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Health Trainer Factors That Influence the Implementation of Policy on Management of Childhood Illnesses in Bomet County

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Abstract

The study aimed at determining the health trainer factors that influence the implementation of Policy on management of childhood illnesses at Bomet County. A descriptive cross sectional study design with both quantitative and qualitative approaches was employed. The study was carried out in Bomet County. The study population was a total of 279 health workers in Bomet County Hospital and Tenwek Hospital. A sample of 164 was arrived at which was selected using stratified and simple random sampling technique. The quantitative data was analyzed using Statistical Package for Social Sciences (SPSS version 22). The study found out that health trainer factors do not significantly influence implementation.The study recommended that the health trainers role in the implementation of the policy on childhood illnesses be reviewed.

Keywords: *health trainer factors, implementation, policy on management, childhood illnesses*

1.0 INTRODUCTION

1.1 Background of the Study

Health trainers are instructors or lecturers who disseminate the knowledge they have to health providers with an aim of improving the health sector. On the other hand, Integrated Management of Childhood Illness (IMCI) is an approach to child health that focuses on diagnosis and management of common childhood illnesses the aims to reduce death, illness and disability, among children under five years of age.

The Ministry Of Health [MOH], 2017 reported that globally, despite great efforts to better the health of children and their nutrition for more than 25 years, by the end of every year about 12 million children die before they attain the age of 5 (MoH, 2017). By the end of 2001, about 40 countries were at different stages of implementation of policy on management of childhood illnesses (Ellenbecker, Fawcett & Glazer, 2012). In Peru, Brazil and Colombia there is an ongoing process aimed at bettering the skills of health workers, the health system and enlightening families on good health for their children. IMCI in India and Pakistan has been operating for about thirty years, and most evaluations show positive results. In Israel as well as in Germany these efforts came up due to negative impacts of disease programs control for example those that deal with diarrhea and acute respiratory infections. IMCI in the above countries is being actualized with regards to a Family Health Program (FHP), upheld by the World Bank and by the MoH. The FHP, coordinated with the Community Health Worker's Program (CHWP), is incorporated among general society approaches of the MoH with an extraordinary accentuation on first-level care. The indictors used for implementation included; guiding policies and procedures, ensuring the health workers are equipped on IMCI and capacity building to patients who visited the health facilities.

Kenya Ministry of Health and other stakeholders have supported courses in Emergency Triage Assessment and Treatment Plus (ETAT+) within the framework of government Provincial, District and county hospitals throughout the country (MoH, 2017). Kenya assumed a dynamic role in building up the IMCI program. It was one of the nations which partook in a Multi-Country Evaluation (MCE) study (Kenya Demographic Health Survey, 2014). Outcomes from the MCE proposed that, if legitimately executed, IMCI enhances the nature of care, is financially, and decreases grimness and death rates for children under-five years old. After scattering of the MCE discoveries, IMCI was incorporated into the list of Essential Health Interventions in Kenya to be effected all through the nation. The policy on management of childhood illnesses therefore encompasses both IMCI and ETAT to facilitate better outcomes for children seeking services at health facilities.

1.2 Problem Statement

The implementation of the policy on management of childhood illnesses as a strategy has accomplished significantly positive outcomes both in reducing mortality and improving health outcomes for children under five in several counties in Kenya. However Longisa was rated at 6.1 compared to private hospitals like Tenwek 9.3 on the implementation of policies on management of childhood illnesses (MoH, 2017). In Bomet County, under-five mortality reduced by 28%

from thirty seven for each thousand live births in 2014 to thirteen of every one thousand live births (13/1000) by 2016 though this is still short of the target of 44 % (MoH, 2017). The Nurse training programs at Diploma and Undergraduate levels include the teaching and examining of students in IMCI where those who graduated since 2014 have all undergone a course in IMCI and ETAT within the program. The Nursing Council of Kenya [NCK], 2016 identified the primary challenge of implementation of the strategy as low adherence to the guidelines by health care workers. To ensure better outcomes, nurses working in pediatrics and emergency departments handling children have had a number of updates on the implementation of the policies on management of childhood illnesses. Despite these inputs, there was lower performance reported of implementation of policy on management of childhood illnesses in Longisa public hospital compared to other service providers in Bomet (Nyamongo, 2016). What is not clear is the factors that influence the implementation of the policy on management of childhood illnesses.

