

Experiences of Clinic Managers Implementing the Integrated Management of Childhood Illness (IMCI) in Limpopo Province South Africa

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ABSTRACT Integrated management of childhood illness (IMCI) strategy was developed for reduction of under-five child mortality. The strategy's implementation is still inadequate even among trained professional nurses in the presence of clinic managers. A qualitative, descriptive phenomenological research design was used to explore and describe the lived experiences of clinic managers regarding the implementation of the IMCI strategy in Primary health care (PHC) clinics of Limpopo province, South Africa. Semi-structured individual interviews were used to collect data from sixteen (16) purposively selected clinic managers with more than three years of clinic management experience. The seven steps of Collaizi were used to analyse data. Trustworthiness was ensured throughout the study. Positively, managers experienced IMCI as a good strategy which improved nurses' skills and knowledge, whilst the negative experiences included staff barriers, management barriers and lack of resources that need interventions. Clinic managers to strengthen and prioritise IMCI programme implementation.

INTRODUCTION

Integrated management of Childhood Illness (IMCI) is an integrated strategy that aims to reduce death, illness and disability and to promote growth and development among children under five years of age. The strategy was developed to manage childhood illnesses and promote health for children under five years of age. This strategy was introduced globally in 1995 to all the countries in phases to improve child survival in countries with more than 40 deaths per 1000 live births and provide integrated prevention, treatment and care for the sick child (Kilov et al. 2021). The IMCI strategy is currently adopted and implemented by over 100 low- and middle-income countries (Fick 2017), in whole or in part, its three components: improving health worker skills, strengthening health systems and improving family and community practices (Boschi-Pinto et al 2018). South Africa is one of the countries that adopted the IMCI strategy as the standard of care since 1997 to improve professional nurses' skills and management of under-5 children's illnesses, strengthening the health system support and improving family and community practices (Fick 2017),

Integrated Management of Childhood Illness (IMCI), an algorithmic approach has been adopted for primary healthcare (PHC) settings in SA since 1997 (Cheema et al. 2013) and the National Department of Health (NDoH) SA adopted IMCI

as its primary strategy for providing care to sick children under the age of five years in primary health care (PHC) facilities in 1998 (Fick 2017).

Among the aims of the IMCI strategy are the reduction of under-5 child deaths in developing countries and improvement of the performance of health workers in managing childhood illnesses through its three components: improving health worker skills, strengthening health systems and improving family and community practices. Evidence suggests that IMCI has contributed to reductions in child mortality over the era of the Millennium Development Goals (MDGs), and a recent Cochrane review in 2016 found the strategy was associated with a 15 percent reduction in child mortality when activities were implemented in health facilities and communities (Kilov et al. 2018). Robust studies further provided evidence on IMCI's role in reducing hospital admissions, and improving key newborn and childcare practices such as early and exclusive breastfeeding and increased health-seeking for acute respiratory infections and other illnesses covered by IMCI (Renosa et al. 2021)

Literature reveals that globally most countries implementing the IMCI strategy have had challenges that hamper the implementation of the strategy (Idindili et al. 2018; Meno et al. 2019). In Pakistan and Benin, the IMCI trained nurses reported an increased workload and time taken to assess a

sick child as constraints to adequate implementation of the IMCI strategy (Pradhan et al. 2013). In the Philippines key challenges which were seen as hampering the implementation of IMCI were insufficient financial resources to fund program activities, inadequate training, mentoring and supervision among and for providers, fragmented leadership and governance, substandard access to IMCI relevant written document (Renosa et al. 2021) to name but a few.

The implementation gaps in Botswana and South Africa included the poor assessment and management of children by IMCI-trained professional nurses irrespective of the availability of guidelines (Meno et al. 2019; Mulaudzi 2015; Mupara and Lubbe 2016).

