NURSES' PERCEPTIONS ON PRIMARY HEALTH CARE IN RURAL COMMUNITIES IN KASOA, GHANA

by

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DECLARATION

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I declare that the above dissertation is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

22/11/2018

SIGNATURE DATE

DEDICATION

I dedicate this work to the almighty God for the grace and strength He has granted me to this far in my academic journey. I also wish to dedicate this work to my parents for the encouragement and guidance during all the phases of this research. Finally, I dedicate this

work to all my friends who contributed in various ways to make my research study at Unisa a success.

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ABSTRACT

The purpose of the study was to explore the perceptions nurses have regarding PHC in rural communities in Kasoa, Ghana.The study was carried out in Kasoa in the Central Region of Ghana. The data were collected purposively using individual in-depth interview; the data were analysed using thematic data analysis approach. A total of 24 nurses were interviewed. This sample size was attained at saturation. The population for this study included all the nurses irrespective of category, qualification and experience and who are working in the PHC facilities in Kasoa rural areas. The categories of nurses were registered general nurses, enrolled nurses, midwives and community health nurses. The thematic analysis yielded 5 themes as follows:

Participants' interpretation of the meaning of Primary Health Care.The participants further perceived health education and patients' rights provided at PHC facilities as helpful in achieving health outcomes. The participants had the perception that the provision of outreach services seems to be acceptable to communities and there are referral systems at PHC facilities, which are well-structured, clear and acceptable. The participants also perceive the CHPS zones as helpful to provide PHC services.

Keywords: Nurses' Perceptions, rural communities, Primary health care.

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

White (2015:105) views Primary Health Care as “Health care that starts at time of first contact between a physician or other health care provider and a person seeking advice or treatment for an illness or an injury”. Primary health care relies, at community and referral levels, on health workers as well as traditional practitioners who are trained socially and technically to work as a health team so as to respond to the expressed health needs of the community (Abosede & Sholeye 2014:1). Primary health care is defined in the Declaration of Alma Arta as “essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford”. Primary health care must be an essential part of any country's health system of which it is the focus and of the overall social and economic development of the community (Howe 2016:4).

Primary health care nursing is the nursing practice that occurs within a range of primary health care settings, each sharing the characteristic that they are a part of the first level of contact with the health system (Howe 2016:4). Currently in Ghana, the Community-based Health Planning and Services (CHPS) is being operationalised as an ideal way for achieving universal health coverage as the basic package of essential primary health services. The CHPS concept was aimed at making health care accessible to the community (Community-based Health Planning and Services Policy 2014:4). This concept was adopted primarily as one of the strategies to help address the primary health care needs in rural areas in Ghana with community health nurses playing pivotal roles.

1.2 RESEARCH PROBLEM

The Ghana Health Service (GHS) has been operating community-centred health care system through the Community-based Health Planning and Services (CHPS) since 2000, where community health nurses were placed in communities to offer public health, outreaches such

as school health, community health services etc., and to act as the first point of clinical contact and referral. The CHPS compounds were designed to serve on an average, a population of 500 and the compounds are demarcated according to the government's 6135 electoral areas (Lawson & Essuman 2016:1). The Ministry of Health in Ghana has been concerned about quality of care, but improvement of said quality has been slow partly due to prioritisation (Yue & Turkson 2009:65) as cited in Antwi, Yiranbon, Appau-Yeboah, Ansong, and Yeboah (2014:144). Many problems, which included poor quality of service, clients' mortality, crunch on revenue, material resources, staff, recognition, trust and respect in individual and communities' apathy towards health services, are contributing to lowered effectiveness and efficiency (Turkson & Gunning 2013:28) as cited in Antwi et al (2014:144). Kelly (2014:87) found that clients recommended that health workers at the Kasoa clinics should change their attitude and be polite in caring for patients. Patients persistent complains about services in PHC has led to the current study exploring the perceptions of nurses in Kasoa, Ghana with the sole purpose of understanding their perceptions.

1.3 AIM AND OBJECTIVES

1.3.1 Research purpose

The purpose of the study was to explore the perceptions nurses have on PHC in rural communities in Kasoa.

1.3.2 Research objectives

- To understand the perceptions nurses, had with regard to primary health care delivery in rural communities in Kasoa.
- To describe the perceived factors that hindered primary health care delivery in rural communities in Kasoa.
- To identify measures that can be put in place to promote primary health care services.

1.4 RESEARCH QUESTION

One grand tour question was used to explore the nurses' perceptions on primary health care in rural communities in Kasoa, Ghana. The grand tour question that the nurses were asked entails: What is your understanding of Primary Health Care in Kasoa? Follow up questions

were used dependent on the participant's responses and in line with the objectives. Some of the questions covered were as follows:

What challenges did primary health care nurses faced in the course of their work?

What were the challenges, if any, in the implementation of the PHC services that made the patients to complain about the nurses' attitude?

1.5 SIGNIFICANCE OF THE STUDY

The study added to the existing knowledge why policy makers should seek private participation in the provision of primary health care in rural communities. In addition, not-for-profit organisations were encouraged to participate in the development of PHC in rural communities.

The findings in this study assisted the authorities to understand the nurse's perceptions and concerns regarding PHC service delivery.

The authorities planned how to address the patient's complaints based on the findings of this study.

1.6 SCOPE AND LIMITATIONS

The study focused on rural health development.

The study was carried out in rural communities located in Kasoa, Ghana.

The study sought to identify best health care practises elsewhere, which can be modelled in rural communities in Kasoa, Ghana.