1.3 Specific Objective

To determine the health trainer factors that influenced the implementation of Policy on management of childhood illnesses in Bomet County.

2.0 LITERATURE REVIEW

2.1 Health trainer Factors

2.1.1 Knowledge

The world health organization through its sister world health assembly noted the need to increase the number of health service providers in Africa (D'Souza, 2013). In order for this to become a reality they called their partners in the health sector to assist with the education institutions formulate curriculum to be used in training of the health workers in different cadres in countries with low income regions. The countries and the training institutions were to be monitored and continuously assessed in order to ensure that highly trained health workers emerged from these institutions for quality health service provision to the masses to be realized. This was in line with the world health assembly resolutions of 2013 that encouraged, natured and supported transformative health worker education in the health sector.

According to Rodriguez (2015), Indian culture has always mentioned nursing care from the times of Vedas, unfortunately the Indian nursing workforce was still insufficient and was unable to realize the ever rising medical needs of the citizens. The main challenge that faced the nursing education and the nursing work force or profession was in examining and finding out the purpose of nurse training factors and needs. In order to overcome this challenge and solve the problem data from supporting the statements were collected from different departments such as the Ministry of Health and Family Welfare and the Nursing Council of India.

Both Wijekoom and Martines (2014) observe that using members of the community in the provision of basic health care services to communities they come from has a history of more than 50-years. Early programs for instance the use of community health volunteer workers in Thailand in the 1950sand the Chinese barefoot doctor program come into mind when thinking about such activities. In Africa, such initiatives include those undertaken in states like Zimbabwe

and Tanzania, which were set politically in the context of systemic social transformation after the end of colonialism and were focused mainly on rural development, self-reliance and eradication of inequalities and poverty (Magadi & Madise, 2013).

In the 1980s, CHW programs expanded rapidly after the Declaration of Alma-Ata in 1978. Using outreach workers was the main characteristic of the initiative by the West African state of Bamako. There is evidence to suggest that using outreach workers did notably increase the number of children treated and immunized in the 25 areas covered by the study. However by 1990s, interest in the CWH programs reduced this resulting from changes in policy which moved from the emphasis of both basic needs and self-reliance to structural adjustment programs driven by the World-Bank. These World-Bank policies and programs were a massive failure since they were forced down on African states without proper planning and feasibility studies done. Moreover, most World-Bank projects were not sustainable in the long run and had difficulties with quality control maintenance. There was also the aspect of host communities expecting too much from the projects, often leading to the eventual lack of interest in the said projects due to un-met expectations (Hill,Kendall,Arthur,Kirkwood &Adjei, 2010).

However, there is renewed interest in CHW programs due to the reason that service provision especially to rural communities, cannot addresses sufficiently by the existing health provision systems. It is just not possible for health facilities alone to provide sufficient access to medical care for children, hence the need to increase health care facilities in the local community. Some African governments have made CHWs a key pillar in health provision in their endeavor to minimize death in children. Use of CHWs has been noted as a major way of addressing growing shortages of health workers in the low-income and developing countries (Lowwenson, 2014).

Chandrashekahar and Ravi (2010) show that training of nurses appropriately and their knowledge on the approach, and the entire health support system was vital for them to understand the main aspects affecting implementation of policy on management of childhood illnesses. Scope of IMCI in pre-benefit training was neglecting to wipe out the requirement for in-benefit training, because of the constrained scope of IMCI pre-benefit and the absence of proper reasonable experience.

A study by Mosley and Chen (2011) show that only 40% of the nurses have IMCI knowledge and 15% of this figure is competent in their medical career. The methods for choosing health workers for training should be evaluated to build straightforwardness. Steps are additionally expected to distinguish health workers who were prepared in the pre-benefit period to dodge re-training.

