disease prevention could be enhanced through awareness as part of patient care (National Core Standards, 2011:30). Caregiver counselling component in IMCI is very important in child health and caregivers' understanding on when they are supposed to return for follow-up visits at the health facilities. Given the findings of this study, caregiver awareness is still a challenge as caregivers in Mafikeng sub-district seem not to be aware of the IMCI process and the implementation challenges associated with it. This was further emphasized by Chopra, Sanders, Patel, Cleoete and Peterson (2016:400) that there is less or no improvement on counselling and understanding of caregivers. This was also supported by Prosper and Borghi (2008:34) that caregivers counselling is poor especially on feeding and follow up.

4.5 BEHAVIOUR AND ATTITUDE OF NURSES TOWARDS IMCI IMPLEMENTATION

The nature in which professional nurses conduct themselves when rendering IMCI services is very vital. It should be ethically and professionally sound. Attitudes and behaviours impact on the caregiver or mother who brought the child for IMCI. However, this happens to be a two-way process; nurse attitudes and behaviours towards the mother and caregiver and vice versa. Attitudes of nurses play an important part on one's behaviour, and attitude can either be negative or positive. However, in most cases there are factors in a work place that trigger negative or positive behaviour and attitude. The implementation of IMCI has been reported to be influenced by behavioural and attitudinal factors.

Lack of interest on IMCI implementation has been evidently high as shown in this study. This was shown by professional nurses' shifting of responsibilities when the child comes for child

health monitoring and many professional nurses would not even look for chart booklet or use it during child assessment. Such attitudes demonstrate ignorance of services needed by the child. This kind of behaviour may be linked to factors such as high workload, increased time pressure and lack of resources. Prosper, Macha and Borghi (2009:9) indicate that health care professionals resort to different behaviours mainly because of the frustrations they come across when implementing IMCI. Professional nurses may show work-related behaviours and attitudes when there are no medications, when they are tired or when it is close to their time of knocking off. Professional nurses resort to these defensive mechanisms against the tasks that they need to accomplish. Hence it is important for other factors to be resolved in order to prevent these negative behaviours which inhibit the successful implementation of IMCI.

Negative attitudes are also projected during the implementation of IMCI and this have a very negative impact in the communication between the mother or caregiver and the professional nurse. This creates an unfavourable conditions for both caregiver and the professional nurse, thus they end up not reaching their desired goal which is for the child to receive utmost care and treatment. However, this is also influenced by organisational and structural factors, caregiver-related factors and nurses personal attitudes. Kiplagat *et al.* (2014:6) reported that poor attitude of health care workers affect the implementation of IMCI. In addition, the importance of having positive attitude lies in the availability of skills needed to implement IMCI. Mugela (2010:6) states that professional nurses lose confidence in implementing IMCI when they are referring to the chart booklet because caregivers perceive them as incompetent. When professional nurses have a positive attitude to IMCI, this could motivate her/him to implement IMCI, regardless of the situations they face in PHC/CHC facilities. Attitude of professional nurse improves post training (Kiplagat *et al.*, 2014:7). Some non-trained professional displays a negative attitude towards IMCI trained, when a sick child comes to the facility they leave them for trained

professional nurse (Prosper & Borghi, 2008:46). Thus the availability of interest towards IMCI promotes better and proper IMCI implementation.

4.6 CAREGIVER RELATED FACTORS TOWARDS IMCI IMPLEMENTATION

There are also factors related to mothers or caregivers that have an impact on implementation of IMCI in PHC/CHC facilities. These factors include inability of care givers to provide adequate information about the child illness. Inaccessible facilities are also inhibitive factors as patients are unable to reach facilities when a child is sick due to the distance they travel and mother or caregivers that are very un-cooperative during to IMCI implementation.

4.6.1 Inability to Provide Adequate Information

Professional nurses face a huge challenge during assessment and this affects the way they are supposed to classify the child as they sometimes do not receive enough information regarding the child's illness or child information in totality. Mugela *et al.* (2010:3) highlights that it is a challenge when a caregiver has to give information about the sick child particularly on HIV related issues. Lack of HIV disclosure by HIV positive mothers to their caregivers militates against successful diagnosis because there is a partial history of the patient. Horwood *et al.* (2009a:317) highlighted that mothers are concern about confidentiality and that they fear to discuss their HIV status with professional nurses. Prosper and Borghi (2008:39) also indicate that some of the mothers or caregivers fail to identify danger signs thus making it difficult for them to provide full information or clear information about the illness. This is a challenge given that the child may have shown other signs while in transit or before arriving at the clinic. When such signs and symptoms are not visible, there is also no evidence that could be used to have an impact on the child's wellbeing.

