Challenges experienced by nurses regarding the involvement of guardians in integrated management of childhood illnesses in Vhembe District

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ABSTRACT

The involvement of families and communities in healthcare services by healthcare providers enhances accountability towards the communities they serve. Guardians need to be involved in the integrated management of childhood illnesses (IMCI) to improve child health outcomes. The study aimed to explore challenges experienced by nurses regarding the involvement of guardians in the management of childhood illnesses in the Vhembe district. A qualitative, exploratory-descriptive design was followed in this study. Fifteen participants were purposefully selected for the study. One-on-one interviews following a semi-structured interview guide were conducted face-to-face with the participants. A voice recorder was used to record the interviews. Data analysis was done following Tesch's eight steps. Trustworthiness was ensured throughout the study. The study yielded two themes, namely: guardians-related challenges, which are lack of knowledge and understanding of IMCI, language barrier and lack of continuity of care and healthcare service-related challenges, which are lack of human resource, staff attitude towards the IMCI strategy, shortage of material resource and erratic water supply. For the strategy to be effective in reducing the complications of childhood illnesses and child mortality, the government needs to avail the required resources and develop measures to empower guardians in child health management.

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Introduction

In 2019, nearly 5.2 million children under five years died globally from the preventable and treatable childhood diseases (WHO, 2020a). The childhood diseases include pneumonia, diarrhoea, measles and malnutrition. To curb morbidity and mortality, the integrated management of childhood illnesses (IMCI) strategy was introduced (Carai et al., 2018). The IMCI strategy also supports the Sustainable Development Goals (SDGs) call to end preventable deaths of children under five by having 25 or fewer deaths by 2030 (UNICEF, 2022 & UNICEF, 2021). The strategy was formulated to improve child health through three components. The components include improving health worker skills by training professional nurses in implementing IMCI and enhancing case management standards and guidelines, strengthening the health systems with a focus on district planning and management, availability of IMCI drugs, quality improvement, and supervision of health facilities and improving family and community practices (WHO, 2020a). Family and community practices are improved by assisting family and community with appropriate knowledge on when to seek care from the health facilities, education regarding nutrition, home case management, and adherence to recommended treatment (Malan et al., 2018).
In aiding community and family involvement, guardians of children under the age of five need to be empowered to take part in the optimal care of their children. Guardian refers to a parent or any other person with full or specific parental responsibilities to children under five years (Children’s Act 38 of 2005). The roles of the guardians include prevention of illness, assessment of sick children, provision of home treatment for less severe illness at home and timeous healthcare-seeking for sick children. However, literature reveals challenges in the healthcare system when involving these guardians in IMCI implementation (USAID & Momentum, 2022). This study aims to explore challenges experienced by nurses regarding the involvement of guardians in the management of childhood illnesses in the Vhembe district.

Literature review

The WHO and UNICEF have identified 16 essential family and community practices in childcare. Some vital family practices include giving sick children appropriate home treatment, recognising when sick children need treatment outside the home, seeking care from appropriate providers, and following the health worker's advice about treatment, follow-up, and referral. If the targeted communities adequately promote and adopt the strategy, these practices might improve child survival, growth, and development (WHO, 2017).

In South Africa, the community components of IMCI have been implemented sporadically and have yet to reach a large scale. The National Department of Health (NDoH) remains committed to strengthening community based IMCI initiatives by training community health workers (CHWs). The CHWs are expected to screen children for health and nutritional status and provide health education on disease prevention and management while referring those needing care to health facilities. The CHWs' service is crucial as it was recognised that most caregivers attempt to treat their children at home first before seeking help at the health facilities. Their treatment includes medicines previously given at the clinic, over-the-counter, and traditional medicines (Haskins et al., 2017). Therefore, caregivers' knowledge and understanding of community IMCI is crucial; thus, families and caregivers should be involved in implementing the IMCI strategy.

Community and caregiver involvement

Community involvement refers to developing partnerships and shared responsibility between guardians and healthcare workers in the health sector. It enables them to work together to address health-related issues and promote well-being to achieve positive health impacts and outcomes (WHO, 2020b). It also allows the community to participate fully in decision-making regarding their health and to judge the success of interventions (WHO, 2020b).