Mupara and Lubbe (2016) pointed out that there are challenges related to health systems, which include among others, the low-training coverage and poor physical layout of facilities, as well as the inadequacy of supervisor support and follow-up training visits. Recent evidence suggests that leadership and governance, resources, training, mentoring and supervision have been identified as the bottlenecks and challenges that impede implementation of the IMCI strategy (Renosa et al. 2020).

Despite the inception of the IMCI strategy, South Africa remained challenged with the under-5 mortality which was estimated at 45.1 percent death per 1000 births in 201 (South Africa Statistics 2015). The 2nd Triennial Report on Morbidity and Mortality in the Limpopo Province indicated that 95 percent of primary health care (PHC) nurses were IMCI trained in 2014, but under-5-year-old child mortality in 2015 in that province was the highest—more than all the eight provinces in South Africa (South Africa, Department of Health 2014).

The World Health Organisation evaluated the status of IMCI program implementation in 2013 and determined that the Philippines had effectively adopted key technical policies and guidelines, with coverage in 72 percent of districts (Renosa et al. 2021). In South Africa, despite the IMCI Implementation challenges experienced like in other countries, there has been no recent review of IMCI implementation despite increasing questioning of the utility of the strategy both locally an internationally (Fick 2018). The objective of this paper was thus to explore and describe the implementation of IMCI in the low-re-

sourced PHC clinics of Limpopo province: managers' experiences.

If optimally implemented, the IMCI strategy could assist in the reduction of under-5 deaths and most countries could attain the Sustainable Development Goal (SDG) number three (3) which seeks to ensure healthy lives and well-being for all at all ages by the year 2030 (United Nations A/RES/701/1). Specific to this paper, the SDG seeks to end preventable deaths of new-born babies and children under five years of age by 2030 (United Nations A/RES/701/1). Through optimal use of the IMCI strategy in ill children, danger signs such as lethargy, obtaining history such as the child's ability to drink, breastfeed, vomiting everything and the presence of convulsions are identified and given immediate attention.

Supervision and mentoring which was highlighted as a challenge in the implementation of IMCI in the Philippines (Renosa et al. 2021) and many other countries, is integral for implementation of the IMCI strategy as per IMCI strategy planning. Each health facility is expected to have a scheduled supervision plan for monitoring the implementation of the IMCI strategy (WHO 2014). An operational manager should be appointed to each PHC clinic in Limpopo Province. The responsibility of an operational manager at a PHC clinic is to ensure proper implementation of PHC programmes, for example, family planning, IMCI, antenatal care and treatment of chronic illnesses (Dikic et al. 2019). In attempting to find solutions to the poor implementation of IMCI this study sought to explore and describe the implementation of IMCI in a low-resourced area of Limpopo Province: operational managers' experiences.

METHODOLOGY

Qualitative, explorative and descriptive phenomenological research was used to obtain information from the participants. A descriptive phenomenology study was conducted in a primary health care clinics of Vhembe district to explore the lived experiences of clinic managers in relation to the implementation of the IMCI strategy. The researchers followed a descriptive phenomenological approach in order to describe the clinic manager's world and to make sense of the manager's perceptions of the world from the participant's viewpoint (Babbie 2020). A descriptive

phenomenological study was undertaken with an aim of seeing the phenomenon to be studied through the eyes of those who have experienced it (Bless et al. 2018). The approach was suitable to explore the experiences of clinic managers in the context of their working environment in the IMCI strategy implementation.

Clinic managers who were responsible for management role in the PHC clinics of Vhembe were the population for this study. The studies done in South Africa and elsewhere blamed lack of supervision as reasons for poor IMCI implementation (Fick 2020; Mupara and Lubbe 2016; Tshivhase et al. 2020). Clinic managers are responsible for planning, organizing, leading and controlling in their healthcare management work and therefore the researcher believes they could meaningfully share lived experiences from their own perspective (Booyens and Bezuidenhout 2018; Polit and Beck 2018). There was no study that was done for primary health care clinic managers, so exploring the phenomenon on nurse manager was believed to could enhance better understanding of the concept from the manager's viewpoint.