4.6.2 Inaccessible Facilities

The distance mothers or caregivers travel to reach the facilities are perceived to be the challenge that also inhibit the smooth implementation of IMCI. Given the geographical situation of communities in this study context, which is mainly rural, access to PHC/CHC facilities is a serious challenge. This was further emphasized through Human Resources for Health, South Africa 2030 (2011:25) that in rural areas, access to PHC/CHC facilities is a serious problem and this contributes to high child mortality. It was estimated that in urban areas infant and child mortality is at 32.6% whereas in rural areas this is quite high at 52.6%. This also shows that even the implementation of IMCI differs by geographical situation of the communities. Transportation was also revealed as a challenge as others cannot afford to pay, hence they either resort to walking which could lead them to arriving late or they resort to staying at home until they have the money for transport. This has an impact on the child's health as the child could deteriorate since they rely on the mother or care-giver for their wellbeing. This was also emphasized in South African Committee on Morbidity and Mortality in Children under 5 years (CoMMic) report (2012:xi) that distance is a challenge especially in the rural area communities, where PHC/CHC facilities are very far and people still need to travel more than 30 min per foot to get to the primary health care facilities.

4.6.3 Uncooperative Clients

Professional nurses are perceived incompetent by caregivers or mothers when they refer to the chart booklets during assessment. They are also perceived to be asking so many questions during assessment which distresses the caregiver or mothers. This also impact negatively on the process of IMCI implementation as the mother can feel demoralised or bored with the lot of questions hence the mother/caregiver knows what she wants. Vhuromu and Davhana-Maselesele (2009:66) also indicated that caregiver's displays negative attitude when a child is being

assessed. This also affects the other patients sitting and waiting in the queue. Maleshane (2012:47-48) indicates that other patients when queuing accuses professional nurses for being slow and say nurses don't know their work, so professional nurses tend to rather not implement IMCI to satisfy patients. Un-cooperating patients become a challenging barrier to IMCI implementation and this is true given that mothers or caregivers demand medication even when it is not recommended by IMCI strategy (Horwood *et al.*, 2009b:8).

4.7 SUMMARY

This chapter focused on literature related to IMCI. The themes and sub-themes of factors inhibiting implementation of integrated management of childhood illness were described fully. The next chapter concludes the study, points out the limitations and submits recommendations.

CHAPTER FIVE

LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

5.1 INTRODUCTION

This chapter indicates the limitations of the study, provides recommendations and submits conclusions gleaned from the study. Recommendations are based on the findings of this study and they focus on nursing education, practice and research.

5.2 LIMITATIONS

Ngaka Modiri Molema District has five sub-districts and the study was undertaken in only one of these sub-districts where data was collected. Therefore the findings of this study cannot be generalised to apply to other settings. The language in the study was English, and some participants found it difficult to express some of the points in English. These used Setswana in a number of instances and in the transcription, the essence of their contributions is captured in literal translation.

5.3 RECOMMENDATIONS

Recommendations of the study focus on Nursing Education, Nursing practice and Nursing research and they are based on findings.

5.3.1 Nursing Education

Findings of the study have highlighted factors inhibiting successful implementation of integrated management of childhood illness related to education and training. The following approaches are recommended:

- Integrated management of childhood illness (IMCI) course or training must be incorporated into the curriculum of the undergraduate studies by Nursing Education Institutions as this is envisaged to improve competency since the nurses would be implementing the strategy under full supervision.
- Professional nurses need to be provided with regular in-service training.
- There is need to identify a strategy that keeps Health care providers updated at all times with regard to IMCI.
- Short courses on case management and counselling of caregivers/mothers ICATT ought to be designed and taught, and in many cases they need to be strengthened so that they are implemented effectively.
- It is recommended that training duration for IMCI ought to be increased.

5.3.2 Nursing Practice

Nursing practise is anticipated to benefit from this study as professional nurses revealed that they go through challenges while rendering IMCI service. This shortfall could be addressed through the following recommendations:

- The strengthening of Human Resources for Health in the province as well as timeous provision of material resources could promote proper, correct and effective IMCI implementation.

- Professional nurses should be effectively supported, mentored and supervised throughout IMCI implementation processes so that they can reach the state of self-confidence, accountability and ability to take responsibility towards IMCI implementation.
- The MCWH coordinator should monitor and evaluate the implementation of IMCI so that issues such as IMCI providers, caregivers' and mothers' challenges, shortage of resources, outcomes and implementers' needs could be identified and resolved timeously. This would improve the implementation of IMCI in the CHC/PHC facilities.
- The PHC re-engineering team should be empowered on IMCI strategy to help them to identify sick children in the community and this may reduce the influx of patients in the facilities.
- Adequate provision of updated chart booklets is a necessity.
- Students and untrained professional nurses should also be mentored and supervised effectively by IMCI trained professional nurses as it was identified that some untrained professional nurses and students do attend to sick children without supervision and cannot even implement IMCI.
- Caregivers and mothers and other patients need to be made aware of the importance of IMCI and processes that need to be taken during assessment, classification, and treatment as well as counselling. This would reduce their uncooperative behaviour and instil understanding towards the goal of IMCI implementation.