Community involvement in the IMCI, as compared to other approaches, may accelerate progress towards ending preventable childhood deaths of under-fives. The provision of services through this approach is capable of reaching many people and populations in much need (WHO, 2017). Consequently, an empowered community gains control over their health and better understands their responsibilities as individuals in the health system. Conversely, the lack of community involvement results in delayed healthcare-seeking behaviors and non-adherence to medications, resulting in severe illness, which increases the mortality burden (Bozad, 2018). Based on a study in Ghana by Nsiah-Asamoah et al. (2019), providing feedback to guardians encourages active participation and interest in dealing with problems associated with children. The study suggested that educating guardians and bringing services nearer to families may reduce child morbidity and mortality. Additionally, Coats et al. (2018), indicated that parents, caregiver, and health professionals are considered to play a critical role in the consulting processes of pediatric cases. The same study shared reflections on the benefits and challenges of family intimidations when nurses involved guardians in child care in an intensive unit.

Barriers to the involvement of guardians in IMCI

It is widely accepted that the IMCI is a good strategy. However, not enough attention has been paid to the complex challenges facing health systems that impede their implementation, including human resources, supply chains, health information systems, governance, and financing (USAID & Momentum, 2023). Additionally, USAID and Momentum (2022) have revealed that barriers to the successful delivery of the IMCI, such as insufficient human resources, inadequate material resources and the length of time required for effective IMCI consultations, conflict with competing demands.

A study by Meno et al. (2019) reports that some nurses have highlighted that the lack of resources renders the strategy less effective and meaningful and thus leads to poor guardians' involvement. Furthermore, Afolalu (2020) reported that the shortage of essential IMCI drugs and supplies has been problematic in implementing IMCI. As a result, it is discouraging for nurses to assess sick children, knowing that, in the end, they are faced with the challenge of explaining to the guardian the unavailability of drugs (Rowe et al., 2018). Refosa et al. (2020) assert that budget allocation difficulties have hindered the IMCI implementation in most provinces in South Africa. The provinces had no specific financial plan that included, the funding for implementing the IMCI strategy.

Furthermore, the implementation of the strategy is affected by the lack of human resources. A study by Rahmah and Astuti (2021) found shortage of IMCI-trained healthcare workers compared to the number of under-five children seen in the PHC facilities. The shortage increased the waiting times in the facilities. As a result, the available nurses cannot fully implement the strategy (Afolalu, 2020). Some would even skip activities such as feeding assessment and counselling, crucial for guardians’ involvement in child health care (Pandya et al., 2018).
In addition to the challenges from the healthcare system, guardians were found to lack knowledge of how childhood illnesses are managed, consequently becoming uncooperative. Meno et al., (2019) found that caregivers demand medicine even if the strategy does not recommend it. Some guardians do not follow treatment management protocols nor attend clinic follow-ups as advised by nurses (Rénsola et al., 2021). Even more concerning, some guardians are seeking care late at facilities, resulting in children experiencing disease complications that could have been prevented (Kilov et al., 2021). For the strategy to be effective, guardians must be involved at every step, starting with health promotion, disease prevention and management. Therefore, the study explores the challenges experienced by nurses regarding the involvement of guardians of children under five years of age in implementing the IMCI strategy in the Vhembe district.

Research and Methodology

Design
A qualitative approach, using an explorative-descriptive design was followed to explore and describe the challenges experienced by professional nurses regarding the involvement of guardians of children under five (5) years of age in implementing the IMCI strategy. The design is appropriate in collecting narrative data in order to develop an in-depth understanding of the problem (Grove & Gray, 2022). The design also enables the researcher to understand the challenges from the nurse's viewpoints and within their context (Polit & Beck, 2021). The researcher's choice of the design was influenced by its ability to provide a detailed account of its significance and generation of the participants world view (Holloway & Wheeler, 2010 cited in Hunter et al., 2019).

