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Health Care Provider 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 care provider 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 through descriptive and inferential statistics using the Statistical Package for Social Sciences (SPSS version 22) and presented through frequencies and percentages. The study also established a significant positive relationship between health care provider factors and implementation of policy on management of childhood illnesses where a unit increase in health care provider factors leads to an increase in implementation of policy by 0.759, $p>0.01$. The

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study recommended that Health care providers require support to be able to use the knowledge and skills acquired for implementation of the policy on management of childhood illnesses.

Keywords: *health care provider factors, implementation, management, childhood illnesses*

1.0 INTRODUCTION

1.1 Background of the Study

Health providers are specialized, trained officers who work in health facilities. On the other hand Implementation of integrated management of childhood illness (IMCI) is a comprehensive approach that forms the basis of child health towards ensuring that the child attains the fifth birthday. The strategy had the aim of preventing through early diagnosis and management of malaria, pneumonia, diarrhea, measles and malnutrition.

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 this efforts came up due to negative impacts of disease programs controls 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 care provider factors that influenced the implementation of Policy on management of childhood illnesses in Bomet County.

2.0 LITERATURE REVIEW

2.1 Health Care Provider Factors

2.1.1 Knowledge

The services offered at the many health centres are generally affected by the Health care provider knowledge level on IMCI (Hill et al, 2010). Health care provider in the regional clinics who offered out-patient and in-patient services, and laboratory services and obstetric lacked knowledge on IMCI. The type of health specialist's practices focused by IMCI has, on its own, influence application. The key essence is on health specialist case administration practices; though, these are difficult to watch impartially and hard to screen by use of routine records (Wijekoom & Martines, 2014). Also, members are for the most part uninformed of IMCI or the advantages of key case administration practices and, therefore, neither customers nor managers have enough knowledge to observe health specialist conduct, and health workers may not see any advantages to convention adherence. A comparable asymmetry of information exists between the national and region levels, with the DOCH unfit to precisely observe the level of exertion and supervision put into the application of IMCI by local directors.

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.

A significant majority of South African population served the public system while the private and public health systems existing in parallel (Nolan, Angos & Cunha, 2014). A new dawn was marked in south Africa with the arrival of missionaries such as the Roman Catholics who included priests and nuns of different orders, the Anglican entity was also not left behind in this new venture that helped improved the health provision.

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.

The population distribution is skewed in Uganda with more than half of the citizens staying in the upcountry (Pokhrel & Sauerborn, 2011). The state therefore in a bid to improve the service provision health wise, improved on the accessibility to the health services in the upcountry. This was done through conversion of the farmhouses into health centers and equipping them with basic equipment to enable them provide basic health services such as minor accidents and simple illnesses. The situation was so dire that incases of emergencies, patients were expected to provide their own transportation.

The National Government of Kenya has encouraged its citizens to enroll and register with the main national health insurance (Kamat, 2010). Those are employed have a percentage deducted from their salaries while those who are self-employed are also encouraged to get into the scheme much as it's entirely voluntary. The NHIF covers a wide range of illnesses and conditions as well as surgeries depending on the premiums one gives. The Government of Kenya through the ministry of health formulated a policy guideline in line with vision 2030 envisioned by the ministry of planning. The policy mandated the docket of health to identify activities that would help the government achieve the health goals. The policy was aligned with the new constitution of Kenya promulgated in 2010 and global health communities.

The Muranga County Government runs dispensaries across the county and manage simple ailments such as common cold, flue, malaria and minor skin problems as well as minor injuries (Mosley & Chen, 2011). These dispensaries are run by highly trained and experienced nurses who work under the nursing officers of the respective areas. The dispensaries act as the first point of contact between the patient and the health facilities. In the event the personnel encounter a case that is above the health centers there was protocol for referral.

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2.1.2 Skills in Management of Childhood Illness

According to Caldwell and Caldwell (2014), in 2003 after the Afghanistan Ministry of Public Heath had realized a deteriorating health and increased mortality, included the new approach of managing childhood diseases and promoting health services at the lowest levels and at the same assessing its outcome (Thind & Cruz, 2013). High cost of training, classification, treatment and counselling were some of the key problems that were subsequently identified. The rate at which trained and experienced workers were leaving jobs for greener pastures and the improper ways of implementing the planned projects and were also noted to be a challenge.

South African Government decided to use a strategy in which health was improved at the primary level in order to reduce both morbidity and mortality (Hill et al., 2010). In order to realize this, workers had to be trained and monitored for performance and a greater coverage of the populace in order to increase survival of the children in case of illnesses in as much as there were great constraints. The training of the personnel was in depth and involved well thought out questionnaires that was to be tackled after close to two weeks of training that included both the lecturer room and clinical hands on sessions. Comprehensive training methodologies were used as well as materials that made understanding on the new concept easy to learn. Tutors were also trained on how best to deliver the knowledge to the students.