5.3.3 Nursing Research

The following areas require further research:

- Research could be done on professional nurses who are trained on IMCI using ICATT and those who are trained using the traditional IMCI case management to ascertain the effectiveness of ICATT.

- There is a need for a study to determine an approach to promote effective IMCI implementation.
- There is need for research to determine and describe the psychosocial and work related well-being of professional nurses implementing IMCI.
- There is also need for research to determine and describe the effectiveness of IMCI on managing children under 5 years of age.
- Research on perceptions or experiences of caregivers and mothers on IMCI service provided in different primary health care in Ngaka Modiri Molema district needs to be conducted.

5.4 CONCLUSION

The study revealed several factors inhibiting IMCI implementation. The factors identified were as follows: Organisational and structural factors inhibiting IMCI implementation, education, training and awareness, behaviour and attitude of nurses' towards IMCI implementation, and caregiver related factors. It is imperative that the Department of Health and nursing managers consider these factors with regard to the effective implementation of IMCI. Organisational and structural factors suggested that issues pertaining to time as a pressure factor, lack of human resources, lack of material resources, poor referral system and work-related factors cumulatively become gross negative impediments towards implementing IMCI. The time taken to implement IMCI is often perceived as too long and exerts pressure on professional nurses with many other protocols or programmes to implement. Hence, professional nurses felt that they are under pressure. Lack of resources such as space, shortage of professional nurses, chart booklets and IMCI recommended drugs all make it difficult for professional nurses to implement IMCI. There is a strong need for promoting education, training for professional nurses both trained on IMCI and those who are not. Professional nurses who are trained in IMCI highlighted issues like poor

IMCI supervisory support post training, lack of updates and in-service training. Professional nurses stay longer without IMCI training and it is a challenge for them. Caregivers and mothers awareness was identified to be minimal as professional nurses' are pressured by time when implementing IMCI.

Furthermore, the negative behaviour and attitudes of professional nurses towards IMCI implementation was also highlighted as an inhibiting factor, as nurses have shown no interest towards professional implementation of IMCI. These behaviours were evidently shown by poor confidence in assessment, classification and treating a sick child according to IMCI. Professional nurses further demonstrated negative attitudes towards mothers. This cascaded to mothers who also exhibited negative attitudes towards professional nurses, more especially when the professional nurses were referring to the chart booklets. This reference to booklets was perceived as a sign of inadequate training on the part of the professional nurse. Caregivers provide minimal information with regard to child health; especially the HIV/AIDS and caregivers have a challenge when they are supposed to get to PHC facilities because they do not have enough money for transport. During the process of consultation caregivers and mothers would demand certain medication.

For IMCI to be implemented properly and efficiently, the following should be in place: adequate space for consultation, staffing, and adequate updated chart booklets. PHC facilities should be adequately provided with drugs. Professional nurses need effective support, mentoring and supervision throughout IMCI implementation by the MCWH coordinators. Supportive supervision reduces work-related stress and nurtures a positive attitude towards implementation of IMCI. There is a dire need to ensure capacity building of professional nurses with regard to IMCI. Caregivers and mothers need to know the importance of providing comprehensive child

history to professional nurses and therefore they need to be encouraged to disclose all relevant information during IMCI process.

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ANNEXURE A: Ethical Clearance



NORTH-WEST UNIVERSITY
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NOORDWES-UNIVERSITEIT

Private Bag X6001, Potchefstroom
South Africa 2520

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Web: <http://www.nwu.ac.za>

Institutional Research Ethics Regulatory Committee

Tel +27 18 299 4849
Email Ethics@nwu.ac.za

ETHICS APPROVAL CERTIFICATE OF PROJECT

Based on approval by the Health Science Ethics Committee (FAST), the North-West University Institutional Research Ethics Regulatory Committee (NWU-IRERC) hereby approves your project as indicated below. This implies that the NWU-IRERC grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the project may be initiated, using the ethics number below.

Project title: Factors inhibiting implementation of integrated management of childhood illness (IMCI) in Mafikeng sub-district																															
Project Leader: Ms O Meno/Dr L Makhado/ Mr MJ Matsipane																															
Ethics number:	<table border="1"><tr><td>N</td><td>W</td><td>U</td><td>-</td><td>0</td><td>0</td><td>1</td><td>4</td><td>5</td><td>-</td><td>1</td><td>5</td><td>-</td><td>A</td><td>9</td></tr><tr><td colspan="3">Institution</td><td colspan="6">Project Number</td><td colspan="2">Year</td><td colspan="4">Status</td></tr></table> <small>Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation</small>	N	W	U	-	0	0	1	4	5	-	1	5	-	A	9	Institution			Project Number						Year		Status			
N	W	U	-	0	0	1	4	5	-	1	5	-	A	9																	
Institution			Project Number						Year		Status																				
Approval date: 2015-08-14	Expiry date: 2020-08-13	Category: <table border="1"><tr><td>N/A</td></tr></table>	N/A																												
N/A																															

Special conditions of the approval (if any):

- All corrections must be made as communicated to the researcher in the letter from the Health Science Ethics Committee on 14 August 2015.