Study setting
The study was conducted in a community health centre (CHC) in Vhembe district, Limpopo Province, South Africa. The facility has one operational manager and 26 professional nurses (Department of Health, 2021). The facility offers a comprehensive primary health care package for minor ailments, reproductive health, maternity, chronic, mental health, and child health services (including the IMCI). The facility has a high under-five catchment population and a higher headcount than other facilities in the district. According to the Department of Health, (2021), the CHC had an under-five headcount of 16134.

Population and sampling
The study's target population were 18 IMCI-trained professional nurses working in the selected CHC in the Vhembe district. A non-probability purposive sampling strategy was used to select 15 IMCI-trained nurses as described in Polit and Beck (2021). Purposive sampling is the process of manually selecting participants based on the researcher’s knowledge of the population (Botma et al, 2021; Brink & van Rensburg, 2023). The selected professional nurses were providing child health services in the facility and were expected to involve the guardians when implementing the IMCI strategy. The researcher believed that the professional nurses included in the study had the experience needed for the study. Hence, they were able to provide valuable information about the challenges of involving guardians in the management of childhood illnesses using the IMCI strategy. The inclusion criteria were professional nurses trained in IMCI and who had been rendering child health services for one year or more. The sample size was determined by data saturation, which is the point where new information cannot be obtained from the participants (Brink & van Rensburg, 2023).

Data collection
Data collection for this study commenced after recruitment was done with the participants following the permission sought and received from the relevant authorities governing the facility. An office space was used for collecting data. Data was collected using face-to-face semi-structured one-on-one interviews by the researcher to obtain in-depth information on the participants’ challenges of involving guardians of children under five in implementing IMCI. Questions related to the participant’s demographic information, number of years practising as a professional nurse and number of years implementing IMCI were asked during the interview. Furthermore, a set of questions was covered to determine the challenges they encountered while involving guardians in IMCI implementation. The interviews lasted between 30 minutes to an hour. Probes were asked following the participants responses. Saturation was reached on the 13th participant, but two more participants were interviewed to confirm that no new data was emerging. A total of 15 participants were interviewed for this study.

Data analysis
All interviews were conducted in English and transcribed verbatim. Participants’ direct quotations were captured in italic format to support findings. Data were analysed using the eight steps of Tesch's open-coding qualitative data analysis method (Creswell & Creswell, 2018). At first, the researchers read all the transcripts and wrote down ideas. The researcher picked interviews individually to get an underlying meaning from the information drawn and wrote down thoughts. The researchers then formulated topics and categorised them into themes and sub-themes. The codes were written next to the appropriate transcribed text, and descriptive wording was created for the codes. Finally, the researcher decided on the abbreviations for each category, alphabetised the codes, assembled data into categories, and recorded existing material (Creswell & Creswell, 2018). The researchers analysed data independently and sought the service of the independent coder. An independent coder analysed data independently and then held a consensus meeting with the researchers to discuss the findings and agree on the themes and sub-themes developed independently.
Measures to ensure trustworthiness

The criteria suggested by Lincoln and Guba (1985) in (Creswell & Creswell, 2018) for developing the trustworthiness of qualitative research were followed. Credibility was ensured by building rapport and trust with the participants. The participants were interviewed for about 30 minutes to an hour to gain insight and understand their views (Brink & van Rensburg, 2023). The researcher also ensured that honesty was maintained by giving information regarding the study to the participants. Dependability was ensured by keeping the voice recordings and transcripts available to other researchers who might need them for verification (Polit & Beck, 2021). The researchers ensured the transferability of the study by providing a thorough description of the research methods and setting in the research report so that the reader can evaluate the applicability of the data to another context (Polit & Beck, 2021).

Ethical considerations

The researcher obtained ethical clearance from the Sefako Makgatho University Research Ethics Committee (SMUREC) with clearance certificate number SMUREC/H/280/2022: PG. Permission was obtained from the Limpopo Department of Health and the CHC manager to conduct the study. Informed consent was obtained from participants before conducting the study. The participants were informed that they could withdraw from the study at any given time during the study. The researcher ensured justice by including everyone who met the study’s inclusion criteria. Confidentiality was ensured by using allocating participants pseudonyms instead of real names during data collection and presentation of results. Participants were promised that whatever they discussed with the researcher would be confidential (Dhai, 2019).