Dilapidating health systems in Egypt forced the government to have a complete change of the entire health system for quality health service provision to be realized (Wijekoom & Martines, 2014). The overhaul involved both the public and the private sector. The government decided that the Public health coverage was to be provided by the health docket which was already running a number of health programs and were also provided free services. It was realized that a paltry percentage of the Egyptian population had enrolled for health policies from the insurance companies. This is because there was great disappointment and dissatisfaction with the level of services offered.

Robinson (2011) study shows that citizens paid for over 70% of the health cost from their pockets in spite of the fact that the services offered were not commensurate to what they were paying for as they below par leading to great disillusionment from the masses and in essence discouraging those had not taken insurance policies from doing so. It was an open secret that the state health facilities were known to be steaming with incompetence besides lackluster performance by the staff not to mention that they were understaffed and the few staff were overwhelmed. The Egyptian health insurance system covered those in employment, those who were schooling and widows. This was done through monthly deductions by the employer from the employee's income and channeled to the insurance companies. This allowed the insurance firms to manage a fleet of medical operatives and sometimes worked closely with the private sector to help augment the deficit.

Mosley and Chen in 2011 noted how planning guides and suggest areas which can be improved in the health care system so as to effectively implement the IMCI. These areas include; the introduction of IMCI classifications into health information systems, introduction of IMCI into routine supervision by for example revising of checklists so as to include aspects of IMCI case management, ensuring the availability of pre-referral drugs at lower level health facilities and improving the drug procurement system. It also includes; the improvement of referral pathways

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by upgrading lower level facilities while improving care at referral facilities and improving care-taker compliance to referral advice and provision of guidelines when referral is not possible and the documentation of the experiences of early IMCI implementation (Mosley & Chen, 2011).

Countries should acquire generic IMCI training materials and guidelines suitable to their local conditions through tool translation and the modification of language and pictures as per the Adaptation Guidelines of WHO. This Adaptation Guidelines encourage countries to put into consideration other factors applicable to their situation for instance drugs, drug resistance history and culture, disease patterns and epidemiology in their decisions on how to implement the IMCI (Rodriguez, 2015). Thind and Cruz (2013) do assert that appropriate and prompt health care services have the capacity to significantly reduce deaths resulting from common illnesses amongst children. Treating a sick child will depend on many factors such as; the financial situation of each individual household and the cost, quality and availability of the health services.

Mosley and Chen (2011) observe that an estimate of 30 interventions could go a long way in the elimination of more than 60% of child deaths each year if delivered to the families and children in need and are able to reach universal coverage levels. The right treatment of malaria, pneumonia, and diarrhea is one of the most effective interventions in reducing the under five year old child mortality.

Efforts that have been put in place so as to reduce infant deaths include; the widespread use of oral rehydration therapy in the treatment of diarrhea as per Mosley and Chen, and the increase in immunization coverage which improves survival among children in the developing world should center on the management of pneumonia and other chronic illnesses, in addition to immunization and other preventive measures undertaken (Mosley & Chen, 2011).

2.2 Conceptual Framework

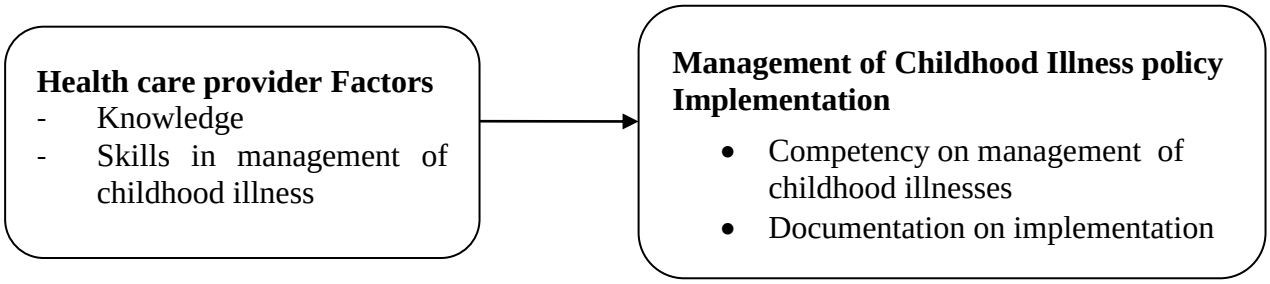

Figure 1 Conceptual Framework

3.0 RESEARCH METHODOLOGY

A descriptive cross sectional study design with both quantitative and qualitative approaches was 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 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.

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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 4.2, 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.

