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## Factors influencing implementation of intergraded management of neonatal and childhood illnesses among health workers at Kabale regional referral hospital, Kabale district

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### Abstract

**Introduction:** The Integrated Management of Childhood Illness (IMCI) which later (2003) modified into Integrated Management of Neonatal and Childhood illnesses (IMNCI), is a strategy which was developed by the World Health Organization (WHO) and the United Nations International Children's Fund (UNICEF) in 1992 as an integrated approach to improve child health (Hope *et al.*, 2012).  
**Objectives:** The objective of this study was to assess factors influencing the implementation of IMNCI in Kabale Regional Referral Hospital, Kabale District.

**Methodology:** A descriptive cross-sectional design with quantitative and qualitative data collection methods on 59 health workers who were directly involved in child care and management of childhood illnesses selected by simple random sampling. More data was collected from five key informants using an interview guide.

**Results:** Majority of the respondents (54.2%) were aged between 31-40 years, 44.1% had spent 5-10 years in service, and majority (62.7%) were diploma holders. Majority (53%) had had IMNCI training and 61% could identify at least one danger sign. Also 76.3% reported lack of enough booklets, 47.5% mentioned inadequate staffing, and 52.5% mentioned lack of regular training and 84% reported lack of regular follow-up. 90% of all respondents reported not to use IMNCI approach in management of children in their respective departments.

**Conclusion:** Health workers had average knowledge on IMNCI strategy and had a poor attitude towards the approach as they intimated that its time consuming.

**Keywords:** Integrated management, neonatal & childhood illnesses, health workers, Kabale regional referral hospital

### Introduction

Globally, every year some 12 million children in developing countries die before they reach their fifth birthday. Seven in ten of these deaths are due to acute respiratory infections (mostly pneumonia), diarrhea, measles, malaria or malnutrition. It is also estimated that every minute eight under five children die in sub-Saharan Africa. This is partially attributed to the low utilization of IMNCI approach in management of childhood illnesses as this aims at early diagnosis and treatment of children with common childhood illnesses (WHO, 2017). In Kenya, IMCI was introduced in 1996 and then their first training towards the full implementation was in 2001 in their 4 major districts. Then between 2005 and 2006 the bulk of training took place and covered 16 districts of Kenya (Mupara & Lubbe, 2016). Mupara & Lubbe (2016) <sup>[4]</sup> in their survey showed that there is a low level of IMCI implementation at the facility.

Health workers frequently do not recognize that a child may have more than one condition at a time, which requires treatment, with IMNCI being adopted at the lowest level of health care, this would greatly prevent such unnecessary deaths of young children (Tanzania IMNCI policy [TIMNCIP], 2019).

### Statement of the problem

Factors influencing implementation of intergraded management of neonatal and childhood illnesses among health workers at Kabale regional referral hospital, Kabale district.

**Objective**

1. To identify the individual factors influencing implementation of IMNCI at KRRH, Kabale District.
2. To find out the organizational factors influencing implementation of IMNCI at KRRH, Kabale District.
3. To determine the level of implementation of IMNCI among health workers at KRRH, Kabale District.

**Research questions**

1. What are the individual factors influencing implementation of IMNCI at KRRH, Kabale District?
2. What are the organizational factors influencing implementation of IMNCI at KRRH, Kabale District?
3. What is the level of implementation of IMNCI at KRRH, Kabale District?

**Review of literature**

Researcher done an intense literature review. And the review was organiged in following heading.

1. Individual factors hindering implementation of IMNCI
2. Organizational factors hindering implementation of IMNCI
3. Level of implementation of IMNCI

**Methodology:** In this study descriptive cross-sectional research design was used with simple random sampling to identify factors influencing implementation of IMNCI among health workers.

**Tool:** A pre- tested questionnaire was used to collect data from the health workers. Pre-testing was done on five health workers of a neighboring health facility of Rugarama Hospital within Kabale Municipality  
The research study was done in Kabale Regional Referral hospital (KRRH), Kabale district.