Findings

Table 1 below summarises the demographic characteristics of the study participants. This table highlights that the study participants are experienced and knowledgeable, making them well-suited to provide meaningful contributions to research on IMCI implementation. Their insights can inform efforts to improve healthcare practices and training programs for better child health outcomes.

Fifteen participants, aged 30-62, were interviewed for this study. The participants years of experience working in PHC clinics ranged from seven to 23 years and years implementing IMCI strategy ranged from seven to 18 years. The average number of years participants have been implementing IMCI is approximately 11.8 years.

Table 1: Demographic characteristics of the participants.

<table>
<thead>
<tr>
<th>Number</th>
<th>Participant’s pseudonyms</th>
<th>Age in years</th>
<th>Gender</th>
<th>Years in practice as a Professional nurse</th>
<th>Years implementing IMCI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Agnes</td>
<td>39</td>
<td>Female</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>2.</td>
<td>Betty</td>
<td>42</td>
<td>Female</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>3.</td>
<td>Clementine</td>
<td>47</td>
<td>Female</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>4.</td>
<td>Constance</td>
<td>33</td>
<td>Female</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>5.</td>
<td>Ester</td>
<td>53</td>
<td>Female</td>
<td>20</td>
<td>13</td>
</tr>
<tr>
<td>6.</td>
<td>Isabel</td>
<td>30</td>
<td>Female</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>7.</td>
<td>John</td>
<td>47</td>
<td>Male</td>
<td>18</td>
<td>15</td>
</tr>
<tr>
<td>8.</td>
<td>Lucky</td>
<td>41</td>
<td>Female</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>9.</td>
<td>Maria</td>
<td>44</td>
<td>Female</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>10.</td>
<td>Peter</td>
<td>49</td>
<td>Male</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>11.</td>
<td>Pinky</td>
<td>41</td>
<td>Female</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>12.</td>
<td>Rendani</td>
<td>45</td>
<td>Female</td>
<td>23</td>
<td>18</td>
</tr>
<tr>
<td>13.</td>
<td>Sarah</td>
<td>46</td>
<td>Female</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>14.</td>
<td>Sebo</td>
<td>49</td>
<td>Female</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>15.</td>
<td>Tebogo</td>
<td>62</td>
<td>Female</td>
<td>22</td>
<td>12</td>
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</tbody>
</table>

The participants are highly experienced both in their general nursing practice and specifically in implementing IMCI. This suggests that the insights and data gathered from these participants are likely to be informed by substantial practical experience. The predominance of female participants reflects the gender distribution often seen in the nursing profession. However, including perspectives from the male participants is also valuable for a more comprehensive understanding. The age diversity among participants can provide a wide range of perspectives, from those who may be newer to the profession to those nearing retirement. This can help in understanding how IMCI implementation might vary across different stages of a nursing career. Given the extensive experience of the participants with IMCI, their feedback can offer valuable insights into the strengths and areas for improvement within the program. Policymakers and healthcare administrators can use this information to refine and enhance IMCI training and implementation strategies.
Themes and sub-themes
Two themes emerged from data analysis (as shown in Table 2): (1) guardians-related challenges and (2) Health service challenges.

Table 2: Themes and sub-themes

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Guardians related challenges</td>
<td>Lack of knowledge and understanding of the IMCI strategy</td>
</tr>
<tr>
<td></td>
<td>Language barrier</td>
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<td></td>
<td>Lack of continuity of care</td>
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<tr>
<td>2. Healthcare service challenges</td>
<td>Lack of human resource</td>
</tr>
<tr>
<td></td>
<td>Staff attitude towards IMCI algorithm</td>
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<tr>
<td></td>
<td>Shortage material resource</td>
</tr>
<tr>
<td></td>
<td>Erratic water supply</td>
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</table>

Theme 1: Guardian related challenges
The study's findings have revealed that various constraints and challenges inhibit guardians' involvement in IMCI and their ability to offer adequate care to children. These are supported by four sub-themes below: lack of knowledge and understanding of the IMCI strategy, language barrier, and lack of continuity of care.