Limitations of the study

Purposive sampling did not make the data representative enough and therefore the findings could not be transferred to other locations

Some nurses had little knowledge about PHC and therefore their perceptions about it were scanty. This affected the comprehensive appraisal of the findings.

1.7 DEFINITIONS OF TERMS

1.7.1 Community-based Health Planning and Services

Community-based Health Planning and Services is the mobilisation of leaders of a given community and its decision-making systems and resources together with the placement of trained Community Health Officers, who are provided with adequate logistics support in the spirit of community volunteerism to deliver health care services in accordance with the principles of primary health care (Simon, Abdul-Hakim & Akwetey 2017:35).

1.7.2 Health promotion

The World Health Organization (2016: [sp]) defines health promotion as the process of enabling people to increase control over, and to improve their health.

1.7.3 Primary health care

Primary health care refers to the immediate health care service individuals come into contact with the health system, that brings the health care closer to the people or community. It takes into consideration all the services in the community that support the everyday health needs of the community at every stage of their life (Government of Alberta 2018: [Sp]).

1.7.4 Perceptions

Perception is the sensory involvement of the world in which we live and involves both identifying environmental stimuli and responding to the stimuli. Through the process of perception, we acquire the details about the properties and elements of the environment that are critical to our survival (Cherry 2018: [S.p]). In this study, perception could be defined as the sense nurses make of the primary health care, they are involved in at rural communities in Kasoa.

1.7.5 Rural community

Rural community refers to a collection of people who relate with each another and whose singular interests or characteristics form the basis for a sense of belonging. It can be a society of people holding common rights and privileges, sharing common interests, example, a community of farmers (Allender, Rector & Warner 2014:7). In this study, a rural community refers to the group of people who live in remote areas or communities and under the leadership of a chief.

1.8 RESEARCH METHODOLOGY

This study adopted the qualitative research approach. According to Leavy (2014:2) qualitative research is a way of obtaining insights about social reality. Qualitative approaches to research can be employed across many fields to inquire a wide range of topics. Qualitative researchers believe in the viewpoint that advocates, knowledge building is reproductive and process-oriented. The fact is not complete and ready to be uncovered by unbiassed researchers, instead it is dependent, circumstantial, and varied (Saldaña, 2011) as cited in Leavy (2014:3). In this study, qualitative approach was used because the researcher explored the perceptions nurses have on PHC in rural communities in Kasoa. Furthermore, the unavailability of a conceptual framework made it necessary for the researcher to explore the perceptions of participants using qualitative methods.

1.8.1 Research design

The research design for the study was qualitative exploratory design. According to Manerikar and Manerikar (2014:95) when a researcher is limited in terms of the experience with or understanding about a research issue, exploratory research is useful. It ensures that a more thorough, more definite future inquiry will begin with a sufficient appreciation of the nature of the inquiry at hand. The researcher held the view that nurses' perceptions can be thoroughly investigated by exploration and thus the choice of this design. The exploration of the perceptions of the participants would reveal other important information that will allow for future study and will also aid policy makers.

1.8.2 Setting and population

The setting of the study was Kasoa in the Central region of Ghana. Kasoa is a cosmopolitan community, which faces problems ranging from the lack of clean drinking water, poor sanitation and the absence of a robust health care system. It is a rapidly growing community in Ghana with trading being the major occupation of the residents. The population for the study was all nurses irrespective of category; qualification; experience and who are working in PHC setting, and are willing to take part in the study.

1.8.3 Sample and sampling

The sample for the study was twenty-four (24) nurses including community health nurses, registered nurses, enrolled nurses and midwives. They constituted the sampling frame for the study. The size was reached at saturation during the data collection phase and this provided

in-depth study of the phenomenon. Purposive sampling approach was used since this sampling method targeted the participants of interest because they met the set criteria for the study. In qualitative studies, small sample sizes are used because they gave accurate information, and qualitative studies adopt saturation in data collection.

1.8.4 Data collection

In this study, the data collection tool the researcher used to obtain information from participants was individual in-depth interview which was recorded. According to Kvale (1996: 174) as cited in Alshenqeeti (2014:39) an interview is a kind of interaction, which aims at soliciting information about the real life of the interviewee with the objective of obtaining understanding of the 'described phenomena'. Similarly, Schostak, (2006: 54) as cited in Alshenqueeti (2014:39) adds that an interview is a prolonged conversation between partners that aims at having a deeper information about a certain topic or subject, and through which a concept or phenomenon could be explained in terms of the meaning interviewees bring to it.

1.8.5 Data analysis

Good data management reduced the risk of data loss, increased accuracy and verifiability. The data in the audio tape and field notes were saved using codes for the purposes of confidentiality. The tapes and the notes were kept at a safe place by the researcher to offer greater potential for longer-term data preservation.

1.9 TRUSWORTHINESS

Researchers agree that research needs to be trustworthy and should demonstrate both rigour and relevance. Trustworthiness represents the validity of research as done in quantitative research. Rigour represents the process of arriving at the results and relevance represents whether the end-results are relevant or not (Mandal 2018:529). The researcher, maintained trustworthiness through:

Credibility: Credibility refers to the believability or the truth in research findings. To this extent, participants are given the interview transcripts and the research reports and are asked to either agree or disagree with them. This seeks to ensure the truth of the findings. Credibility can also be attained by persistent observation and triangulation of data. Credibility is among the various ways of ensuring internal validity of the qualitative research findings. Credibility can also be built through prolonged engagement in the field (Mandal 2018:529).