Setting

The study was conducted at PHC clinics in the Vhembe district of Limpopo Province located in the northern part of South Africa. Vhembe district is the northern largest most rural part of Limpopo Province which shares its borders with Zimbabwe, with poor infrastructure such as roads. The district is made up of six sub-districts, 124 PHC facilities and seven hospitals. One of the sub-districts has no local hospital. Vhembe district is the most densely populated district of the province with 23.9 percent of the population of Limpopo (Makhado IDP report 2018/2019). This district has the highest number of PHC facilities (124) in Limpopo Province.

Population

The population studied comprised of clinic managers (OPMs) in Vhembe PHC clinics that were implementing the IMCI strategy. The total number of OPMs for Vhembe PHC clinics were estimated at 130.

Sampling

The researchers used convenience, non-probability sampling to obtain data from the participants, but only those clinic managers who volunteered to participate and had worked in the PHC clinics for three or more years in the clinic were interviewed. The researchers first visited the three PHC clinics and interviewed one participant in each in order to check the validity of the instrument. Other PHC clinics were randomly selected based on the availability of participants. Data saturation was reached after the researcher had interviewed sixteen (16) participants, as no new data was emerging on the sixteenth participant (Polit and Beck 2018). In minimising the sampling bias of accessible participants, the researcher interviewed participants from various PHC clinics and as such the participants were heterogeneous.

Data Collection

Semi-structured one-on-one interviews were used to collect data from the participants. An interview guide with broad open-ended question was constructed as follows; *“Can you tell me about your experiences on IMCI strategy implementation as a clinic manager working in PHC clinic?”* Follow-up questions were asked to encourage the participants to clarify some of the information they gave during the interview to get in-depth understanding of the information shared by the participants.

Interviews were recorded using an audio recorder with the consent of the participants, in order to capture the respondents' information properly and was transcribed for data analysis. The researcher took field notes, recorded non-verbal cues, behaviours and feelings that were expressed during the interviews.

Data was collected from the 1st of March to 15th of April 2017. All the data was collected through one-on-one interviews which lasted for thirty (30) to forty-five (45) minutes each.

Data Analysis

The researchers followed Collaizzi's (1978) seven steps of data analysis. The choice of the Collaizzi's steps was due to its suitability to provide insight into the phenomenon under study

and for ensuring reliability and credibility of the study results. The data analysis was done during data collection with an aim to retain originality of the participants lived experience and the researcher giving attention to the phenomenon under study.

The researchers listened to the audio-recorded interviews and transcribed them verbatim, including field notes and comparing with non-verbal cues when transcribing information. The researcher then listened to the audio-recorded interviews again to verify if the transcripts were accurate and to make corrections where necessary.

Each transcript was reviewed and important statements were extracted. Important statements were marked using coloured markers. The colours of each marker and the meanings given to them were written on the field notes to ensure that the meanings were given the correct colours. The researcher was then able to organize, identify, retrieve and analyse the data accurately.

The researchers gave meanings to the formulated grouped statements according to their colours, which then was linked with the collected data in order to make sure that each statement was correctly marked. The formulated meanings were then assembled into a cluster of themes.

The researchers examined the clustered meanings and grouped those categories that reflected the lived experiences of clinic managers regarding the implementation of the IMCI strategy. The researchers also used an independent coder who independently coded the data and an agreement of the clustered themes and comprehensive descriptive meaning of the lived experiences of clinic managers regarding the implementation of the IMCI strategy were formulated.

Trustworthiness

Trustworthiness of the study results was established through credibility, dependability, confirmability and authenticity (Lincoln and Guba in Creswell 2014). Credibility of the study results was ensured through involvement of the independent coder during the data analysis phase of the study and the study was also supervised by experienced qualitative researchers. Dependability was ensured by keeping audit trails of the data collected and analysed. To ensure reflexivity, the researcher consciously had self-awareness

and did introspection by bracketing her fears, preferences and biases regarding the study phenomenon throughout the research process so that they did not affect the data collected and interpreted. The inclusion of verbatim quotes in the results ensured authenticity of the study.