**Data collection procedure**

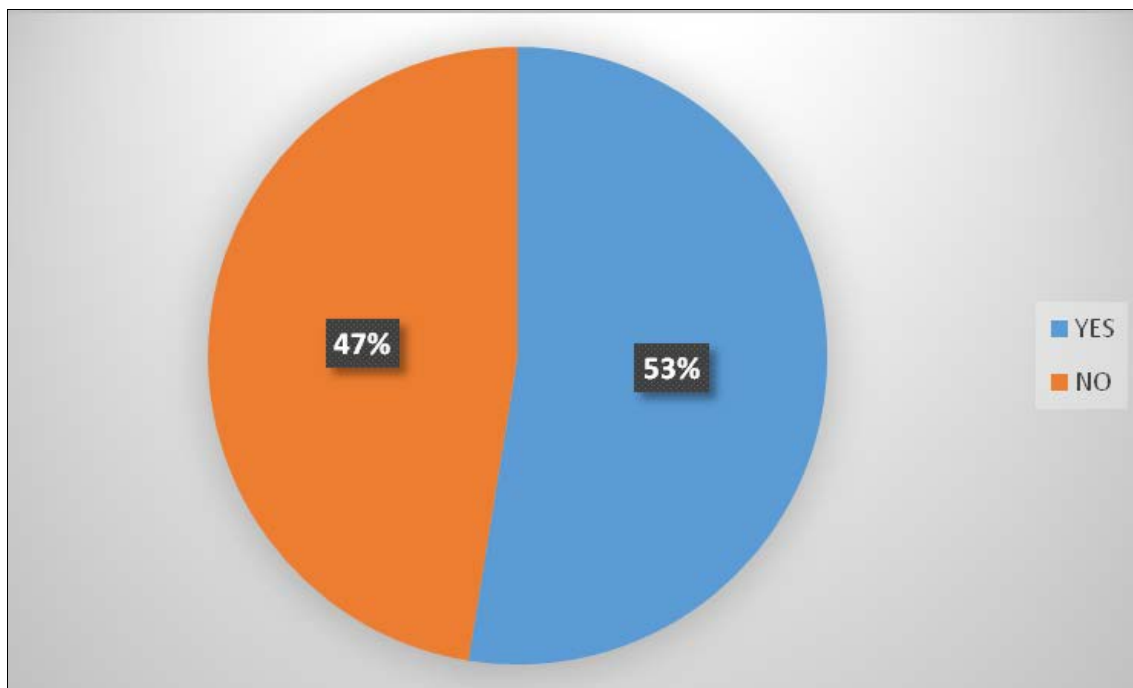
After approval by the hospital management, the researcher identified the departments where IMNCI is implemented that are OPD, YCC and Pediatric wards, she then introduced self to the in charges of the departments and then the staff and sought consent from them. Questionnaires were self-administered to collect data on individual factors, organizational factors and level of implementation of IMNCI, under direct supervision of the researcher.

**Results**

**Table 1:** Individual factors influencing IMNCI implementation

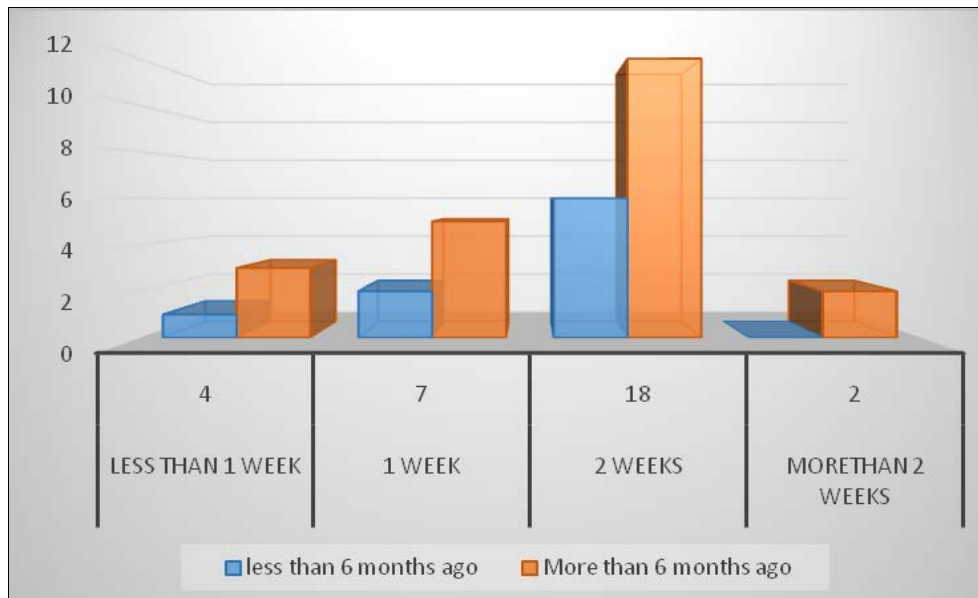
Variable	Category	Frequency (f)	Percentage (%)
Profession	Nurse	35	59.3
	Midwife	20	33.9
	Clinical officer	04	6.7
Years in service	Below 5 years	13	22.0
	5-10 years	26	44.1
	10-20 years	15	25.4
	Above 20 years	05	8.5
Level of qualification	Certificate	16	27.1
	Diploma	37	62.7
	Bachelors	05	8.5
	Masters	01	1.7