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- The project leader (principle investigator) must report in the prescribed format to the NWU-IRERC:
 - annually (or as otherwise requested) on the progress of the project,
 - without any delay in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.
- The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the NWU-IRERC. Would there be deviated from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date, a new application must be made to the NWU-IRERC and new approval received before or on the expiry date.
- In the interest of ethical responsibility the NWU-IRERC retains the right to:
 - request access to any information or data at any time during the course or after completion of the project;
 - withdraw or postpone approval if:
 - any unethical principles or practices of the project are revealed or suspected,
 - it becomes apparent that any relevant information was withheld from the NWU-IRERC or that information has been false or misrepresented,
 - the required annual report and reporting of adverse events was not done timely and accurately,
 - new institutional rules, national legislation or international conventions deem it necessary.

The IRERC would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the IRERC for any further enquiries or requests for assistance.

Yours sincerely

Linda du
Plessis

Digitally signed by Linda du Plessis
DN: cn=Linda du Plessis, o=NWU,
ou=Vaal Triangle Campus,
email=linda.duplessis@nwu.ac.za,
c=ZA
Date: 2015.09.03 14:35:37 +02'00'

Prof Linda du Plessis

Chair NWU Institutional Research Ethics Regulatory Committee (IRERC)

ANNEXURE B: Request for Permission to Conduct Study

REQUEST FOR PERMISSION TO CONDUCT THE STUDY

P.O Box 5863

Mmabatho

2735

Department of health (Provincial)

Private bag X

Mmabatho

2735

Dear Sir/Madam

REQUEST TO CONDUCT A STUDY

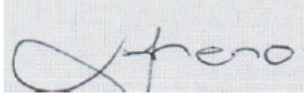
I hereby request to conduct a research at your health care facilities, Am a researcher from the North West University (Mafikeng campus).The research will be focusing on **the factors inhibiting implementation of integrated management of childhood illnesses (IMCI) in Mafikeng sub-district.**

Professional nurses are being trained on proper implementation of this strategy. Researcher's experience as a professional nurse and as clinical preceptor during student accompaniment has seen that in IMCI some of these children are missed due to poor implementation of the strategy. Despite the training provided and the child booklets Primary health care (PHC) nurses diagnose rather than classify children according to the guideline, even treatment is wrongly prescribed. As far as IMCI is concerned the researcher has identified some omissions of the strategy such as, Oral Rehydration Corner and some clinics don't have the child booklet or they are limited. When professional nurses attend sick children they only focus on the history provided by mother or care giver other than applying all principles of IMCI as stipulated in the guideline. The professional nurses focus on finishing up patients quickly and end up neglecting the guideline. Therefore the researcher found it important to conduct this study to explore more about professional nurse's opinions on implementation of IMCI in Mafikeng sub-district.

The purpose is to explore and describe factors inhibiting implementation of integrated management of childhood illnesses (IMCI) in Mafikeng sub-district.

I hope my request will be taken into consideration.

Yours sincerely

A handwritten signature in black ink on a light gray background. The signature appears to be 'F.O. Meno' written in a cursive style.

Ms. F.O Meno

Clinical Preceptor/Junior Lecturer

Department of Nursing Science

North-West University

ANNEXURE C: NWPG Permission to Conduct Study



health
 Department of
 Health
 North West Province
 REPUBLIC OF SOUTH AFRICA

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 www.nwhealth.gov.za

POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

Name of researcher : Ms O Meno
 North West University

Physical Address : cnr Albert Luthuli & University drive
 (Work/ Institution) Mmabatho
 2735

LEPAPHA LA BOITEKANELO
 DEPARTMENT OF HEALTH
 Kgotsana Post / Private Bag X2068
 Mmabatho, 2735
 13 NOV 2015
 NORTH WEST PROVINCE
 REPUBLIC OF SOUTH AFRICA

Subject : Research Approval Letter- Factors Inhibiting
 Implementation of Integrated Management of Child
 hood Illness (IMCI) in Mafikeng Sub-District.

This letter serves to inform the Researcher that permission to undertake the above mentioned study has been granted by the North West Department of Health. The Researcher is expected to arrange in advance with the chosen facilities, and issue this letter as proof that permission has been granted by the Provincial office.