Lack of knowledge
Participants acknowledged that the lack of guardians' knowledge and understanding of how the IMCI strategy is applied to manage childhood illnesses is challenging. The guardians demand medication when it is necessary, which is challenging for the nurses. The following extracts demonstrate:

“I have realised that guardians' lack of knowledge about IMCI is a problem. They do not know that not everybody will come to the clinic and go home with medication”. [Peter-Male-49]

“Maybe the child is having a cough and classified as ‘cough or cold’ according to IMCI. The guardian will be educated on soothing the throat, and no antibiotics will be given. However, guardians do not seem to accept this. They feel that if they go to the health facility, they must come back with medication. This is not only health education. It shows they lack information on the IMCI strategy.” [Constance-Female-33]

Some participants highlighted that some guardians even consider nurses incompetent if they do not receive medication. The Participants ended up giving some medication to satisfy the guardian.

“They think we do not do things the way they want. They do not have faith in us. They think we are incompetent, yet we would be managing the child as per IMCI guidelines. They come and tell us how we should treat their child instead of heeding our advice on how to manage the child's condition.” [Sebo -Female- 49]

“(sigh) ..., most of them insist that you give them treatment because they are here, and most of them are reluctant to use home remedies. When you tell them about home remedies, for instance, if the child has a cold, you tell them about them. ... Ahh! Sometimes, you end up giving them panado. I give panado to make, to satisfy the guardians.” [Sarah-Female-46]

Participants also mentioned that some guardians are grandmothers with low levels of literacy and numeracy, yet the Road to Health Card instructions require them to read and measure. Other participants also stated that creche’ owners also have little information regarding the care of children under the age of five left in their care.

“You will find that, the guardian is too old. Moreover, the guardian cannot read because even the Oral Rehydration Solution is in the baby’s card, but they cannot read.” [Isabel-Female-30]

“We had many children from creches coming here with diarrhoea and vomiting. So, when you ask, no oral rehydration was given” [Betty-Female-42]

Language barrier
Some participants indicated that language barriers also worsened the problem. They are unable to give proper and meaningful health education because some guardians who come from neighbouring countries do not speak or understand South African languages and English making communicating healthcare messages difficult. The participant states that:

“Sometimes we have those people from Zimbabwe and Mozambique. Communication with some of them becomes difficult as some don't understand English well. I can't even speak their language, and even the Road to Health Card (RiHC) is written in English. It is difficult to counsel them.” [Tebogo-Female-62]
We have many women from the farms who are not South African. It becomes hard to give instructions for follow-up and counsel on home treatment to someone who cannot speak English or the local languages. [Sebo-Female-49]

Lack of continuity of care

Participants indicated that most children under five are left in the care of grannies and creches, while the mothers who initially brought the children to the clinic are at work or school. These are the support structures for parents who are working or those who are still at school. The mothers do not communicate the instructions and health education to the people taking care of the children in their absence. The participants verbalised that:

"In some instances, especially during weekends, the child is brought by a teenage mother who could be at college and does not fully know about the child’s illness. On the next follow-up visit, the child is brought by someone else’s grandmother or a helper. This causes many inconsistencies in taking the child’s history and assessing progress on the child's illness." [Ester-Female-53]

“I think there is an existing gap affecting treatment continuity, particularly when the guardian has to go to work and leave the child at preschool. Sometimes, the prescribed medicine is left at home and not taken to the preschool, and the preschool teachers are unaware that the child has not been well or that they are on treatment. It would be crucial that the preschool teachers are involved in IMCI activities.” [John-Male- 47]

Theme 2: Healthcare service challenges

This theme is about the challenges within the healthcare service that are affecting the healthcare facilities and the ultimate implementation of the IMCI activities. The healthcare service challenges that emerged were lack of human resources, shortage of material resources, erratic water supply, and staff attitude towards the IMCI algorithm.