Confirmability: Confirmability implies that the research findings of an inquiry must be representative of the opinions of the participants and the objectives that form the basis of the study and not of the desires, inclinations, benefits, standpoints of the inquirer (Guba 1981:80) as cited in Moon, Brewer, Januchowski-Hartley, Adams and Blackman (2016: [2]).

Transferability: Transferability refers to whether the results obtained from the analysis could be used to draw conclusions for other research settings and circumstances. Transferability serves as a check for external validity of the study findings. In qualitative inquiries, researchers provide copious description of the settings and the context in which the research is conducted. This ensures that readers are provided with sufficient description of the study setting to make their own judgement whether the findings of the study are applicable to other research settings (Mandal 2018:529).

Dependability: Dependability in qualitative study is similar to reliability as applied in quantitative research. A measure is reliable when independent but similar measures of the same trait or idea of a given object agree. Reliability depends on how much of the variation in scores is attributable to random or chance errors (G.A. Churchill, 1979) as cited in (Mandal 2018:529). Reliability cannot be checked in qualitative research as it is done in quantitative research. Qualitative researchers ensure dependability by having proper documentation of data, methods, and taking proper decisions about research (Mandal 2018:529).

1.10 STRUCTURE OF THE DISSERTATION

Chapter 1 introduced and gave background to the current inquiry and provided brief description of the community. It outlined the problem statement of the inquiry and succinctly stated the purpose of the study, its significance, and the objectives. Issues of trustworthiness were also elaborated. The chapter further discussed the ethical principles that were considered in the study.

Chapter 2 presented the literature review that was envisaged to guide the discussion of the research findings using data and information gathered from the participants. In this chapter also, the researcher critically reasoned with the views of authors about concepts and theories about primary health care, and also analysed and stated opinions when necessary. The researcher also discussed research findings of authors that are related to the current study.

Chapter 3 of the study dwelt on the methodology employed to gather data from the participants who were included in the study. It also identified the importance or the relevance of the particular research design and the data collection tool that the researcher adopted for the study

The results and findings were presented in Chapter 4 while Chapter 5 discussed the conclusions that were drawn from the study based on its findings. There were also recommendations in this chapter.

1.11 ETHICAL CONSIDERATIONS

Permission to conduct the study was requested through Department of Health Studies Scientific Review Committee and the Ghana Health Services research ethics committee. Some ethical considerations the researcher adopted included the following:

Informed consent

Participants were asked for their participation in the research study. The following information were provided to the potential participants: research topic, purpose, the benefits of the study and that their participation in the study was voluntary. When one felt like withdrawing from participating even after giving informed consent, one did so without any coercion or penalty.

Beneficence: This means doing good work to benefit others. In research ethics, being beneficent requires researchers to keep the welfare of the participant as a goal of any study. This inherently means that no harm should be bestowed upon research participants. Additionally, though, beneficence seeks to maximize benefits and minimize harm, what may be difficult, however, is that it is expected that beneficence will be applied to not only the research participants but also society as a whole (Brann 2017:4). In this study, the researcher acted in ways that furthered others' well-being and it obligated the researcher to balance the potentially beneficial consequences of an action against the potentially harmful ones.

No maleficence: This implies do no harm. Joel Feinberg (1984) as cited in Israel (2015:2) defines harm as the deviation from the interest of a particular study, where the interests of an individual are defined as the number of things in which that individual has a stake. Harm is most often understood in physical terms, it also includes emotional, social, economic, legal and environmental destruction. Indeed, in social science research, harm is generally seen to

be emotional distress, embarrassment, social drawback, denying an individual of his or her privacy or infringement of rights than physical injury (Israel 2015:2).

Autonomy: Autonomy requires researchers to respect the ability of the study participants to think for themselves. The idea that people should be allowed to make choices that are reasonable and best for them, in other words, to exercise control over their own lives (Hammersley & Traianou 2015:2).

1.12 CONCLUSION

This chapter gave the sequence in which the study followed. The background to the study was discussed briefly and the background to the research problem was laid out. The research problem was succinctly stated. The chapter also identified the aim of the study and its objectives. The significance of the study was also stated. The approaches to ensure the trustworthiness of the study were also described in this chapter and the sequence in which the study will progress was also laid out in this chapter. Those principles to ensure ethical compliance were enumerated in this chapter.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Chapter one of the study introduced the problem that gave credence to the current inquiry. It gave background of what primary health care is about and moves by the Ministry of Health in Ghana to address the numerous challenges that confront the implementation of the primary health care policies. Chapter one further described the methodology the researcher will used in arriving at the purpose of the study.

This chapter focuses on the literature that are relevant to the current study and will identify similarity or differences in the works of authors who have carried out similar research. It would also argue for why the current study is important to the field of study. The researcher would also give reasons why the chosen method fits the study and how it would help carry out the inquiry. Literature reviews are done to either agree or disagree to opinions stated in research findings or long held view about concepts and gather evidence that supports stated opinions. The chapter would give alternative opinions when the researcher holds counter views expressed by other researchers.