Ethical Considerations

The study was ethically approved by the (Information redacted to maintain the integrity of the review process) University Ethics Committee (Information redacted to maintain the integrity of the review process) and the (Information redacted to maintain the integrity of the review process) Department of Health Ethics Committee. Permission to collect data from the PHC clinics of Vhembe was obtained from the district PHC manager. All participants provided informed consent prior to data collection. Privacy was ensured by interviewing the participants in a private room. Participants were assigned an alphabetic code to ensure their anonymity.

RESULTS

Description of the Sample

The sample for the study were sixteen clinic managers of which one was a male and fifteen were female. Their age ranged from 38 years to 62 years. The number of years in the manager role ranged from three to fifteen years and years spent in the nursing practice ranged from eight to 40 years. From the sixteen managers three were not trained for IMCI whilst thirteen were IMCI trained. Table 1 present the demographic characteristics of the participants

Categories and Subcategories

Two themes, positive and negative, describing the experiences of clinic managers (OPMs) in the implementation of IMCI strategies were identified. These were supported by categories and subcategories (see Table 2).

Positive Experiences

This category focused on the benefits of the IMCI strategy in improving nurses' capability in providing quality patient care.

Table 1: Demographic data of participants

No.	Age	Gender	No. years in nursing practice	No. years supervising as manager	IMCI trained Yes/No
01	38 years	F	8 years	3 years	Yes
02	60 years	F	34 years	3 years	No
03	51 years	F	34 years	10 years	No
04	54 years	F	36 years	15 years	Yes
05	46 years	F	25 years	13 years	Yes
06	42 years	F	13 years	07 years	Yes
07	53 years	F	35 years	13 years	Yes
08	56 years	M	33 years	15 years	Yes
09	56 years	F	31 years	11 years	Yes
10	50 years	F	32 years	15 years	Yes
11	55 years	F	33 years	15 years	Yes
12	62 years	F	40 years	15 years	Yes
13	48 years	F	25 years	10 years	Yes
14	60 years	F	39 years	15 years	No
15	54 years	F	34 years	15 years	Yes
16	56 years	F	36 years	15 years	Yes

IMCI Improves Nurses' Knowledge and Skills

Clinic managers attested that IMCI was a good strategy, and associated with improving the skills and knowledge of nurses on the management of childhood illnesses. This was expressed as follows:

Through the use of IMCI I am able to follow the steps in the chart booklet and treat ac-

ordingly. I can now classify most of the children's conditions for which I usually refer to the booklet. I mean some common ailments; I already know how it is to be treated even before opening the chart booklet. (P1)

The IMCI programme when following the guidelines is so helpful; if you had opened the book, you cannot miss anything in the child. You cannot even miss malnutrition. (P5)

Table 2: Overview of categories and sub-categories

Themes	Categories	Sub-categories
<i>Experiences</i>		i. Improves nurses' skills and knowledge
		ii. IMCI is user-friendly requiring less equipment
<i>Negative experiences</i>	Staff barriers	i. Limited number of IMCI-trained nurses
		ii. Negative attitudes towards IMCI strategy
		iii. Untrained clinic managers at PHC clinics
		iv. Time-consuming nature of IMCI strategy
		v. 'Supermarket' approach as a barrier to IMCI strategy
	Management barriers	i. Absence of allowance to managers in acting post viewed as unfair
		ii. Lack of refresher courses and updates on IMCI programme
		iii. Lack of supportive supervision in implementation after IMCI training
		iv. Unavailability of supervisory time experienced by OPMs
		v. Lack of funds
	Lack of resources	i. Staff shortage
		ii. Poor infrastructure
		iii. Shortage of medication
		iv. Shortage of IMCI materials
		v. Lack of funds

IMCI is a User-friendly Strategy Requiring Less Equipment

Clinic managers also indicated that the IMCI strategy is user-friendly and requires few equipment such as thermometers, mid-upper arm circumference tapes (MUAC) to measure malnutrition, and weighing scale which are inexpensive. For other diagnostic measures use is made of listen, feel and look at the child to identify the problem.