Lack of human resource

The participants expressed the challenge of lacking human resources, which increases the workload. The high workload negatively impacts the implementation of the IMCI strategy as they do not have time to provide other activities, like counselling, which is required to involve the guardians. The following extracts show the human resources challenges:

"As I said earlier, we do not have enough time, and there is a shortage of staff, so whenever they come, we attend to the kids, and we have little or no time for educating the parents about IMCI." [Sarah-Female-46]

“You see, when you are doing IMCI, you should treat the child and you should teach the mother, even during immunisation. This takes time and needs more staff. That is why we are not doing it. We are supposed to do it daily, but we realised we are short-staffed" [Ester-Female-53]

In addition to the child health service, participants indicated that they provide other services and are expected to attend activities from other health programmes, which results in high work pressure. The high work pressure and multitasking increase the time guardians spend in the facility and their involvement as they become impatient with the nurses.

"Yeah, because in our department, there are so many programmes, and everybody wants his or her program to go well. The very limited staff has to attend to those programmes with different coordinators. This means we ought to be doing everything. With the long queues we are facing, it is a lot for us to do. But there's nothing that you can do; we ought to comply". [Rendani -Female-45]

“….But you are alone here, and there is a long queue waiting for you. You are still waiting; you are still paging IMCI to check the condition where you wanted to assist the guardian as the client and the kids as well. So, it makes the patients waiting outside grumble. They'll say the line is not moving.” [Peter-Male-49]

Staff attitude towards IMCI algorithm

Participants stated that some nurses have a negative attitude toward the IMCI algorithm due to the time it consumes during consultations. They preferred to use other guidelines that seemed to be quicker than the IMCI algorithm. Participants shared that:

“To be honest in most case we focus on the signs and symptoms we do not follow the book because of time, so the child is coughing then it means in most cases, we are going to focus on that part only in most cases, finishing the booklet is highly impossible at the moment because of shortage of staff.” [Sarah-Female-46]

"...and our time is limited, you see when they come for consultation because it takes like 45 minutes with one mother to teach them about this IMCI." [Maria-Female-44]

Shortage of material resources

Participants indicated that a shortage of material resources in the health system affects guardians’ involvement in implementing IMCI. Other participants mentioned that an inconsistent supply of IMCI drugs, a shortage of guidelines, and a shortage of transport and ambulances were barriers to the involvement of guardians in IMCI implementation. The participants' concerns and frustrations were evident in the following quotes:
“The challenge is the shortage of medication…. A shortage of medication, like paracetamol, in the clinic and when a child needs it, is a problem. Mm. And, uh, maybe the mother doesn’t have money or is not financially okay to go and buy, so the IMCI care will be incomplete” (laughing). [Lucky-Female-41]

“We call the ambulance, but the ambulance is a very, very issue because there was a shortage of ambulances. Referring a patient to a hospital becomes a great deal. How do we communicate to a parent who brought a very sick child to hire a car to the hospital?” [Sebo-Female-49]

**Erratic water supplies**

The participants mentioned inadequate and erratic supplies of water, which are worsened by load shedding, as a problem. As a result, teaching hand hygiene and preparing medical solutions from powder becomes difficult. This except captures that point:

“Ah, not about IMCI per se. But maybe if we can talk about this institution, we have a problem with water. We have a borehole that uses electricity. During load shedding, you find this institution without water. This shortage of water affects the reconstitution of medicines that are in powder form, implying that the guardian has to be given instruction on how to do the dilution at home. There is no guarantee that the dilution will be done properly.” [John-Male-47]

“The inadequacy of water also makes it difficult to maintain hygiene, particularly in the ablution facilities. So, if people come with diarrhoea, what do they do when they want to use the toilet and there is no water? How do I teach about hygiene in such instances?” [Isabel-Female-30]

**Discussion**

The study aimed to explore challenges experienced by nurses regarding the involvement of guardians in the implementation of the IMCI strategy in the Vhembe district. The finding revealed that the nurses experienced challenges from guardians and the healthcare service. Nurses found guardians demanding, expecting nurses to always give medication to their children even during mild illnesses like coughs or colds. According to the IMCI guidelines, a cough or cold child only needs homemade cough remedies to alleviate the cough (NDoH, 2022). The demand is caused by the lack of knowledge and understanding of how child illnesses are managed following the IMCI strategy. Similarly, a scoping review on challenges with implementing IMCI found that guardians were used to receiving antibiotics and other medicines, so they were frustrated when they only received advice on how to treat their children at home (Reñosa et al., 2021). Similar to the study in Nigeria, some guardians insisted on having prescription medication even when it was not recommended by the IMCI strategy (Amachree & Eleke, 2022).