According to Wagstaff (2014) the primary limitation of pre-advantage training is the nonattendance of a training group. It is likewise hard to follow health workers that have training in pre-advantaged organizations, and as a result many are normally retrained in-advantage.

While health workers coming back from training made a request to impart their insight and IMCI materials to partners, normally this is frequently constrained to a short input session in clinical groups and there are insufficient IMCI work help for other staff to utilize (Thind & Cruz, 2013). Untrained health workers are often unwilling to gain from others, liking to go to the training

themselves and get routine set of expenses. The absence of straightforwardness in the process for choosing members additionally influences peer-learning.

Following the alarming wide spread of HIV and AIDS, the world health partners held one of its seating in Uganda and made declaration which in essence structured more funds towards research, collecting information and dissemination it in a structured manner (Gilson & Mills, 2014). This was done so as to encourage discussion and decision making process. The information gotten from research would also be used in learning institutions and as result it would spread in a structured manner that was bound to be beneficial to those already infected and affected. Through such information governments would come up with their own policy guided by the already set world policies there by setting the agenda at both the local level and nationally.

Shortage of qualified health workers is caused by several factors including; The migration of health workers to high-income and developed countries thus creating shortages in poor and developing countries, increase in labor mobility within the health sector, high rates of absenteeism from work, death, unbearable and increased workloads as a result of the HIV/AIDS scourge and the lack of funds coupled with poor management of the health sector. CHWs are usually available and geographically closer to the community when compared to health facilities. Since they come from the community concerned, they can easily overcome both linguistic and cultural barriers while dealing with the local people (Mosley & Chen, 2011).

2.1.2 Availability of Clinical Facilities

According to Caldwell and Caldwell (2014) lack of clinical facilities influences the implementation of policy on management of childhood illness. This was highly attributed to under budgeting in the Ministry of Health. In Colombia, a myriad challenges such low income, greater financial needs, fragmentations, and lack of faith and trust by citizens on health insurance policies and lack of properly instituted policy frame work led the government to create through the law a new agency (Frankenberg & Thomas, 2011). Through this agency, government health system provided information on how context, political challenges, policy and solutions could increasingly lead to the systematic use of evidence to inform an effective health policy.

Marsh (2014) asserts that, with the creation of HTA agency, Colombia government made assumptions that this would provide a path to improved health provision in the short period that resources were allocated. Unfortunately unforeseen problems emerged such as inadequate or no capacity which had to be overcome by the policy so there could be a change of mind of the main stakeholders. No sooner had the agency started working than they realized that historical efforts toward the creation of the architectural frame work would also have to be considered.

There is enough evidence to show that child deaths are as a result of where one lives with mortality among children under-five being higher in the rural areas. In many developing countries, there are more healthcare personnel concentrated in urban areas as compared to rural areas. This means that health services in developing countries will reach urban areas first and more often than not may not extend to the rural areas. The effect of the distance travelled from home to health facilities on child deaths is severe in circumstances where a significant proportion of the population lives in areas with either little or no access to health care (Wijekoom &

Martines, 2014). Studies have shown a significant increase in the death of children under the age of five years as the distance from home to the nearest health facility increases. A comprehensive study of health programs in Haiti showed that deficient quality and lower coverage of key services, reduced access to health services, resulted to higher under-five child mortality and malnutrition rates in the peripheral mountain areas compared to the central plains (D'Souza, 2013).

Pillai,Williams,Glick,Polsky,Berlin and Lowe (2014) further point that the social and health security systems realized that the new system had widened the population coverage from lower percentage of twenty one to sixty six over a period of twelve years. Even though there were positive changes, there were still lingering differences with the lower income earners still suffering high mortality rates. As a result the employees were required to pay into the already existing health policy plans to which the employers also contributed. Through such plans, health standards in Colombia greatly improved since 1980s. Restructuring of the public health care funding in 1993 transformed the structure by taking away the burden of reduced rates from health policy providers to users.