The following responses support this:

IMCI is good, for you treat a child with simple resources. Just see the child, you feel, touch and listen. (P12)

The other thing I like about IMCI is that it does not need more equipment, in fact this is the thermometers, watch for child pulse; it does not have this that we may need stethoscope or what. IMCI does not need more equipment, it is user-friendly. (P6).

Negative Experiences

Negative experiences mainly focussed on the barriers that one has to overcome to enable IMCI implementation.

Staff Barriers

Five subcategories including staff barriers to the implementation of IMCI were as follows: limited number of IMCI-trained nurses, untrained clinic managers at the PHC clinic and the time-consuming nature of the IMCI strategy versus nurse-patient ratio. Clinic managers reported inconsistency in the application of the IMCI strategy by professional nurses for different reasons, for example, the strategy was regarded as time-consuming. The limited number of IMCI-trained professional nurses as well as their negative attitude toward the strategy further hampered its implementation. The following quotations support this finding.

Most of our staff members in this health centre are IMCI-trained, but really, they are not implementing it. It is like, they perceive opening the book in front of the patient as like one does not know anything whereas in IMCI we are not to memorize. (P7)

It is not simple to implement IMCI for nurses trained in IMCI are only three (3) in the whole

clinic and myself as the manager have my management duties to perform. The trained nurses could also go for leave, workshop and so forth. (P1)

In our clinic, really, the main challenge they say is that it is time-consuming. The clinic is mostly overcrowded. The consultation of patients must take into account waiting time's policy and for this the nurses push queues than treat accordingly. If a nurse treats using IMCI strategy, she also has to consider the queue outside. (P13)

Management Barriers

Four management barriers were described. These were: (i) lack of appreciation and absence of an allowance for managers in acting posts was viewed as unfair; (ii) lack of refresher courses and updates on the IMCI programme; (iii) lack of supportive supervision in implementation after IMCI training; and (iv) unavailability of supervision from clinic managers. These were regarded by clinic managers as some of their experiences in managing IMCI implementation by trained professional nurses. Participants stated the following:

I am acting as an OPM (clinic manager) and earning as a clinical nurse practitioner, so the extra management roles do not add anything to my monthly pay. It was going to be better if the acting post had extra payments for it increases one's duties. (P1)

The top managers of the programme should come and follow-up the programme and find out if we are still doing what we have been taught. People have been trained but whether they are implementing nobody cares. (P10)

Myself as a manager also fail to supervise these people. The programmes are too many and are demanding that I be able to supervise them all. I cannot manage supervising all these programmes. The other issue is that as an operational manager I am not always available at this clinic. There are meetings of which in a week I can be in the facility only for two days; other days I will be attending meetings. This leaves me in reality not adhering to my supervision work. My supervision is not enough due to this overloaded programmes and the meetings I am always attending. (P15)

Lack of Resources

Clinic managers complained of a lack of resources including, but not limited to, shortage of staff, poor infrastructure, shortage of medication, as well as lack of funds for IMCI training and awareness campaigns. They lamented the fact that these resources are essential for the implementation of the strategy. These shortages make their management difficult. The participants verbal quotes were:

Since 2007 when the clinic was opened, we had only six professional nurses. The population is not stagnant; if our staff is increased then we could allocate some to the programmes we are expected to implement. I can say we are working under pressure, when you look at it you could see nurses acting like they have burnout syndrome. When a nurse is finished with a patient for child health, an antenatal gets inside, then a pregnant woman in labour, then another child enters again; this leaves the nurse being unable to focus well. (P3)