Refusal to give the medication resulted in guardians questioning nurses’ capabilities to manage childhood illnesses and expressing dissatisfaction with the support they receive (Mphasha et al., 2023; Refosa et al., 2021). Consequently, guardians would develop negative attitudes towards nurses and the use of home remedies (Kheir et al., 2021). To prevent a lack of guardians’ trust in IMCI, some nurses resorted to giving medication, like paracetamol, although it was not necessary. This implies that guardians persuaded nurses not to follow the IMCI strategy. To prevent poor implementation of IMCI due to community pressure, nurses must educate guardians on the importance of the interventions prescribed for their children. The education might improve guardians’ trust towards IMCI, improve treatment adherence, and consequently improve the health outcomes of children. Duke et al. (2020) posit that guardians with knowledge in IMCI show better health practices.

Low literacy levels, mainly among the grandparents and some daycare minders at the créches, posed a challenge in involving the guardians in the children’s healthcare. The inability to read the instructions on the Road to Health booklet (RTHB) resulted in guardians not being able to provide immediate home management of illness to prevent disease severity or complications. A similar study in South Africa also reported the challenge of low literacy levels. Children were brought to the clinic with dehydration due to diarrhoea, which could have been prevented by giving oral rehydration (Meno et al., 2019). Win and Mlambo (2020) posit that despite the provision of beneficial messages in the RTHB booklet, it is written in English, which poses a challenge for most guardians in comprehending its contents, primarily due to low literacy levels. Furthermore, the low literacy compromises the collaboration between nurses and the guardians. As a result, guardians miss important messages that are essential for delivering comprehensive care that facilitates the advancement of early childhood development (NDoH, 2020).

Furthermore, involving guardians was also difficult when treating children of guardians from the neighbouring countries as some of them could not speak or understand local languages (Sepedi, Tshivenda & Xitsonga) or English. The language barrier made it difficult for the nurses to provide counselling and health education on preventing and managing childhood illnesses. Similarly, Meno et al., (2019) revealed that guardians often cannot receive and comprehend information from nurses due to language barriers. For this reason, nurses were unable to perform counselling, which is one of the pivotal roles of the IMCI strategy that is necessary in reducing child morbidity and mortality.

The nurses were further challenged by the practice of having children brought to the clinic by different people. At times, the child will be brought by the mother, then brought by the grandmother or the nanny for a follow-up without proper reporting and feedback on the child’s health status and treatment. Some of the children are sent to creche with no medication or a report that the child is ill, which affects the continuity of care. Continuity of care enhances the healthcare experience and treatment outcomes for children under
five. Moreover, it is crucial for those who require ongoing care in various environments such as their homes and childcare facilities (Kao et al., 2019). Thus, children need to continue receiving adequate care, even in the absence of the mothers.

In addition to the challenges nurses encountered with guardians, the healthcare system also made it difficult for the nurses to involve guardians in IMCI. Nurses experienced high work pressure due to the shortage of IMCI-trained nurses and the increased number of patients. As a result, nurses needed to see every client in the clinic before the clinic closed, making it challenging to counsel and educate the guardians. Meno et al. (2019) assert that the increased nurse-patient ratio makes it difficult to involve guardians in implementing IMCI. The work pressure is further increased by other responsibilities that nurses must undertake in the clinic besides patient care, which includes attending meetings and training required for the programme to run effectively. This observation was also reported in a similar study in South Africa and Nigeria, where nurses were overwhelmed by multiple responsibilities (Pandya et al., 2018; Oladokun et al., 2022). The few remaining nurses had to undertake all patient caring responsibilities, consequently increasing waiting times and making the guardians waiting for the service impatient with the providers. To reduce the long waiting times, nurses only provided care without counselling. Lack of education and counselling disrupts the continuity of care since the guardians might not be able to effectively treat the child at home without the relevant information. Consequently, the quality of care is affected negatively (Matlala et al., 2021).