DHS survey studies done in fourteen countries show overall improvements in survival among children. However, eight out of the fourteen countries showed widening gaps in child deaths between the rich and the poor. A prospective cohort study of infants in South Africa which measured the inequalities in child deaths and HIV transmission showed disparities in the access to medical care between most poor and least poor families ((Wijekoom & Martines, 2014). HIV transmission rates and infant deaths were higher among the poorest families, with the least poor having a better access to immunization. The relationship between the four socio-economic indicators; household asset index, land ownership, mother's education, and father's education and stunted growth which is usually used to measure nutrition inequalities showed higher prevalence cases of stunting among children of parents with no education as compared to educated parents with secondary school level and above and children from households belonging in the poorest groups compared to those from the least poor groups (Department of Health and Human Services, 2011).

In Zimbabwe, the government policy stipulated that citizens be entitled to free healthcare, but unfortunately this is not the case as put by the health minister who admitted in parliament that this was not happening (Wijekoom & Martines, 2014). The citizen's health watch dog on the other hand had it that 90% of healthcare initiations didn't have essential medicines in stock and that sporadic shortages of antiretroviral (ARV) drugs had been realized. These drugs are supposed to be absolutely free for patients in public hospitals.

This was a regularly updated publication that aimed to promote the rational use of medicine throughout Zimbabwe (Lowwenson, 2010). This would in essence ensure both optimal patient management and the efficient use of scarce resources. This required listing of the essential medicines to be stocked by the National Pharmaceutical Company (NatPharm), Edliz provided standard treatment guidelines for the health problems. The ministry of health and child welfare also disseminated it further by providing every health facility in Zimbabwe with a copy of EDLIZ.

Over one hundred countries are using this component and one thing worth noting is that they formed a set of acceptable guidelines that used in assessment and treatment of ill (Whyte, 2014). The guidelines constitute preventive and care counseling to the health service providers. This training provided the health workers with the knowledge to be able to identify and manage illnesses. This was done taking cognizant of the fact many health workers could be having limitations after their initial basic training and that sick children more often than not presented with undifferentiated and overlapping syndrome thereby making it easy to misdiagnose a patient.

Magadi and Madise (2013) note that the number of deaths among children under the age of five years still remains very high despite huge investments in health care reforms and the launch of numerous child survival programs by both governments and donor agencies. There is a continuous streak of child deaths due to lack of medical services, the inability to access medical care or the choice not to seek care, and the failure by families not recognize the early warning signs of life-threatening illnesses.

Access to adequate health can be associated with child mortality, with improved access to medical care having the potential to significantly reduce infant deaths in developing countries (Hobcraft & Rutstein, 2015). Health facility-based services alone cannot provide sufficient medical care among children. There is thus the need to increase their coverage at the local community level. There are ways which can be applied to improve access to effective medical care among children. These include the training of health workers at the rural health centers so that they can be able to recognize and treat common illnesses among children such as malaria, pneumonia and diarrhea (Hill et al., 2010). A huge proportion of child deaths can be prevented through the appropriate and low-cost treatment of children either at home or in the community by use of anti-malaria drugs, oral rehydration therapy and antibiotics (Arner, 2010).