Majority of the respondents 35(59.3%) were nurses, while the minority 04 (6.7%) were clinical officers. Most of the respondents 26 (44.1%) had worked for 10-20 years, while the least 05 (8.5%) had worked for more than 20 years. The majority 37 (62.7%) had diploma level qualification, while the minority 01(1.7%) had masters level.



**Fig 1:** whether respondents have ever had IMNCI training

Figure 1 above, 31(53%) have ever had IMNCI training while 28(47%) have never had the training.



**Fig 2:** duration of training and when the respondents were last trained

Majority of the respondents 18 (58.1%) had had their IMNCI training for 2 weeks, while the minority 2 (6.5%) had had their training for more than two weeks. The figure also shows that the majority 20 (64.5%) had had their

training more than 6 months ago, while the minority 11 (35.5%) had their training less than 6 months ago.

**Respondents understanding about IMNCI**

**Table 2:** Respondents understanding of IMNCI and general danger signs n=59

Variable	Category	Frequency(f)	Percentage (%)
Individuals understanding of IMNCI	Combined treatment for management of neonatal and childhood illnesses	15	25.4
	Systemic approach to child health that focuses on wellbeing of the whole child	20	33.9
	Prevention of childhood illnesses through improved nutrition and immunization	24	40.7
Knowledge on danger signs (multiple responses)	Unable to drink or breast feed	36	61.0
	Vomiting everything	27	45.8
	History of convulsions or convulsing now	14	23.7
	Difficulty in breathing	16	27.1
	Lethargic or unconscious	13	22.0
	Fevers	17	28.8
Main symptoms in IMNCI (multiple responses)	Cough and difficulty in breathing	39	66.1
	Diarrhea	34	57.6
	Fever	21	35.6
	Ear problem	13	22.0

Majority of the respondents 24 (40.7%) could hardly give the right definition of IMNCI while the minority 15(25.4%) were able to define IMNCI about the general signs, a few respondents were able to identify all the general signs. Majority 36 (61.1%) identified fever as a general danger

sign while the minority 13 (22.0%) identified lethargic or unconscious as a danger sign.

**Other organizational factors influencing implementation of IMNCI approach**

**Table 3:** organizational factors influencing implementation of IMNCI n=59

Variable	Category	Frequency(f)	Percentage (%)
Enough chart booklets	Agree	2	3.4
	Strongly agree	1	1.7
	Disagree	11	18.6
	Strongly disagree	45	76.3
Availability of drugs for management of childhood illnesses	Agree	9	15.3
	Strongly agree	5	8.5
	Disagree	28	47.5
	Strongly disagree	17	28.8
Enough staffing in the department	Agree	4	6.8

	Strongly agree	4	6.8
	Disagree	36	61.0
	Strongly disagree	15	25.4
Regular IMNCI training	Agree	9	15.3
	Strongly agree	11	18.6
	Disagree	31	52.5
	Strongly disagree	8	13.6
Effective supervision and follow up	Agree	12	20.3
	Strongly agree	4	6.8
	Disagree	33	55.9
	Strongly disagree	10	16.9