This letter of permission should be signed and a copy returned to the department. By signing, the Researcher agrees, binds him/herself and undertakes to furnish the Department with an electronic copy of the final research report. Alternatively, the Researcher can also provide the Department with electronic summary highlighting recommendations that will assist the department in its planning to improve some of its services where possible. Through this the Researcher will not only contribute to the academic body of knowledge but also contributes towards the bettering of health care services and thus the overall health of citizens in the North West Province.

Kindest regards

Dr. FRM Reichel
 Director: PPRM&E

LEPAPHA LA BOITEKANELO
 DEPARTMENT OF HEALTH
 Kgotsana Post / Private Bag X2068
 Mmabatho, 2735
 13/11/2015
 Date
 13 NOV 2015
 NORTH WEST PROVINCE
 REPUBLIC OF SOUTH AFRICA
 Date
 16 NOV 2015

Researcher

Healthy Living for All

ANNEXURE D: INFORMATION SHEET

SCHOOL OF NURSING SCIENCE (FAST)
NORTH-WEST UNIVERSITY (Mafikeng Campus)

This informed consent form has two parts:

- Information sheet (to share information about the study)
- Certification of consent (for signature if you choose to participate)

Part 1: Information Sheet

INTRODUCTION: I Omphemetse Felicia Meno, am working for North-West University, Mafikeng campus and a student at North-West University doing a Master's degree in Nursing Science. I want to conduct research on Factors inhibiting implementation of Integrated Management of Childhood Illness in PHC facilities in Mafikeng Sub-District. I am going to give you information and invite you to be part of this research.

PURPOSE: The purpose of this study is to explore and describe Factors inhibiting implementation of integrated management of childhood illness in Primary health care facilities in order to make recommendations on proper implementation of this strategy.

PROCEDURE: The study will include in-depth face to face individual interviews in health care facilities in Mafikeng sub district. The researcher will conduct an interview for professional nurse. The professional nurses will be required to participate in an interview. The dignity and privacy of Professional nurses will be respected and protected by upholding the rights and confidentiality, anonymity, informed consent and their right to withdraw from the study.

BENEFITS: There will be no direct benefits to participants, but your participation is likely to help us find more on how best this strategy can be implemented.

REIMBURSEMENT: You will not be provided with any incentive during the study or to participate in this study.

RIGHT TO REFUSE OR WITHDRAW: Your participation in this study is voluntary. If at any time you do not want to answer any question the researcher asks during the interview, you may request not to answer it. You have the right to withdraw from the study at any time that you wish without your job being affected. An opportunity at the end of the interview will be given to you to review your remarks.

WHO TO CONTACT: The study is approved by Ethics Committee of the North-West University (Mafikeng Campus). In case of any questions and clarity I can be contacted at 085320311/0764411243 or you can contact my supervisors, Dr L Makhado and Mr M Matsipane at 018 389 2000.

ANNEXURE E: INFORMED CONSENT

INFORMED CONSENT FROM NORTH-WEST UNIVERSITY-MAFIKENG CAMPUS

Title of Project: Factors inhibiting implementation of integrated management of childhood illness (IMCI) in Mafikeng sub districts.

Principal Investigator: Felicia Omphemetse Meno

I, the undersigned _____ (Full names and surname), volunteer to be a participant in a study on Factors inhibiting implementation of integrated management of childhood illness (IMCI) in Mafikeng sub district conducted by the researcher.

- I understand that I will be engaged in an individual interview lasting for 30 to 60 minutes in a venue of my choice to protect my right to privacy.
- I understand that a tape recorder will be used during the interview and I have consented to that.
- I am free to discontinue participation at any time without fear of being punished in anyway.
- I understand that this consent form, voice records and any other material that may contain my identity or any clues thereof will be kept safe and accessed only by the researcher and the supervisor to protect my right to anonymity.
- I will not receive any kind of payment for participating in this study.

Signature of Participant : _____ Date: _____

Signature of Investigator : _____ Date: _____

Signature of Witness : _____ Date: _____

ANNEXURE F: INTERVIEW TRANSCRIPT

R: Are you ready we can start?

P: Yes we can start

R: The first question: generally how do you view implementation of IMCI in this facility or IMCI as a whole?

P: Ok am going to start with how I view implementation of IMCI in my facility, nne, to be honest I have never seen anyone very serious with IMCI some of them I understand they know things by head but to refer to the IMCI it's not that good and most of them are not IMCI trained in this facility. Some of them find it difficult in reading the book.

Then my view on IMCI as a whole it's a good booklet especially the latest 2014 it has stipulated everything that we need to know in case of monitoring wellbeing of under 5 child then also IMCI is good to help us see or diagnose the child because sometimes we take something for granted. Let's say a child comes for diarrhoea we just look at child and assume we can just give oral rehydration whereas we could've read IMCI we could've seen there are better things to give for the child and monitoring of the child.