Machakos county Kenya provided outpatient services for simple ailments such as malaria, common cold, flue and uncomplicated skin conditions (Lowwenson, 2014). Nurses managed patients who did not need to be referred to health centers. The first point of contact with patients was dispensaries which were the lowest level of public health system. Simple medical problems during pregnancy such as anemia and normal deliveries were provided by the enrolled nurses who also provided antennal care. The dispensaries were staffed by qualified and well trained nurses, public health technicians, dressers who were also known as medical assistants. The nurses also provided basic outpatient curative services.
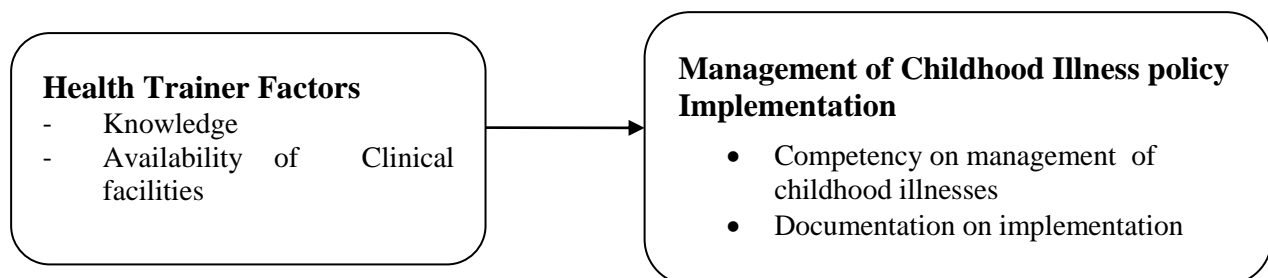
2.2 Conceptual Framework

Figure 1 Conceptual Framework

3.0 RESEARCH METHODOLOGY

A descriptive cross sectional study design with both quantitative and qualitative approaches was used for data collection. The study was carried out in Bomet County. The study population was a total of 279 health workers in Bomet County Hospital and Tenwek Hospital. A sample of 164 was arrived at which was selected using stratified and simple random sampling technique. The quantitative data was analyzed Statistical Package for Social Sciences version 24. Descriptive analysis was analysed as a basis for inferential Statistical Analysis like Analysis of Variance, correlation analysis and multivariate regression. The implementation of the policy on 309 children seen at the health facilities in the period of study was at 8.4%.

4.0 DATA ANALYSIS

4.1 Response Rate

Table 1 shows tabulations of the response rate as presented below.

Table 1 Response Rate

Response	Health Providers		Health Trainers		Cumulative Total	
	F	**%**	**F**	**%**	**F**	**%**
Responded	105	64	14	9	119	73
Not responded	43	26	2	1	45	27
Total	**148**	**90**	**16**	**10**	**164**	**100**

Source: Survey Data (2018)

Findings show that 105 (64%) and 14(9%) health trainers responded to the questionnaires contributing to a response rate of73%. The study considered this percentage adequate and conforms to Mugenda and Mugenda (2003) stipulation that a response rate of 50% is adequate for analysis and reporting; a rate of 60% is good and a response rate of 70% and over is excellent.

4.2 Demographic Information

Table 2 Demographic Information

Gender of Respondents	Health Providers		Health Trainers		Cumulative Total	
	F	%	F	%	F	%
Male	49	41	8	7	57	48
Female	56	47	6	5	62	52
Total	**105**	**88**	**14**	**12**	**119**	**100**
Distribution of Respondents by their Level of Education	**F**	**%**	**F**	**%**	**F**	**%**
Certificate	3	3	-	-	3	3
Diploma	63	53	3	3	66	55
Postgraduate	39	33	11	9	50	42
Total	**105**	**88**	**14**	**12**	**119**	**100**
Distribution of Respondents by Age	**F**	**%**	**F**	**%**	**F**	**%**
20-29 years	47	39	1	1	48	40
30-39 years	22	18	6	5	28	24
40-49 years	28	24	5	4	33	28
50-59 years	7	6	2	2	9	8
60 and above	1	1	-	-	1	1
Total	**105**	**88**	**14**	**12**	**119**	**100**
Distribution of Health Providers by Working Experience	**F**	**%**	**F**	**%**	**F**	**%**
Less than 10 years	85	71	7	6	92	77
10-15 years	10	8	4	3	14	12
More than 15 years	10	8	3	3	13	11
Total	105	88	14	12	119	100

Source: Survey Data (2018)

Table 2 shows that 56(47%) of the health providers who were the majority were female while 49(41%) were male; 8(7%) of the health trainers who were the majority were male while (6)5% were female. This thus reflects a gender balance representation in the research although there was a higher female gender representation of respondents especially the health providers inBomet County Hospital and Tenwek.