Some nurses in the current study found the IMCI strategy challenging to implement. The IMCI algorithm was considered lengthy and time-consuming, and there are many patients who need health care services. As a result, these nurses skip some of the algorithm's activities, such as nutritional status classification, immunisation, feeding assessment, and counselling of guardians. Similar studies found that nurses do not avoid implementing IMCI but skip some IMCI steps to hasten workflow and reduce waiting time. (Amachree & Eleke, 2022; USAID & Momentum, 2022). Furthermore, nurses found IMCI laborious and placing undue pressure on nurses who are responsible for all disease control programs, not singularly focused on IMCI (Reñosa et al., 2021). Accordingly, some nurses would not even use the IMCI chart booklet. These nurses resorted to doing what they thought was right at that point (Meno et al., 2019). In contrast, the study in Botswana found that some nurses perceived the IMCI guidelines as easy to follow, taking a shorter time to follow the step-by-step algorithms and consequently using the IMCI guidelines consistently (Scotch, 2020).

The shortage of material resources like medication and ambulances was another challenge faced by nurses. The nurses found it difficult to involve the guardians and could not even provide essential medications like paracetamol. In addition, nurses struggled with the transportation of very ill children to the hospital due to the insufficient number of ambulances. Having to ask the guardians to go and buy medicine or hire a car to take the child to the hospital was found to be unacceptable. The resources challenge was not unique to the current study, as shortage of medication, poor infrastructure and funds for awareness campaigns were found to impede the effectiveness of the IMCI programme in several countries (Meno et al., 2019; Oladokun et al., 2022; Reñosa et al., 2021; Tshivhase et al., 2021). For this reason, the community tends to lose confidence in the healthcare system and not even trust the providers’ advice because they do not receive the full service they require (Meno et al., 2019).

Another significant finding that was challenging for nurses was the water shortage in the clinics. The country's current load-shedding status has worsened the water shortage. Although the clinic had a borehole for water, the system could not function during load-shedding. The disruption of water supply due to power outages was found to be the cause of shortages in most public healthcare facilities (Sobuwa, 2023). As a result, nurses found it difficult to maintain good hygiene or even to teach parents hand hygiene. Kretzmann (2022) and Mehlwana (2022) assert that a water shortage disrupts clinic services and creates an unhygienic environment. The shortage further aggravates health risks across the spectrum of childhood diseases (Mochoari, 2021). The shortage also prevented nurses from reconstituting medications that come in powder forms. They instructed the guardians to mix at home, even though they were uncertain about how accurately the guardians would prepare the medication at home. The provision of health service in an unhygienic environment defies the recommendation by the National Institute for Communicable Diseases (NICD) and UNICEF, which states that delivery of quality healthcare should take place in a hygienically clean and safe environment (NICD, 2023; UNICEF, 2023).

Conclusions

While the involvement of guardians in the management of childhood illnesses is crucial for the effectiveness of the IMCI strategy in reducing child mortality, there are challenges inhibiting guardians’ involvement. Guardians’ lack of knowledge and understanding of managing childhood illnesses, low literacy level, and lack of continuity of care among guardians hindered nurses from involving them adequately. Guardians who are not involved might be reluctant to adhere to treatment regimens, especially home remedies. The lack of adherence can compromise the treatment's effectiveness and ultimately impact children's health outcomes. Equally important, the resources required to effectively implement IMCI by involving the guardians were a challenge. The staff shortage resulted in a high workload for nurses, thus not having time to counsel the guardians. The shortage of medicine, insufficient ambulances, and interruptions in water supply worsened the situation. It can be concluded that the empowerment of guardians and the availability of human and material resources are critical for effectively implementing the IMCI strategy and, consequently, improving the children’s health outcomes.

National Department of Health to develop policies to strengthen communities through training of community healthcare workers in the preventive strategies of childhood illnesses and management of ill children. Nurses to improve their communication strategies
with guardians whom they treat and counsel when bringing children for health care services. Further research to be conducted with guardians on strategies to improve child healthcare services from other areas too.

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