R: So you saying it [is] a good strategy?

P: It's a good strategy if it was used.

R: So that's your view on IMCI?

P: Yes.

R: And you mentioned earlier that *eerh* it's partially used. Meaning if I heard you well some are implementing some are not?

P: Yes.

R: Ok, is that all you can say with regard to the implementation?

P: Umh, also the implementation can be poor, sometimes there are students they don't work under supervision sometimes because of the workload in the facility sometime. I know it's wrong for them not to work under supervision but then at times then yes implementation becomes poor and also because of the long lines it sometimes become a problem to refer to the IMCI booklet.

R: So you saying students are allowed to implement IMCI?

P: No they are not.

R: So what happens then if students come across children? Do they ever use IMCI or they don't?

P: They don't use sometimes they would just ask verbally let's say you are in the next consulting room they can just ask by just through the door, what do I give then what is on my head if diarrhoea I would say give oral rehydration then will just end it there.

R: So these students are they trained on IMCI or not?

P: They are not yet trained some of them I've heard that they were trained for IMCI.

R: Ok, have you exhausted all or do you have anything ?

P: I think I've exhausted all on implementation.

R: Ok, so what are challenges in implementing IMCI in your facility, challenges you come across when you implementing IMCI?

P: Ok, the first challenge is that we only have one booklet for IMCI 2014 which is the recent one so there is another consulting room you have to ask for the book sometimes you will never find it. You will be looking around the facility nobody knows where it was and the one that come before 2014 it has less things compare[d] to the new. So you can't really implement some of the things due to that.

R: Ok, so you meaning that there's shortage of booklets in this facility?

P: Yes, there is shortage of updated chart booklets even old ones.

R: Ok, so can you think of more of the challenges that maybe encountering?

P: Yes, the other challenge is that some of the nurses in the facility are not trained on IMCI so tend not to implement it because somehow they don't know how to use the booklet.

R: So roughly if you can estimate how many nurses do you have and those who are trained for IMCI and not trained?

P: I would say in total we have 10, then who are trained I would say it's 6 out 10.

R: So how often do they send professional nurses for IMCI training let's say in 6 months in this facility?

P: Mmh, never.

R: Never?

P: Mmh, because I remember last year they were asking around the facility, who is not IMCI trained then since from then the names were taken but nothing was done about it.

R: So you are saying [no] training?

P: Even besides training we hardly have in service training within this facility.

R: Ok.

P: Ok, other challenges are that we tend to look at the line and forgetting the quality of work, you will be the only nurse versus your workload here. I have to do ANC (Antenatal clinic), IMCI etc., so we tend not to implement it due to timeframe so you will be saying if I start with IMCI, what time am I going to finish with the next patient.

R: So are you saying it's time, you mentioned time can you elaborate more on that?

P: Some conditions are time consuming when you look in the IMCI chart booklets because would refer you to another page, then you have to go back to that page they say you should go to sometimes the patient will be complaining (" We've been here for a long time, why are we not assisted?").

R: Which patient complaining, the one you are assisting?

P: The one outside in the waiting area.

R: What about the caregiver/mother you are assisting?

P: Sometimes I will be reluctant to ask questions because if you ask the mother or caregiver questions in relation to IMCI booklet, the mother or caregiver will ask you as to 'why are you asking so much questions, am just asking for Panado (Paracetamol)?

R: Ok.

P: Do you get it?

R: Yes.

P: Mostly patients don't like to tell you what [is] wrong with the child rather they come and prescribe 'no my child was having fever can I just have Panado' then when you try sit with them

with that questionnaire of IMCI booklet they would be telling, you are wasting their time they have to get back to work and their child is getting restless. And say why not give Panado like previous sisters normally do. So they will be giving you attitude when you trying to implement.

R: So patients have attitude?

P: Yes towards nurses when they try implement that IMCI booklet.

R: Ok, I sense you mentioned impatient, maybe if you can elaborate...

P: Our patients their problem is they don't want to wait on the line, when you busy with another patient maybe you taking more than the normal time you would take because you dealing with something problematic for example, they will be shouting at you saying bad things about you 'that patient have been there for a long time "They will be knocking on the door saying "are you not done with that patient?

R: Is it?

P: 'Am outside why you don't help my baby is just here for weighing for example. So the one inside becomes restless that people are knocking on the door, can we just finish.'

R: So I pick patients are not aware of this strategy?

P: Some are aware especially when you do it during child immunisation. You always have to check through immunisation schedule they are very impatient.

R: So can we kindly go back you mentioned quality, can you maybe elaborate you said something about quality of work.

P: OK, I was just saying sometimes we don't use the booklet we are just chasing the line of which the IMCI chart booklet will guide us to deliver quality work.

R: Ok.