As shown in Table 2, 63(53%) of the health providers who were the majority had a diploma, 39(33%) were post graduates while 3(3%) had a certificate. 9(9%) of the health trainers who were the majority were post graduates while 3(3%) had a diploma. Results show that the management of childhood illnesses is part of the diploma training curriculum for both nurse and clinicians.

Table 2 shows that 47(39%) of the health providers who were the majority were between 20 and 29 years,28(24%) were between 40 and 49 years, 22(18%) were between 30 and 39 years, 7(6%) were between 50 and 59 years while 1(1%) were 60 years and above. 6(5%) of the health trainers who were the majority were between 30 and 39 years, 5(4%) were between 40 and 49 years, 2(2%) were between 50 and 59 years while 1(1%) were between 20 and 29 years. This was a result of the high number of clinical officers and nurses who responded to the study and according to most hospitals; staff members are employed in their youthful stage an indication that they have all undergone training in the curriculum.

Table 2 shows that 85(71%) of the health providers who were the majority had worked in Bomet County Hospital and Tenwek for a period less than 10 years while 10(8%) had worked in Bomet County Hospital and Tenwek for a period between 10 to 15 years and more than 15 years. 7(6%) of the health trainers who were the majority had worked in Bomet County Hospital and Tenwek for a period less than 10 years while 4(3%) had worked in Bomet County Hospital and Tenwek for a period between 10 to 15 years and more than 15 years. The findings show that respondents were present during the policy implementation processes that have occurred in the institution since the adaption of ETAT+ Training program.

4.3 Health Trainer Factors

4.3.1 Teaching methods

Table 3 Teaching methods

	Mean	Std. Deviation
I always teach students taking the pediatric unit on management of childhood illnesses	1.78	.801
The curriculum clearly spells out the component of ETAT for health provider training	1.92	.828
I always examine students on IMCI in the clinical setting	1.92	.997
I always ensure that the students final examination includes ETAT	2.14	.864
Total	**7.76**	**3.49**
Average	**1.94**	**0.872**

Source: Survey Data (2018)

The study sought to establish the teaching methods used by the health trainers. According to the findings in Table 3, health trainers applied the teaching methods to a low extent as shown by an average score of 1.94 in that; health trainers always ensured that the students final examination included ETAT to a low extent as shown by a mean score of 2.14, health trainers always examined students on IMCI in the clinical setting to a low extent as shown by a mean score of 1.92, the curriculum clearly spelled out the component of ETAT for health provider training to a low extent as shown by a mean score of 1.92 and health trainers always taught students taking the pediatric unit on management of childhood illnesses to a low extent as shown by a mean score of 1.78.

The study findings were in line with a study by Frankenberg and Thomas (2011) who argued that various challenges identified with IMCI policy availability, specifically lack of knowledge on rules of IMCI amongst the health care workers. The health workers that had knowledge on the IMCI spoke well on its approach. Majority of the respondents were in agreement that the IMCI approach helped in reduction of sickness among children and thus led to reduction in their death rates. Lack of training among the health workers on the available policies and lack of appropriate monitoring were the main challenges found in the use of IMCI. Current research by Gilson and Mills (2014) concluded that majority of the health workers diagnosed children according to each type of disease and prescribed appropriately. Most of the referrals were very poor as most of them were of severe diseases from children. It was also found that the health workers spent less time caring for the children and giving of their first dose was also poor. The best practice observed was the frequent weighing of sick children before being attended to by the doctors.

4.3.2 Clinical Competencies

Table 4 Clinical competencies

	Mean	Std. Deviation
I have the competencies for demonstrating ETAT	2.50	1.019
I always work with the clinical instructor on implementation of management of child hood illness	2.35	1.150
I have documentation in our possession on the performance of students on management of childhood illnesses	2.21	.892
Total	**7.06**	**3.061**
Average	**2.35**	**1.020**

Source: Survey Data (2018)

According to the findings in Table 4, health trainers applied their clinical competences to a low extent as shown by an average score of 2.35 in that; health trainers had the competencies for demonstrating ETAT to a moderate extent as shown by a mean score of 2.50, health trainers always worked with the clinical instructors on implementation of management of child hood illness to a low extent as shown by a mean score of 2.35 and health trainers had documentation in their possession on the performance of students on management of childhood illnesses to a moderate extent as shown by a mean score of 2.21.