2.2 HEALTH

Health care is seen as a key indicator of human and economic development. The World Health Organization (WHO) posits that every individual has the fundamental right to obtain the most acceptable standard of health. Owing to this, most countries have developed strategies aimed at improving the health outcomes of their citizens through various mechanisms. In the views of the WHO, the right to healthcare implies the ability of individuals to have access to timely, acceptable, and lower cost healthcare services that meet quality standards (IMANI 2017:2). According to Ncube, Abou-Sabaa, Lufumpa and Soucat (2013:1) the health sector in Africa has developed so much since the independence of the countries about half a century ago, this progress is projected to continue over the next half-century. Africa has made significant progress towards obtaining better health outcomes for its member states in the face of the difficulties posed by prevalent poor living conditions, epidemic diseases, and food insecurity. The notable disease conditions like HIV/AIDS, malaria, and tuberculosis remain the major contributors of mortality on the continent. Despite these challenges, the health systems

however, remain underfunded and overstretched with less staff. This poses a huge burden on government towards addressing the challenges that confront the eradication of traditional diseases. Good health is a prerequisite for human growth and development, and it is becoming evident that the attainment of good health does not depend on the health delivery system alone; instead it is facilitated by other factors such as the environment, social, good infrastructure, and governmental interventions (Ncube, Abou-Sabaa, Lufumpa & Soucat 2013:1).

According to Vergunst (2018:2), rural health in Africa can be compared to the health of the less privileged communities in the country, which are inhabited largely by poor people in the society. In view of this, although health is seen as a fundamental right of all the people living in a country, people living in rural communities are marginalised and thus, nations keep devoting funds with the aim of improving the health of the rural community dwellers to narrow the gap between the urban and the rural communities in terms of health care delivery. The inability to unravel the underlying causes of poor health outcomes is compounded by the inadequate appropriation of capital to address important needs with equity, for example, universal health, access to health and lower cost of health care. Instead, when involved in discussions on health care, health care administrators are seen as prioritising high-cost items (White 2015:104).

The Economist and Intelligent Unit (2017:3) finds that African countries face multifaceted healthcare difficulties as the countries attempt to address a range of infectious diseases, while at the same time contending with the rapid development of non-communicable diseases and accidents, all against a background of health systems that are heavily weak relative to those in other regions affect the health of the people. Nwankwo, Udeobasi, Osakwe and Okafor (2017:122), and the World Health Organization (WHO, 1978) define health as the state of absolute physical, social and mental well-being and not simply the absence of disease or sicknesses. Universal health coverage (UHC) has been accepted as the most important global health policy and according to the United Nations Sustainable Development Goals, all UN Member States have acknowledged the need to attain Universal Health Coverage by 2030.This includes financial risk protection, the availability and affordability of essential health-care services and access to safe, reliable, quality and lower cost of essential medicines and vaccines for all citizens (Tsimtsiou 2017:1).

Nwankwo et al (2017: 122), observe that, at the Alma-Ata Conference held in Russia in 1978, member states of the World Health Organization (WHO) adopted primary health care (PHC) strategy, which is considered comprehensive enough to address problems that existed in countries, which adversely affected quality of life. The World Health Organization in 1978 at Al Ata conference explained primary health care to mean the “essential health care which is based on practical, scientifically sound, socially acceptable methods and technology and which is made universally accessible to individuals in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development.” This definition though comprehensive, falls short of key professional actors of primary health care. The researcher is of the view that nurses when placed at the front lines of primary health care delivery will be impactful and thus, the need to conduct this inquiry to solicit their perceptions.

Tsimtsiou (2017: 1) recognises that primary health care can offer much more than the affordability of health care. For example, a study on 102 low and middle-income countries realised that comprehensive coverage of primary care services was associated with longer life expectancy, lower child mortality and lower under-five mortality. This implies that a well-funded primary health care will result in improved health outcomes.

2.3 PRIMARY HEALTH CARE

Osahon (2017:1) views Primary healthcare (PHC) as a vital approach to health care delivery which produces efficient and convenience ways of health care to the general public anywhere around the world. This can possibly be realised when there is active involvement of the public while intensively maintaining the development and growth of community health services and their independence. The global discussion about Primary Health Care (PHC) approaches has intensified over the past ten years and strategies to strengthen primary health care forms a central part of the restructuring of healthcare in European and Latin American countries (Fracolli, Gomes, Nabão, Santos, Cappellini & Almeida 2014:4852). In the view of the researcher, African countries could also intensify the debate on PHC strategies and thus, the need for the current study exploring perceptions of nurses about PHC in rural communities in Kasoa.

According to Papp, Borbas, Dobos, Bredehorst, Jaruseviciene, Vehko and Balogh (2014:2) the provision of health care services is viewed as the sum of doctor-patient contacts which take place in an organisational and social context and within a system of infrastructure. In order to appreciate the quality of health care services provided, it is necessary to assess opinions from multiple standpoints to have balanced views of patients and different health care professionals. Papp et al (2014:2) further explain that patients will serve as th right source of information to evaluate their health care experience, however, other research findings raise doubts whether this experience could be an appropriate indicator of the success of care. Research indicates that patients' opinion of quality is motivated by various factors, such as the characteristics of the national health system practice and the health care providers' personal and clinical skills. This study is relevant to the current study because the research by Papp et al (2014:2) sought the perceptions of consumers and health service providers using focus group discussions. The perceptions of nurses in rural communities for instance, cannot be underestimated since the perceptions would fill the literature gap concerning perceptions as revealed in the assessment by the findings of Papp et al (2014:2). Furthermore, the research by Papp et al (2014:2) did not consider the views of the nurses who play vital roles in health care delivery and thus, the choice of the nurses as participants in this study will provide invaluable contribution to the debate of perceptions on primary health care. The community could be urban or rural. The provision of efficient rural health has been adopted by many countries. For example, the Ghana government has adopted the Community-based Health Services and Planning (CHPS) as a way to improve the PHC of the rural communities with community health nurses and other nurse cadres playing pivotal roles. The current study will also use individual in-depth interview as opposed to the focus group discussion used above.