These things; infrastructure, that rooms are few, is true, but we have the problem in issues like staff. Even if the staff is increased, we will still have the infrastructure and if the infrastructure is improved, we may still have a staff gap. If they could add the staff, improve the infrastructure by adding more rooms it could be better for we took one room to be a counselling room. (P6)

Like now with this utilization rate, we raise it if the district was funding the activities in the community. We were to invite people to come for awareness but because we had to ask for donations from people and sometimes we fail to get those donations. Our district and the province do not support such functions and we feel they do not support us. We are working because there is nothing else to do (shaking her head). (P8)

DISCUSSION

The findings revealed inconsistencies in IMCI implementation that emerged as positive and negative experiences. Although most of the experiences of the managers were negative, a few positive experiences did emerge.

Positive Experiences

Most clinic managers agreed that IMCI is a good strategy while others pointed out that it

does not require sophisticated equipment and in addition does not require a large number of drugs. Some clinic managers reflected that if IMCI is used, children under-five will not be mismanaged and thus poor outcomes could be prevented.

These findings are supported by Renosa et al. (2020) where the majority of the nurses believed that implementation of the IMCI guidelines would have a positive effect on their skills in paediatric management and bring about improvement in children's health. Several studies have shown that the health worker's skills and self-esteem regarding child management improve by means of the IMCI strategy (Fick 2017; Horwood et al. 2009; WHO 2016). Furthermore, Kiplagat et al. (2014) concurred in that the IMCI strategy allows health care workers to classify illness and treat the child even without a laboratory investigation or sophisticated equipment. The implementation of the IMCI strategy if strengthened could thus improve the child management skills of those implementing it and thus the child health could be improved.

Negative Experiences

The majority of experiences shared by the clinic managers were negative. They considered that these negative experiences hampered IMCI implementation and included staff barriers, management barriers and a lack of resources.

Staff Barriers

Staff barriers to the IMCI strategy implementation were the limited number of trained professional nurses and clinic managers. The lack of training resulted in inconsistencies when treating children under five years of age. Some children were case managed using the IMCI strategy and some treated without considering IMCI. Some clinic managers indicated that they were not IMCI trained and were thus unable to supervise the IMCI programme. Similar findings had been reported in other studies in Botswana and South Africa which noted the limited number of IMCI-trained personnel thereby limiting implementation of the IMCI strategy (Creswell 2014; Horwood et al. 2009; Kiplagat et al. 2014; Meno et al. 2019; Mupara and Lubbe 2016). Furthermore, Munyewende and Rispel (2014) highlighted the manager's pivotal role in planning, allocating re-

sources and monitoring health policy targets and outcomes. This finding suggests that the lack of training of such managers could hamper IMCI implementation as they may not be in a position to motivate for resources to support the programme. Renosa et al. (2020) found that coordinators managing vertical programmes, such as the expanded programme on immunisation, were not trained on IMCI. The non-training of such coordinators is worsening poor IMCI implementation for both are child health programmes that are running parallel instead of complementing each other. In Botswana registered nurses also recommended that managers be trained in order for them to motivate for resources in support of the IMCI programme (Mupara and Lubbe 2016).

Some of the IMCI-trained professional nurses appeared to be uninterested and had a negative attitude towards using IMCI when treating children under five years of age. The same findings were reported in several IMCI studies (Fick 2017; Lange et al. 2014; Meno et al. 2019; Steinhardt et al. 2015). Clinic managers also pointed to the time-consuming nature of the IMCI strategy which they felt increases patient waiting times as nurses have to go through the booklet for each and every symptom. If professional nurses were to accept and use the strategy more often as recommended, the less time it would take for them to assess/consult the child. The time consuming nature of IMCI findings in this study are in keeping with several other studies which reported its negative impact on the strategy implementation (Ahmed et al. 2010; Miller et al. et al. 2014; Mullei et al. 2009; Steinhardt et al. 2015). Similar sentiments were also raised by family practitioners (Taba et al. 2012). The current study also reveals the many programmes that are rendered at the clinics in one cubicle by one nurse (one-stop approach) as a challenge to IMCI implementation. Nurses were reported to lose focus and not master whatever they were working on. This was also confirmed by Vhuromu and Maselesele-Davhana (2009) that it is difficult to implement IMCI with a 'supermarket' approach especially when nurse-patient ratios are a challenge. IMCI-trained professional nurses need motivation to follow the IMCI guidelines. In support of the motivation, Horwood et al. (2009) suggested that awarding clinics IMCI excellent accreditation could be used to motivate practitioners to implement this strategy.