This results conform to the findings of Nolan, Angos and Cunha (2014) in that the Ministry of Health in Djibouti is faced with serious supervision manpower who can ensure compliance to IMCI and ETAT in hospitals guidelines to the rural areas which has resulted to an increase in the number of children deaths from 7% in 2010 to 11.3% in 2013. Compliance to IMCI guidelines have been influence to a great extent by short-staffing and untrustworthy medication supplies;

and the absence of genuine decentralization of compliance to IMCI guidelines control to the local level. In Zimbabwe, health provision was provided by the government through the Ministry of Health (Magadi & Madise, 2013). Health provision was greatly subsidized as citizens only paid half of the total cost incurred during treatment in the public hospital. This was supported by different entities such as the local government, missionaries, industrial organizations and the private sector. Due to high inflation rates in Zimbabwe, there were limited medical supplies marked with chronic shortage of drugs, deteriorated infrastructure and a thin well trained work force leading to very low rating of the country's health system by the world health organization.

Table 5 Analysis of Variance for Health Trainer Factors

		Sum of Squares	df	Mean Square	F	Sig
Between People		30.531	13	2.349		
Within People	Between Items	9.816	6	1.636	2.926	.013
	Residual	43.612	78	.559		
	Total	53.429	84	.636		
Total		83.959	97	.866		

Grand Mean = 2.0204

The grand mean for the responses to items under health trainer was 2.202 (F=2.926; p>0.013). This was statistically significant.The study findings were in line with a study by Frankenberg and Thomas (2011) who argued that various challenges identified with IMCI policy availability, specifically lack of knowledge on rules of IMCI amongst the health care workers. The health workers that had knowledge on the IMCI spoke well on its approach. Majority of the respondents were in agreement that the IMCI approach helped in reduction of sickness among children and thus led to reduction in their death rates. Lack of training among the health workers on the available policies and lack of appropriate monitoring were the main challenges found in the use of IMCI. Current research by Gilson and Mills (2014) concluded that majority of the health workers diagnosed children according to each type of disease and prescribed appropriately. Most of the referrals were very poor as most of them were of severe diseases from children. It was also found that the health workers spent less time caring for the children and giving of their first dose was also poor. The best practice observed was the frequent weighing of sick children before being attended to by the doctors.

4.4 Implementation of Policy on management of Childhood illnesses

Table 6 Item Statistics on Implementation of Policy

	Mean	Std. Deviation	N
I always refer to the policy on IMCI when managing patients	1.5714	.85163	14
I have been trained on IMCI	1.7143	.46881	14
I have been trained on ETAT	1.8571	.77033	14
I have documentation on performance of students on IMCI	2.2143	.89258	14

The dependent variable was implementation of policy which was rated using the items in table 6 above. Though there was variation in the mean between the documentation (2.2; SD .89) and the other items, training on IMCI (mean 1.7; SD 0.467) was least varied.This results conform to the findings of Nolan, Angos and Cunha (2014) in that the Ministry of Health in Djibouti is faced with serious supervision manpower who can ensure compliance to IMCI and ETAT in hospitals guidelines to the rural areas which has resulted to an increase in the number of children deaths from 7% in 2010 to 11.3% in 2013. Compliance to IMCI guidelines have been influence to a great extent by short-staffing and untrustworthy medication supplies; and the absence of genuine decentralization of compliance to IMCI guidelines control to the local level. In Zimbabwe, health provision was provided by the government through the Ministry of Health (Magadi & Madise, 2013). Health provision was greatly subsidized as citizens only paid half of the total cost incurred during treatment in the public hospital. This was supported by different entities such as the local government, missionaries, industrial organizations and the private sector. Due to high inflation rates in Zimbabwe, there were limited medical supplies marked with chronic shortage of drugs, deteriorated infrastructure and a thin well trained work force leading to very low rating of the country's health system by the world health organization.