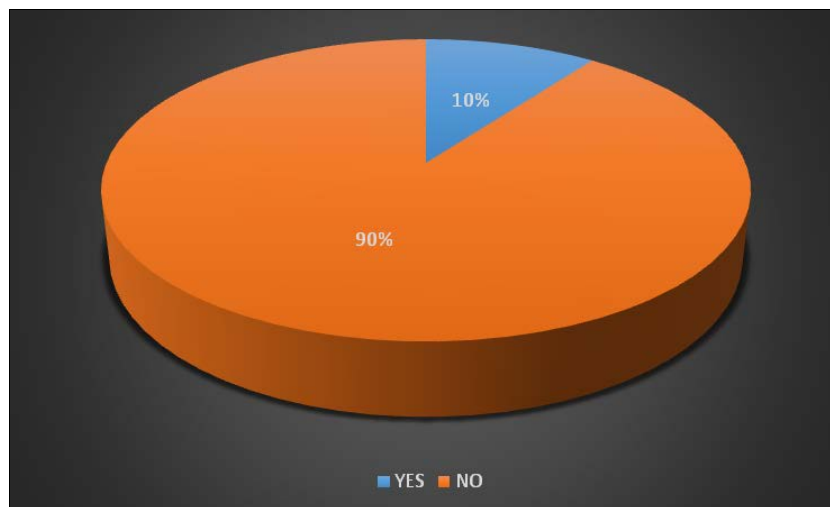
**Source: Primary data**

Majority of the respondents 45 (76.3%) strongly disagreed about the availability of enough booklets in the department and only 1 (1.7%) strongly agreed that there are enough booklets in the department. On availability of drugs for management of childhood illnesses, majority 28(47.5%) disagreed on the availability while the minority 5(8.5%) strongly agreed that drugs were available. Most of the respondents 36 (61.0%) disagreed on enough staffing in the department while the minority 4 (6.8%) agreed and strongly agreed that there was enough staffing in the hospital. When

asked about the regular IMNCI trainings in the facility, 31 (52.5%) disagreed while the least numbers 8 (13.6%) strongly disagreed about the regular IMNCI trainings in the facility. A great number of respondents 33 (55.9%) disagreed about effective supervision and follow up by management, while a few 4 (6.8%) strongly agreed to effective supervision and follow up by management.

**Level of implementation of IMNCI approach**

Use of IMNCI approach in Management of childhood illnesses



**Fig 4:** Use of IMNCI approach in management of childhood illnesses

Of the 59 respondents, Majority 53 (90%) intimated not to use IMNCI approach in management of children, while only 6 (10%) agreed to use IMNCI in routine management of childhood illnesses.

**Table 6:** reasons of health workers not using IMNCI approach in management of childhood illnesses.

Variable (multiple responses)	Frequency (f)	Percentage (%)
Limited knowledge	35	59.3
Limited time	28	47.5
Overwhelming number of patients	47	79.7
Lack of resources(booklets, sundries)	43	72.9
Limited support from supervisors	16	27.1

Most respondents expressed overwhelming number of patients 47 (79.7%), lack of resources 43(72.9%) and limited knowledge 35 (59.3%) as the leading reasons why IMNCI was not being implemented while a few 16 (27.1%) revealed limited support supervision.

**Discussion**

An average number of respondents had ever had IMNCI training and still an average number had the training lasting for 2 weeks. A good number of respondents also confirmed that the last training was done more than 6 months ago. This could be due to the fact that most facilities organize these IMNCI trainings annually in line with the financial years. There was a high possibility that the long periods without training affected the implementation of IMCNI approach as the practitioners become reluctant and forget the skills with time. This is in line with a study done by Renosa MD *et al.* (2020) [5] on key challenges of health workers in implementation of IMNCI which showed that the health workers who had more than 10 years in service hardly used IMNCI approach in management of childhood illnesses compared to those who had less than 10 years in service. Results from this study also indicated that respondents disagreed to the regular IMNCI trainings at the facility. This meant that the refresher training courses rarely happened at the facility. This could be attributed to the fact that the hospital management are aware that IMNCI is taught during the course of study by different cadres and therefore saw no

need for more training. Such findings were still got in results by Temitope *et al.* (2022) <sup>[8]</sup> where slightly above average out of the participants had strong perceptions of lack of adequately trained staff (52.8%) and scarcity of trained staff concerning numerous children searching for treatment (52.8%) as barriers to implementing IMCI. The identified motivators for implementing IMCI were the training and retraining of healthcare workers and the provision of working aids.

### Conclusion

Some challenges were observed and these contributed a big deal in reducing the implementation of IMNCI in Kabale Regional Referral Hospital. Among the factors were limited knowledge and poor attitude of the health workers on the approach of IMNCI. The study also identified lack of support supervision, limited in service training, low staff to patient ratio and lack of drugs as the leading factors for implementation of IMNCI in Kabale Regional Referral Hospital.

**Conflict of interest:** nil

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### How to Cite This Article

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