The Canadian Nurses Association, (CAN) (2015:1) posits that Primary health care (PHC) is an ideal strategy which is central in improving the health of the people and the effectiveness of health service delivery in all care settings. PHC places emphasis on the ways services are delivered and places the people who will benefit from primary health care services at the centre of health care delivery. CNA opines that PHC principles are efficient ways to provide non-discriminatory, timely and accessible health care while supporting individuals and families to make the best choices for their health, and communities make the best decisions for healthy

public policy. CNA further stresses, that, implementing PHC principles in all societies and health-care settings across the continuum of care is fundamental to improving the health and well-being of the people. The CNA argues further, that PHC and nursing are wholly interrelated, and the standards, skills, education and practice of nursing should be grounded in PHC principles and ideas. It is therefore imperative to integrate PHC competencies into entry to practice and continuing education throughout the career lifecycle. CNA believes that care delivery entrenched in PHC principles while using interprofessional collaborative teams in which the roles of nurses and other health-care providers are optimised to their full scope of practice will result in improved health outcomes (CNA 2015:1).

In the views of Onokerhoraye (2016:29) primary health care teams in Africa can contribute their expertise towards the Sustainable Development Goals (SDGs). For example, primary health care can contribute to ending poverty on the continent, improve nutrition in malnourished communities, provide health education for the people to gain knowledge about their health and environment and promote lifelong learning. Furthermore, primary health care could be used to empower individuals and communities to reduce discrimination and promote fairness, enable access to clean drinking water and sanitation, encourage productive and sustainable employment, advocate healthy and sustainable living environments, while ensuring peaceful communities. Irrespective of the vital roles which primary health care can play towards achieving the SDGs, the promotion of a reliable and cost-effective primary health care system has eluded many governments, policy makers, funders, and health-care providers in many developing countries including African countries (Onokerhoraye 2016:29).
Basing the argument on the statements above, the researcher holds the opinion that, PHC and nurses' roles are indispensable, for example health promotion and health education, and therefore the current study with the sole purpose of identifying and describing the perceptions of nurses would contribute to existing literature and reveal possible gaps in PHC-based systems in rural communities that have caused the roles that primary health care play towards achieving the SDGs to elude governments and policy makers.

Yaya, Bishwajit, Ekholuenetale, Shah, Kadio and Udenigwe (2017:2) argue that there are research findings that support the fact that Universal Health Coverage is not attainable through the facility-based health care delivery system and cannot meet the goal of Alma Ata.

Notwithstanding these evidences, PHC is yet to gain adequate policy attention particularly in the developing nations in Asia and Africa. Some common situations in PHC include poor existing infrastructure, inadequate skilled health workers, low remuneration of staff and professional status of health workers and lack of openness in health care administration, which ultimately result in reduced service quality, lack of trust, deteriorating patient-doctor relation and low care seeking behaviour. Yaya et al (2017:2) argue further that, among the factors that determine patients' satisfaction is service quality; other factors affecting the perception of quality primary healthcare services depend on the healthcare delivery set up. The researcher agrees with the view expressed above and queries; is the CHPS concept adopted by Ghana delivering its mandate? In addition, is primary health care all about health care setting?

Yaya et al (2017:2) conclude that, policymakers needed to understand the factors that determine satisfaction among patients with the health system. Again, how the diverse socio-demographic groups perceive satisfaction with healthcare services to address the inequalities in the health system that exist between the urban and rural areas within the same country. This conclusion fails to include how health care providers, specifically nurses perceive the services they provide to patients. This is so because the health care provider may have little or no idea about the philosophy underpinning the service they provide to patients and therefore the need to conduct inquiries to solicit their perceptions. There could also be challenges health care providers face when implementing some of the primary health care policies. One research question of this study seeks to find answers to this.

The World Health Organization (2016:9) has identify that, measures of PHC performance have focused on quantifying the inputs such as human resources, facilities, and financing, and describing service delivery volume and outcomes, including disease-specific morbidity and mortality. Measurement of quality service delivery has been neglected, as has the experience of patients, health workers, and communities in seeking, accessing and delivering health services.

Before the Declaration at Alma-Ata in 1978, PHC had being the strategy for strengthening the health care service delivery in Low and Middle-Income Countries (LMICs), and after the declaration, it became a major subject in global health. The World Health Report of 2000

evaluated work in the preceding decades, and noted that PHC programmes in African countries could be viewed as “partial failures.” Underlying this criticism was that primary health care programmes had failed to deliver accessibility for all. This may have been due to the fact that health service delivery was not targeted at responding to the numerous problems facing developing countries; such problems included lack of access to essential drugs and lack of health care workers (Rule, Ngo, Oanh, Asante, Doyle, Roberts, & Taylor 2014:340). Other problems facing rural communities include the lack of clean drinking water, lack of proper sanitation and an efficient and reliable rural health clinic to respond to the health needs of the communities.

Another finding of World Health Report of 2000 was also that, in the decades following the declaration of Alma-Ata, changes in economic fundamentals, encouraged by the World Bank and grounded on market forces and competition, resulted in the discouragement of PHC policies through so-called health sector reforms. As a result, there became the decline in PHC approaches and this was followed in many countries; people living in under privileged communities still had no access to fundamental services and gaps continued to widen. The inequity in the availability of PHC was because the World Health Organization (WHO) principles of PHC had been weakened and put side (Rule, et al 2014:340).