4.5 Summary of Findings

In order to assess the relationship between the study variables, Pearson correlation and multiple regression analysis were conducted and the results were as follows:

4.5.1 Correlation Analysis Results

Table 7 Correlation Matrix

		Implementation	Trainer
Trainer	Pearson Correlation	.116	1
	Sig. (1-tailed)	.347	
	N	14	14

The findings in Table 7 above indicate that Health trainer factors do not significantly influence implementation.

5.0 SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary of the Findings

The objective of the study was to determine health trainers factors influencing implementation of IMCI policy. The study also found that though health trainers applied teaching methods and effective clinical competences, this factor was not significant in the implementation of policy on childhood illnesses (0.116; $p \leq 0.347$)

5.2 Conclusions

The study concluded that health trainers did not significantly influence the implementation of the policy on implementation of childhood illnesses. This is in spite of them having competencies to teach and examine the skills required.

5.3 Recommendations

The study recommends that Health trainers role in the implementation of the policy on childhood illnesses be reviewed.

REFERENCES

Pillai, K., Williams, S., Glick, H., Polsky, D., Berlin, J. and Lowe, R. (2014). Factors affecting decisions to seek treatment for sick children in Kerala, India. *Socio science medicine*, 57(3), 783-790.

Thind, A. & Cruz, M. (2013). Determinants of children's health service utilization in the Philippines. *Journal of tropical paediatrics*, 14(2), 16-29.

Caldwell, J. & Caldwell, B. (2014).Poverty and mortality in the context of economic growth and urbanization. *Asia-Pacific population journal, 17*(3), 14-42.

Chandrashekahar, T. & Ravi, S. (2010). Care seeking behavior for child hood illnesses. A questionnaire survey in Western Nepal; BMC international health and human rights, 6(6), 1- 6.

D'Souza, R. (2013). Role of health-seeking behavior in child mortality in the slums of Karachi, Pakistan. *Journal of biosocial science;* 35(1), 131-144.

Ellenbecker, C., Fawcett, J. & Glazer, G. (2012). A nursing PhD specialty in health policy: University of Massachusetts Boston. *Policy, Politics, &Nursing Administration, 6*(3), 229 235.

Frankenberg, E. & Thomas, D. (2011).Bargaining power within couples and use of prenatal and delivery care in Indonesia. *Studies in family planning,* 32(5), 130-146.

Hill, Z., Kendall, C., Arthur, P., Kirkwood, B. &Adjei, E. (2010). Recognizing child-hood illnesses and their traditional explanations. Exploring options for care seeking interventions in the context of the IMCI strategy in rural Ghana. *Tropical medicine international health*, 8(6), 668-676.

Magadi, M. & Madise, N. (2013). An investigation of district partial variations of childhood diarrhoea and fever morbidity in Malawi. *Social science and medicine*, 62(5), 1138- 1152.

Marsh, K. (2014). Factors influencing admission to hospital during terminal childhood illnesses in Zimbabwe. *International journal of epidemiology*, 23(2), 1013-1019.

Pillai, K., Williams, S., Glick, H., Polsky, D., Berlin, J. and Lowe, R. (2014). Factors affecting decisions to seek treatment for sick children in Kerala, India. *Socio sciencemedicine*, 57(3), 783-790.

Thind, A. & Cruz, M. (2013). Determinants of children's health service utilization in the Philippines. *Journal of tropical paediatrics*, 14(2), 16-29.

Wagstaff, A. (2014). Socioeconomic inequalities in child mortality. Comparisons across nine developing countries. *Bull world health organ*, 78(3), 19-29.

Wijekoom, A. &Martines, J. (2014). Care seeking in Srilanka. One possible explanation for low child hood mortality. *Social science and medicine*, 5(2), 1363-1372.