P: To the patient you will do the right. Monitor relevant things to the patient of which will just put the baby on the scale write and the baby goes but whereas we could sit down with the patient look also through the IMCI chart booklet, screen for danger sings if they are there you can ask the mother if querying something especially with regard to the weight.

R: Ok.

P: You can refer to the book to see if there's no malnutrition. What do I do about it so sometimes we don't really do that because of the line we just thinking am knocking off this time should be pushing the line so slow. Ok let me put in two children at the same time if they are just for scale. So we tend not to do quality work.

R: Ok and then you also said workload, can we unpack this workload?

P: Ok, ummh, for example in my facility when you are allocated to the, they call it MCHW room. That means you are going to do all the children with immunisation, baby weighing, antenatal and antenatal subsequent visits.

R: In that room?

P: In that room. And at time[s] you just the only nurse in that room and maybe there's this new people the mentors, mothers they are just there to assist with regard to breastfeeding. They health educate the patient with regard to breastfeeding so the workload is too much. That long line is just for you, alone so they only tell you the weight from the scale so you sometimes don't use the IMCI because [you will] be thinking my line is too long. This side is antenatal and the other side is children you still have to cater for all.

R: You mentioned an abbreviation you said MCHW, what is this?

P: I just know it includes the Mother children welfare health

R: So you only use IMCI when you are doing immunisation on that room specifically for children?

P: Whether is their date for immunisation and they are sick we help them also.

R: So is it through the whole day and at night ?

P: No at night even after one immunisations after one normally we don't do, they move to room I where it [is] just when they are sick not for their immunisation.

R: So meaning all the children when they come to the clinic they go to that room whether sick or not ?

P: Yes.

R: So you use the guideline?

P: Not always.

R: Can you think of other challenges?

P: The other challenge is you might not know how to use the booklet when you ask someone else to come and help you look through the booklet .They will just tell you what is wrong with the baby they will just prescribe without even looking at the booklet so we end up not implementing IMCI. Not knowing whether what the person is saying she read from the book or what.

R: Is it difficult to use this booklet?

P: It is not difficult just that sometimes you may not know what is wrong with the baby. For example, the would be already putting the treatment for the patient then you don't know or you

don't know the condition. So sometimes it's hard if you don't know what the condition is called medically.

R: So you saying it is user friendly?

P: It is user friendly in most cases, just those small instances where you don't know what is that condition called then the only problem you might encounter.

R: So mam do you have any other points?

P: I think I've exhausted those who are most important.

R: Any important challenge you came across?

P: I think I've mentioned most of them.

R: So in your view what can be done to improve implementation of IMCI in the facilities?

P: Firstly they issue us with adequate number of chart booklets of IMCI especially the recent one. Then also the drugs on the booklet because sometimes you will be looking in the booklet something that is not available in the facility they can always make sure that we have that drug stated in the IMCI booklet so that we can better improve it. Because in a long run we will forget how to use the booklet, some drugs are not there so why should we use it.

P: Do you want to ask something?

R: Yes, am sensing a challenge here you mentioned drugs availability.

(Giggles)

P: Yes I guess now it's a challenge.

R: So I don't know maybe if you can clarify this drug availability, elaborate.

P: Ok, umh something I've noticed on the IMICI booklet, they say we should give ZINC in the facility for a very long time even now it's something that has not been there. It's something that is scarce so at the end of the day you don't use the book because there are no drugs available there's the one I am familiar with. Some of them I don't know if all of them are available mostly they are not available in the facility.

R: So availability meaning not putting words into your mouth. Is it inadequate or availability can you clarify that issue?

P: It's not from ordering because we order then from the main pharmacy they would say it is out of stock.

R: Ok.

P: So when you come to the facility it's nothing then maybe sometimes through last year maybe 2-3months there was no Panado syrup, no Allergex syrups. You can imagine even deworming for worm infestation you cannot treat because it's not available at the main pharmacy ,we order then get it when you get there it's out of stock.

R: So it's a challenge?

P: It's a challenge.

R: So you mentioned that they should provide adequate number of recent child booklets?

P: Yes.

R: And then drugs should be available?

P: Yes.

R: So what more can be done?

P: Umh they can also offer training.

R: Training ?

P: Yes continuous training whether IMCI trained or not sometimes you need a refresher in your head so that we can always be coherent with the book. Even if you were not there may be a small in service training you know they will be saying there are no adequate funds to send people for training but they can come for in service training so that we can all be aligned just the basics. To use the booklet, how do we look for danger signs what is what so that we can all know.

Including students because they are working there, despite the level whether 2nd, 3rd year because they also dealing with children. So that at times they will be at the vitals they don't know it's a danger sign, the baby will be there for a long time in the clinic and we are not aware because students were not aware it is important. If they are trained of the danger signs they can easily identify .

R: Mmh...

P: It can help with triage.

R: So training can help with triage?

P: No I mean for students.

R: Ok.