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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 Care Provider Factors

4.3.1 Knowledge for Training

Table 3 Knowledge for Training

	Mean	Std. Deviation
I have been trained on IMCI	2.21	1.216
I have been trained on ETAT	2.29	1.262
The hospital regularly organizes a session to update health care providers on IMCI and ETAT	2.40	1.089
ETAT was a component of my training	2.09	1.122
Total	**8.99**	**4.689**
Average	**2.24**	**1.172**

Source: Survey Data (2018)

Table 3 shows that health providers agreed on knowledge for training they had acquired on IMCI and ETAT to a low extent as shown by an average score of 2.24 in that; health providers agreed that the hospital regularly organized sessions to update health care providers on IMCI to a low extent as shown by a mean score of 2.40, health providers agreed that they had been trained on ETAT to a low extent as shown by a mean score of 2.29, health providers agreed that they had been trained on IMCI to a low extent as shown by a mean score of 2.21 and health providers

agreed that ETAT was a component of their training to a low extent as shown by a mean score of 2.09.

This results conform to the findings of Chandrashekahar and Ravi (2010) in 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. Findings show that only 40% of the nurses have IMCI knowledge and 15% of this figure are competent in their medical career. Further the study findings coincide with Caldwell and Caldwell (2014) findings in that, in order to improve the number of nurses and to also ensure quality training, the nurses training institutions had to be supported infrastructural to avail the prerequisite requirements and to also build the intellectual support base. These would ensure a conducive environment for both the trainers and the students alike to teach and to learn respectively. It is worth noting that majority of the health education centers are struggling just like their counterparts in other sectors financially. For a long time there was over dependence on short term training sessions that included workshops whose impacts were not felt as much as had been anticipated (SANC, 2011). Lack of a proper systems that would ensure seamless transfer of funds from the donors to the training institutions and accountability for the sent funds were also some of the major challenges that both the donors and the training institutions faced.

4.3.2 Skills

Table 4 Skills

	Mean	Std. Deviation
The medication required for management of childhood illnesses is always available for me to use in ETAT	2.20	1.124
The clinical supervisors are competent in instructing on ETAT.	2.18	1.035
The resources required for IMCI implementation are always readily available	2.20	1.016
The trainers always demonstrate competence in IMCI implementation	1.86	.821
Total	**8.44**	**3.996**
Average	**2.11**	**0.999**

Source: Survey Data (2018)

Findings in Table 4 show that health providers agreed to a low extent on skills they had on IMCI and ETAT as shown by an average score of 2.11 in that; health providers agreed that the medication required for management of childhood illnesses was always available for them to use in ETAT to a low extent as shown by a mean score of 2.20, health providers agreed that the resources required for IMCI implementation were always readily available to a low extent as shown by a mean score of 2.20, health providers agreed that the clinical supervisors were competent in instructing on ETAT to a low extent as shown by a mean score of 2.18, and health providers agreed that the trainers always demonstrated competence in IMCI implementation to a low extent as shown by a mean score of 1.86.

These findings are in line with Kamat (2010) as a result of scarcity of facilitators and funds, the monitoring and follow up is not frequent and does not come up in the required time. ETAT in hospitals is not well combined into the normal monitoring and frequent checkups are not offered. This process is found to take a lot of time and that's why the health workers normally cut corners. The health workers find time limited to undertake the process especially in health centers whereby there are limited workers. Intervention by groups such as the IMCI, find it harder to undertake the supervision procedure (Chandrashekahar and Ravi, 2010). The lack of appropriate mechanism to find out whether IMCI has been applied appropriately has led to majority of the health workers reducing their motivation and this affects compliance.

In support of the findings Wijekoom and Martines (2014) study shows that dilapidating health systems in Egypt forced the government to have a complete change of the entire health system for quality health service provision to be realized. The overhaul involved both the public and the private sector. The government decided that the Public health coverage was to be provided by the health docket which was already running a number of health programs and were also provided free services. It was realized that a paltry percentage of the Egyptian population had enrolled to be trained on IMCI. This is because there was great disappointment and dissatisfaction with the level of services offered.