2.3.1 Values of primary health care

2.3.1.1 The right to the highest attainable level of health

According to WHO (2017: [sp]) the right to the highest attainable standard of health ensures that there are clear sets of legal requirements on countries to provide appropriate conditions for the enjoyment of health for all people irrespective of social and economic status. The right to health is a globally agreed upon human rights standards, and is not different from other human rights. This means achieving the right to health is both at the core, and dependent upon, the realisation of other human rights. These include the right to food, housing, work, education, information, and participation.

2.3.1.2 Equity

Equity in access to primary health care is a basic human right that countries should strive for. Public health policy is based on the principle of meeting the societal conditions for equity in health and “care on equal terms”. Advanced countries like Sweden has publicly financed universal health insurance which is backed by law over the past two decades to provide health care for all of its people on equal terms rather than health care being dependent on factors such as social and economic status, age, gender, and citizenship. To this end, equity in access to primary health care services should be a key objective of government’s health care system (Akhavan 2015:1). Equitable access to health care services is seen as a high importance for eliminating inequitable health status within countries (Benatar, Sullivan & Brown 2017:1).

Most rural communities in developing countries like Ghana are lagging behind in terms of health enhancing environment and still battling with the eradication of preventable diseases like cholera and malaria. Focus of government has been on a robust health system in urban centres while the rural communities are served with ineffective Community-based Health Services and Planning. Research by Grow (2017:3) finds that access to health care remains a challenge for the rural communities and opined that effective management and collaborative strategies must be developed and executed to help improve the accessibility in health care for rural areas, but more specific research approaches should be explored with a systems perspective and the development of a strategic plan. Grows (2017:3) holds the view that the development of effective solutions and providing solutions are essential for the ethical delivery of health care to the rural population and therefore access to health care and the development of health promotion programmes to the rural population through effective delivery of health care services is important to improve public health. Based on these findings, the researcher identified the need to explore the perceptions of nurses about primary health care to identify any leadership gaps in the provision of PHC in these rural communities.

2.3.1.3 Solidarity

In many countries solidarity, not justice, is the driving force underpinning social and health care policies. The idea of solidarity has to do with mutual respect, support for one another and commitment to a common purpose. The basic understanding of solidarity is that everyone should make a fair financial contribution to an organised insurance system that assures equal access to health and social care for all members of society (Meulen 2015:4).

Persistent complains by patients and other community members about the poor quality of services they receive from nurses who they accuse of not communicating with them politely when they visit health care facilities defeats this core value of PHC-based health system. It could also be that nurses solidarise with the patients but patients' attitudes could be attributing factors and this provides this inquiry grounds to solicit the perceptions of nurses regarding primary health care.

2.3.2 Principles of primary health care

2.3.2.1 Responsiveness to peoples' health needs

Mirzoev and Kane (2017:1) define responsiveness as 'when institutions and institutional relationships are designed in such a way that they are cognisant and respond appropriately to the universally legitimate expectations of individuals… [including] safeguarding of rights of patients to adequate and timely care'. Better understanding health systems sensitiveness is mainly important for many low-income and middle-income countries which are witnessing rapid economic and social growth. Responsive health systems expect and adapt to changing needs, maximise opportunities to promote access to effective interventions and improve quality of health services, leading to better health outcomes. While the researcher agrees with the opinion expressed above, the researcher is of the view that, during public health policy implementation, sometimes the culture, needs and the believes of communities are sometimes ignored and this might lead to the resistance from the recipients of such policies. For example, the introduction of family planning regimes to reduce the number of children. Because most rural dwellers are illiterates and rely on cultural practices, such policies though impressive suffer setbacks because the ethnic and cultural believes of the people are ignored. Secondly, the researcher holds the view that the health needs of the peoples may not always be the case of visiting the

clinics but simply health education by nurse cadres such as the community health nurses and other nurse professionals and in view of this, the researcher advocates an intense health education programmes by nurses stationed in these rural clinics. In the case of evidence-based and comprehensive population health, the researcher observes that is not the situation in rural communities in Kasoa, Ghana as the clinics lack laboratory equipment for basic laboratory investigation to support evidence-based treatment. This causes most patients who visit rural clinics to travel long distances to urban clinics to access laboratory facilities. To this end, the researcher argues for increased responsiveness on the side of policy makers towards PHC needs of the rural communities.

2.3.2.2 Quality–oriented

Primary health care strives for excellence and it is defined by the Health Quality Council of Alberta as acceptable, accessible, appropriate, effective, efficient, and safe. A quality health care system includes an emphasis on continuous learning and improvement from research and experience, evidence-based decision-making, and individuals seeing the right health care provider at the right time (Government of Alberta 2014:16). Quality improvement at primary health care facilities is crucial, however, measures to ensure that quality of care as a causal factor to a country's poor health outcomes receive little attention. Health administration, the organised approach to maintaining and improving the quality of patient care within a health care system, must be at the centre of every effort that aims at improving any health care. To ensure quality of care, facilities are required to ensure functioning structures and processes (Ugo, Ezinne, Modupe, Nicole, Winifred & Kelechi 2016:1).

Ugo et al (2016:2) identify PharmAccess Foundation, a Dutch group of organisations, as among the bodies that are committed to making quality health care accessible in Africa. And to achieve this, a set of quality standards and improvement methodology called SafeCare was established by the group. SafeCare introduces health-care standards that are internationally recognised to health facilities using a stepwise approach. The methodology by SafeCare places emphasis on processes, but does not ignore the need to improve inputs. This approach enables health care facilities to achieve the results despite resource constraints. The researcher agrees with the

authors and beliefs the adaption of SafeCare standards could help improve quality of health care in Ghana and other African countries.