P: Then for us it can help with implementation of IMCI we can all know how to use that booklet.

R: So you saying continuous training by whom?

P: It can be nurses it can be someone from DoH who is working specifically with IMCI.

R: They should come down and do in-service training.

P: Yes, because there [are] some nurses who qualified many years back and they did IMCI many years back so now they will be telling you “I don’t remember most of the things.”

R: They don’t remember they don’t practise because they don’t remember, I pick a challenge there.

P: Yes that’s why I said continuous because with them they can also refresh.

R: Ok.

P: Mmh...

R: Is that all mam can you maybe think of more?

P: With regard to the ...?

R: Improvement so that it can be implemented...

P: I think also to resolve the challenge of patient being so impatient with you, we can also offer always health education to the patient that when the baby comes there are some things we have to look at for example so that they can always know also with regard to the improvement of implementation. It does not always mean you have to implement it when you are with the child there are pages where there’s treatment at home, home remedies we can also offer health education to the patient about those home remedies that are stated in the IMCI.

I think that also crucial way of implementing it because you can’t always reach all the children at the same time so if you do that ,health education so they will always remember at the clinic they said when my baby is like this I can do this.

R: You mentioned health education to patients with regard to IMCI...

P: Yes.

R: Is this not done or is partially how would you rate health education to patients?

P: To be honest, I have never seen it done in front of all patients you only give it individually with regard to the condition that the baby is presenting with so only give it to that one lady s what about other lady who came in and do not have complaints.

R: So education for patients...

P: Mmh.

R: Ok, mmh so more on...

P: Ways improving, can we skip for a bit will come if I have ...

R: With the past questions do you have anything that comes to your mind?

P: I think I have one on how to improve but then it's not just in the clinic based am going to be out of the box.

R: Yes no problem.

P: Like we have a re-engineering nurse who normally goes to the schools for maybe immunisation catch ups, deworming just for children in the schools. I think it can also improve implementation she should be aligned with IMCI so that do it at school mostly we can say she's is a school nurse.

R: Maybe clarify whether they are trained or not...

P: She is an old nurse, I don't want to lie because I think what they do just give HPV then immunisations they do it there can also improve implementation on school health nurse training.

Then there will be better implementation. I think school health nurse can be trained on these things.

R: Ok.

P: And also if we need a doctor in the facility with regard to IMCI because some staff they will be saying we should put in a drip ,we are not trained to put a drip on a baby because it's difficult veins are difficult to find. So if we have a doctor in a facility I think it will also help with the implementation because if we can't put the drip that means we no longer implementing IMCI so we can just go to see the baby to the hospital if it was something we could've done in the clinic.

R: Yes, no I understand is it all?

P: I think I've exhausted..

(Laughs)

R: Is there anything you would like to add with regard to this study or IMCI?

P: Erh to IMCI in generally I would like them to add a page which is describing the contents at the back, I mean difficult concepts.

R: Ok.

P: They can provide a small dictionary at the back that goes with the book for people who don't know some of the conditions. Then with regard to the study it should be done regularly. It should be done in almost all the facilities because they can be aware of the challenges.

The study should help us with regard to solving the problem it was done years back some of the staff would have been corrected by now.

R: Ok, that's a good point, is there anything else you would like to say?

P: With regard to IMCI mmh, no I think the IMCI is fine just the content. I really needs it, it is crucial and with the study I think am ok.

R: So mam without any additions, are you satisfied maybe if we can go back is there something that I left or something that eerh you would to add on points you mentioned?

P: No I think am fine unless you need clarity somewhere.

R: No I think am also fine, eerh I would like to thank you for participating in the study thank you very much.

P: Thank you, it was a pleasure I hope some of the things would improve.

R: Thank you

ANNEXURE G: PROOF OF LANGUAGE EDITING



NORTH-WEST UNIVERSITY
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TO WHOM IT MAY CONCERN

CERTIFICATE OF EDITING

I, **Muchativugwa Liberty Hove**, confirm and certify that I have read and edited the entire dissertation **FACTORS INHIBITING IMPLEMENTATION OF INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES IN PRIMARY HEALTH CARE FACILITIES IN MAFIKENG SUB-DISTRICT**

by **FELICIA OMPHEMETSE MENO** student number **16877608** submitted in fulfilment of the requirements for the degree **Master of Nursing Science** at the North-West University (Mafikeng Campus).

Felicia Omphemetse Meno was supervised by **Dr Lufuno Makhado** and **Mr Molekodi Matsipane** of North-West University.

I hold a PhD in English Language and Literature in English and am qualified to edit academic work of such nature for cohesion and coherence.

The views and research procedures detailed and expressed in the thesis remain those of the authors.

Yours sincerely

A handwritten signature in black ink, appearing to read 'M.L. Hove'.

Dr M.L.Hove

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