Management Barriers

Clinic managers who were acting in management posts felt that were working hard but although they had been in the post for more than three years they were not remunerated for management responsibilities. A lack of appreciation and the absence of an allowance were demotivating and resulted in poor support of the implementation of the IMCI strategy. As outlined by Clarke (2016), poor salaries have a negative effect on the workforce and work outputs. Furthermore, Lange et al. (2014) reiterated that poor remuneration has been viewed by some health workers as a factor leading to low performance while adequate pay was also seen as a way of giving recognition to the efforts of health workers. Appreciating of clinic managers was viewed as a motivating factor that could improve IMCI implementation in this study.

Most managers indicated that there is a need for refresher courses and updates for the IMCI programme as there was a lack of supportive supervision and follow-up after IMCI training. These were perceived as barriers to the implementation of IMCI strategy. The WHO/UNICEF (2005) recommended follow-up of four-to-six weeks post-IMCI training was not done as most managers indicated that they never saw trainers visiting the PHC clinics for this purpose. Similarly, since training there had been no supportive supervision or refresher courses on IMCI, yet supervision, follow-up and refresher courses were deemed important to reinforce what had been learned in training and to provide up-dates (WHO 1999). Lack of supportive supervision, refresher courses as well as follow-up were common experiences in several studies and were cited as challenges to the IMCI programme (Horwood et al. 2009; Kiplagat et al. 2014; Maleshane 2012; Pradhan 2013; Titaley et al. 2014). Ahmed et al. (2010) and Goga and Muhe (2011) also concurred with the findings of this study stating that regular updates promote the implementation of the IMCI strategy. Furthermore, Goga and Muhe (2011) reported that follow-up after training was viewed as important to strengthen practical skills, establish technical support, planning and follow-up. However, on the contrary, some health workers in the same study regarded follow-up as if they are being policed when working (Goga and

Muhe 2011). The participants themselves, as clinic managers, were well aware of their supervisory role for all programmes that were running at PHC clinics but reported their failure to manage them appropriately as a result of the numerous programmes they were expected to supervise.

Most managers attended frequent unscheduled meetings, which also made the IMCI programme difficult to manage. They described having to attend workshops and meetings and learning of requirements that they could not even implement as they were overloaded with work. Munyewende and Rispel (2014) found similar experiences where nurse managers suffered from stress as a result of sudden requests for reports or being summoned to unplanned meetings. Likewise, Armstrong et al. (2015) alluded to the difficulties managers had to endure because of unscheduled meetings leaving their IMCI programmes unattended.

Lack of Resources

Lack of resources, for example shortage of staff, poor infrastructure including shortage of consulting rooms, shortage of medication and of IMCI materials and lack of funding for awareness campaigns to communities were identified as barriers to the implementation of the IMCI strategy. This study found staff shortages among nursing staff, clerks, groundsmen and cleaners. This shortage of staff made the clinic manager's task difficult as there was not enough staff to render services to their clients. Staff shortages were blamed for poor IMCI implementation as nurses were performing non-nursing duties such as cleaning. Nurses were reported to be overworked and could no longer follow the IMCI guidelines while trying to work through a queue of patients. The findings in this study are similar to those of other studies reporting a huge shortage of personnel making IMCI implementation difficult (Kiplagat et al. 2015; Meno et al. 2019; Pradhan et al. 2013).