The work of Bhatia and Rifkin (2013:461) find that the delivery of health services was impeded by the huge burden of communicable diseases and due to this, health care policy focused on cure and prevention. This approach was accepted until the 1970s, when arguments suggested the approach did not tackle the root causes of illness. Owing to these deficiencies in health care policy approach, the International Labour Organization published and promoted the idea of a "basic needs" approach to development. It stressed the importance of health and education, as well as food, water, clothing, and shelter, as critical to improving both the health of the people and development. In view of the findings by Bhatia and Rifkin (2013:461), the researcher supports the shift of paradigm from preventive and curative to more flexible but effective primary health care policy that is rigorous in targeting health education in rural communities so that the rural dwellers will take charge of their health needs. Again, the researcher is of the strong opinion that the provision of good schools, proper sanitation and decent housing schemes would address the myriad health challenges confronting the rural communities.

2.3.2.3 Government accountability

Accountability implies empowering people to take responsibility for their actions. This is evident through good governance, sustainability, and reporting, and is emulated by health care providers through their collaboration with peers and engagement with individuals (Government of Alberta 2014:16). The inquiry conducted by Lodenstein, Mafuta, Kpatchavi, Servais, Dieleman, Broerse, Barry, Mambu and Toonen (2017:1) in Western and Central Africa find that social accountability is an important strategy to increase the quality, equity, and responsiveness of health services. In many countries, health facility committees (HFCs) were seen to act as an interface between health care providers and citizens to ensure accountability and therefore their research explored the social accountability practices facilitated by HFCs in Benin, Guinea and the Democratic Republic of Congo. Lodenstein et al (2017:1) found out that a more inclusive, clear and authoritative social accountability practices can be developed by making clear the mandate of HFC in the planning, monitoring, and supervision of health services; the HFCs must be provided with tools for organising accountability processes at communities; strengthening

opportunities for community input and feedback; and strengthening links to formal administrative accountability mechanisms in the health system. The researcher agrees with this findings and beliefs that if these accountability functions of the HFCs were made part of the PHC principles of accountability, there would be increased efficiency in primary health facilities in developing countries like Ghana. According to Lodenstein et al (2017:3) the main roles of the HFCs include; support health facility and workers; facilitating citizen voice and accountability.

2.3.2.4 Social Justice

To ensure social justice, the Ghana government embarked on ambitious strategies such as the, the Community-based Health Planning and Services (CHPS), the CHPS initiative targets rural areas of high need to deliver affordable health care and quality primary health care services to individuals and households, while engaging the community in the planning and delivery of services. At the CHPS, a community health nurse serves as the first point of contact and offers limited preventive and curative health care services. The CHPS initiative reduces travel time and distance and ensures rural dwellers receive health care in a timely manner. However, its major challenge is the cost of implementing the programme country-wide (Primary health Care and Progress towards UHC, Ghana 2017:1). Another social intervention to ensure social justice is the introduction of the National Health Insurance Scheme (NHIS) by the Ghana government as a risk pooling mechanism. The NHIS was introduced as a social intervention policy towards the attainment of universal health coverage for all. In this policy, citizens were mandated to enrol unto the NHIS and the scheme incorporates both the formal and informal sectors, where both groups must pay premiums (World Bank 2017:1). These strides by the Ghana government to ensure equity and social justice in the health system are laudable but the researcher views primary health care in rural settings as lagging behind compared to the health systems in the urban regions and therefore seeks to conduct this inquiry to explore the perceptions of the nurses who play pivotal roles in PHC delivery all over the world. Again, since the NHIS was primarily introduced to ensure health care delivery affordability, the researcher seeks to find out whether the NHIS is currently performing its mandate as a means of ensuring affordability at the rural areas in Kasoa.

2.3.2.5 Sustainability

Primary health care is delivered in ways that are active and demonstrates value for money, and help ensure that it benefits all the people (Government of Alberta 2014:16). To ensure sustainability of any PHC-based health system, one must be conversant with the cost of health care. Dalaba, Welaga and Matsubara (2017:1) observe knowledge on the cost of providing health care services at primary health care facilities in Ghana is inadequate and this creates challenges in the distribution of resources. Their study valued the cost of providing health care in primary health care facilities such as Health Centres (HCs) and Community-based Health Planning and Services (CHPS) in Ghana. The findings of the study were that the average annual cost of delivering primary health services through CHPS and HCs is US$10,923 and US$44,638 respectively and personnel cost accounts for the majority. Their recommendation was that government should be guided by the cost of delivering primary health care through the HCs and the CHPS in their financial planning, decision-making and resource allocation in order to improve primary health care in the country. Similar studies involving large numbers of primary health facilities in different parts of the country are needed to ensure comprehensive appraisal of the cost of providing primary health care in rural communities in Ghana were the health centres and the CHPS are mostly situated. The researcher is of the opinion that, knowledge of the cost of delivery of primary health will assist policy makers to ensure cost effectiveness and sustainability of PHC in rural areas where CHPS and HC are located.