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Table 5 Analysis of Variance for Health Care Provider Factors

		Sum of Squares	df	Mean Square	F	Sig
Between People		940.356	104	9.042		
Within People	Between Items	65.504	16	4.094	6.197	.000
	Residual	1099.320	1664	.661		
	Total	1164.824	1680	.693		
Total		2105.180	1784	1.180		

Grand Mean = 2.2034

The findings from health provider factors with a grand mean of 2.2034 on all items was statistically significant (F=6.197; p>0.01). These results conform to the findings of Chandrashekahar and Ravi (2010) in that on job 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. Findings show that only 40% of the nurses have IMCI knowledge and 15% of this figure is competent in their medical career. Further the study findings coincide with Caldwell and Caldwell (2014) findings in that, in order to improve the number of nurses and to also ensure quality training, the nurses training institutions had to be supported infrastructural to avail the prerequisite requirements and to also build the intellectual support base. These would ensure a conducive environment for both the trainers and the students alike to teach and to learn respectively. It is worth noting that majority of the health education centers are struggling just like their counterparts in other sectors financially. For a long time there was over dependence on short term training sessions that included workshops whose impacts were not felt as much as had been anticipated (SANC, 2011). Lack of proper systems that would ensure seamless transfer of funds from the donors to the training institutions and accountability for the sent funds were also some of the major challenges that both the donors and the training institutions faced.

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4.4 Management of Childhood Illness Policy Implementation

Table 6 Management of childhood illness policy implementation status in Bomet

February 2018	Number of children managed using IMCI policy guidelines	Number of children referred
1	2	0
2	0	0
3	1	1
4	0	0
5	2	1
6	0	0
7	0	0
8	1	0
9	3	1
10	1	1
11	0	0
12	2	1
13	0	0
14	1	1
15	0	0
16	1	0
17	2	1
18	0	0
19	0	0
20	1	1
21	0	0
22	4	1
23	2	1
24	1	0
25	2	1
26	0	0
27	0	0
28	0	0
Total	**26**	**11**

Source: Survey Data (2018)

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Out of the children (n=309) seen in the two hospitals in the month of February 2018, 8.4% (n=26) were managed using IMCI policy guidelines and only 3.6% (n=11) were referred implying low implementation of integrated management of childhood illness policy in Bomet County. This agreed with Arner (2010) who noted that most of the African states are lagging behind in implementation of the IMCI strategy despite reported gains of its implementation elsewhere. This also concurred with WHO (2012) which noted that that the level of implementation of IMCI in most of the developing countries falls short of the set target and remains very low compared to that of the developed countries.

4.5 Implementation of Policy on management of Childhood illnesses

Table 7 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 7 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 influenced 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 and 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.

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4.6 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:

4.6.1 Correlation Analysis Results

Table 8 Correlation Matrix

		Health Provider	Implementation
Health Provider	Pearson Correlation	1	.759**
	Sig. (1-tailed)		.000
	N	105	105

The findings in Table 8 above indicate that Health provider factors have a significant influence on the implementation of the policy on management of childhood illnesses in Bomet County.

4.6.2 Regression Analysis Results

Table 9 Regression Coefficients Results

		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	3.142	.826		7.484	0.0000
	Health care provider factors	0.824	.289	0.126	2.820	0.0075

Source: Research Findings

Therefore; substituting the regression model $Y_i = \beta_0 + \beta_1 X_1 + \varepsilon$

Becomes: $Y = 3.142 + 0.815X_{1+} 0\varepsilon$

According to the equation above, taking all factors (health care provider factors) constant at zero, implementation of policy on management of childhood illness would be at 3.142. The study also discovered a significant positive relationship between health care provider factors and implementation of Policy on management of childhood illnesses($\beta=0.824;p<0.01$); meaning that a unit increase in health care provider factors leads to an increase in implementation of Policy by 0.824. This agrees with the proposition by Magadi and Madise (2013) who assert that it is of importance to reduce the expenses of IMCI training so as to increase the rate of trained health workers. This can be achieved by; reducing the time period of training, making the training public and ensuring the facilitator to members proportions are emphasized. So as to ensure that the IMCI skills are enhanced there is therefore need for better supervision strategies and more IMCI materials need to be easily accessible.

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5.0 SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1Summary of the Findings

The objective was to determine health care provider factors that influence the implementation of policy on management of childhood illnesses at Bomet County. The study also established a significant positive relationship between health care provider factors and implementation of policy on management of childhood illnesses where a unit increase in health care provider factors leads to an increase in implementation of policy by 0.759, $p>0.01$.

The third objective of the study was to establish patient factors that influence the implementation of policy on management of childhood illnesses at Bomet County. The study found that the level of knowledge respondents provided to the patients on IMCI and ETAT in the hospital and the level of access for patients to the hospital significant at $p>0.01$. The study further discovered a significant positive relationship between patient factors and implementation of policy on management of childhood illnesses where a unit increase in patient factors would lead an increase in implementation of policy by 0.350.

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

Health care provider factors were significantly related to implementation of policy on management of childhood illnesses. A follow up on all that they had learnt would improve on the implementation of the policy on management of childhood illnesses.. Also, a unit increase in health care provider factors e.g. nurse training would lead to an increase in implementation of policy.

5.3 Recommendations

The study recommends that health care providers require support to be able to use the knowledge and skills acquired for implementation of the policy on management of childhood illnesses.

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