Most participants noted the very limited number of consulting rooms as well as the dilapidated condition of clinic buildings in which they were working, which made it difficult for them to perform their duties. To implement IMCI a private room that is conducive to counselling is required because the privacy of a guardian/mother is essential and confidentiality must be respected. In Limpopo Province Vhuromu and Davhana-Ma-

selesele (2009) found that small consulting rooms were not conducive to practising the IMCI strategy. In Kenya Mullei et al. (2008) reported that the inappropriate layout of a medical facility made observation of first-dose medication difficult for IMCI-trained nurses. On the contrary, Pillay (2012) in the eThekweni district in KwaZulu-Natal, reported that the space required for implementation of the IMCI strategy at clinics was adequate which differs from the setting for this study.

Lack of medication was cited as one of the barriers to IMCI implementation due to either its shortage or being out of stock. A shortage of medicine, for example, vaccines, causes an interruption of the IMCI programme when children miss scheduled immunisations. At times, some materials, for example, thermometers, were out of stock thereby making child assessment difficult. There are PHC clinics in which the managers reported having only one or two IMCI booklets, which made it difficult for nurses to consult patients using IMCI guidelines. OPMs described the difficulty of managing a PHC clinic with a shortage of such key IMCI resources. An insufficient supply of IMCI essential drugs made it difficult to follow IMCI guidelines when case managing children (Mulaudzi 2015; Mullei et al. 2008; Titaley et al. 2014; Vhuromu and Masesele-Davhana 2009). On the contrary, Kalu et al. (2012) in a study conducted in Tanzania, indicated that the unavailability of equipment did not necessarily mean that health workers could not implement IMCI.

Clinic manager's indicated that they were expected to raise community awareness with every programme that was offered at their respective clinics, including IMCI, and felt they were expected to work beyond their abilities. Some programmes at the clinics were failing due to lack of funds for such activities. These findings on the lack of financial support for community awareness are discouraging clinic managers. A study conducted in Tanzania reported that there should be better funding for programmes such as malaria, HIV/AIDS and TB rather than for IMCI (Ahmed et al. 2010) which only manages children under years of age. The perceived lack of support seems to discourage clinic managers in their task of community empowerment. It is therefore imperative for South Africa and Limpopo province to provide serious and sustained organisational and

financial support for programme training, implementation and monitoring to ensure maximum and sustained benefits for the IMCI strategy (Ahmed et al. 2010).

CONCLUSION

The findings of this study highlighted both positive and negative experiences of the operational managers in the implementation of the IMCI strategy. The positive experiences highlighted how beneficial it can be if recommended guidelines are followed. The negative experiences included the lack of resources, staff barriers as well as management barriers which impacted negatively on the strategy implementation. The managers' experiences were explored and described and possible solutions recommended. It can be concluded that the objective of the study has been achieved. Based on the findings of the study recommendations to the National Department of Health and the provincial department of health in ensuring the budget for IMCI strategy implementation. There must be improvement of IMCI at operational level which will include infrastructure improvement as well as training and staffing of the PHC clinics.

RECOMMENDATIONS

The participants recommended the appointment of a focal person at each PHC clinic to ensure that implementation of the IMCI programme is monitored on a continuous basis. The district management needs to ensure that supportive supervisory visits are made quarterly and that staff are updated timeously on any changes in the practice area. Paper-based IMCI guidelines should be replaced with electronic versions for them to be more readily available and for time management. Based on the findings the study the operational managers through the district managers to motivate from the provincial department of health for training and employment of more staff for implementation of IMCI strategy. All operational managers to be IMCI trained to be effective in managing the strategy implementation.

LIMITATIONS

The study only included clinic managers in Vhembe district. The inclusion of the district man-

agers could have shed more light on the implementation of IMCI strategy. If mothers/guardian were included they could also have added value to the study findings.

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