2.3.2.6 Intersectoriality

The primary health care system is made up of a continuum of stakeholders. This consists of government ministries, the Non-Governmental Organisations, NGOs, citizenry, and groups working collectively to improve the health of the people. Stakeholders in primary health care work within the framework of their established mandates and with agreed team roles and responsibilities in a principle of collaboration and Intersectoriality (Government of Alberta 2014:16). To be able to improve the health of the local people, the PHC programme needs not only be the duty of the health sector, but also the involvement of other sectors, like the Agric

sector, education and housing (Onokerhoraye 2016:29). In view of this principle, the researcher holds the view that, primary health care should not be viewed as hospital-oriented health care but it must be viewed as a concept that seeks to advance human life through developments as the provision of potable drinking water, access to good roads and good shelter. Therefore, this principle must be incorporated in the development of the CHPS compounds.

2.3.2.7 Participation

Arnstein (1969) as cited in Rifkin (2016:2) describes participation as a hierarchy with the lowest level refered to as manipulation and the highest also called citizen control. Participation in health care means the involvement of beneficiaries or even the community in improving health care. Nevertheless, there has not been any acceptable way of what actually participation in health should be. Participation in health care delivery has been thought of as range of health care programmes carried out by health care professionals to educate the community, they serve about the need to be involved in health initiatives and carry out local activities that promote their health. It has also been understood to mean involving the community members in decisions about programmes, this includes meaningful involvement of the community in planning, implementing and maintaining their health services. Through the involvement of the community, maximum utilisation of local resources, such as workers, money and materials, can be utilised to fulfil the goals of PHC (Onokerhoraye 2016:29). Participation requires ensuring that all relevant stakeholders including non-state own have control over development processes in all phases of the programming cycle: assessment, analysis, planning, implementation, monitoring, and evaluation. Participation does not only involve consulting the local people or adding them to project design; it should include strategies to empower the people, particularly the most marginalised, so that their expectations are recognised by the State (WHO 2017: [sp]).

2.3.3 Elements of primary health care

2.3.3.1 Universal coverage and access

The European Union advocates that “Universality means that no-one is barred access to health care; solidarity is closely linked to the financial arrangement of our national health systems and the need to ensure accessibility to all; equity relates to equal access according to need regardless of ethnicity, gender, age, social status or ability to pay (Council of the European Union, 2006: 2)” as citied in (Wren & Connolly 2016:6). Health care facilities must be enjoyed by all the people irrespective of race, belief or financial status. This concept helps to move the convenience of health care from the metropolis to the remote areas where the needy and susceptible groups of the population live (Onokerhoraye 2016:29). According to a report authored by Save the Child foundation (2017: [S.p]) Universal health coverage (UHC) promises a world in which communities have access to their health needs such as immunizations and drugs without the risk of financial hardship. Universal health care also seeks to ensure the right to health is enjoyed by the over 400 million people who currently lack access to basic primary health care. Recent progress, and modelling published by Save the Children in 2015 shows that with the right restructurings, developing countries can manage to pay for UHC. According to Save the Children report on Primary health care first (2017:1) health is many things: a key determinant of development, an essential human right and a building block for growing successful economies. Under international human rights law, all persons have the right to the ‘highest attainable standard of physical and mental health’. Universal health coverage (UHC) provides that right in action. In a world with UHC, all people will be able to access health care services, vaccinations and medicines they need at affordable costs. Universal health care stresses that all people have the right to health. The Convention on the Rights of the Child and the International Covenant on Economic, Social and Cultural Rights both recognise the universal right to “the highest attainable standard of physical and mental health” regardless of race, sex, gender, age, religion, political views or economic status (Save the Child foundation 2017:1). In order for countries to realise the UHC and particularly if the peoples living in rural communities are been denied or not, the primary health care services must be tackled in ways that make it possible for them to access the highest standards of health as articulated by the dictates of UHC. It is with this opinion that the current study is exploring the perceptions of nurses in order to contribute to the discourse of UHC.

2.3.3.2 First contact

primary health care serves as the main entry point to the health system for all new health problems and the place where the majority of them are resolved. Save the Child foundation (2017:2) emphasises that investment in primary health care is an effective and efficient first step towards UHC. The World Bank estimates that 90% of all health needs can be met at the primary health care level. Good-quality, comprehensive primary health care helps reduce the need for more costly, complex care by preventing illness and promoting general health.

In 2010 the WHO used the World Health Report to signal a return to health systems strengthening, calling for primary health care "now more than ever". Strong primary health care services play central role in early diagnosis and the provision of preventative, curative and palliative care across the life-course. Primary health care provides immediate defence against communicable diseases which are the biggest killers of pregnant women, mothers, children and adolescents in developing countries. Strong primary health systems are associated with more equitable health outcomes between people of different socio-economic status. Primary health care providers are important gatekeepers who guide people through the health system and improve efficiency in health care delivery by ensuring that patients are directed to the appropriate and affordable health care facilities. The World Bank estimates that just 10% of medical conditions require more complex treatment in hospitals or specialist care (Save the 2017:2-3). The discussion above supports the opinion of the researcher that, primary health care, as first point of contact must be efficient and effective and most importantly at the rural communities where majority of the people in developing countries reside. This could only be achieved through thorough investigations that consider the opinions, perceptions of health care providers as ways of identifying and resolving challenges of rural health.

Dorjdagva, Batbaatar, Svensson, Dorjsuren, Batmunkh, and Kauhanen (2017:1) find that the access to primary health care is fully funded by the government of Mongolia. The primary health care is provided by family health centres in urban settings while in rural areas, it is included in outpatient and inpatient services offered by rural health centres. However, primary health care utilisation was seen to differ across population groups. In their study which used data from the Household Socio-Economic Survey of 2012 in Mongolia found out that concentration index for primary health care utilisation at family health centres in urban areas was significantly negative (−0.0069) and this indicates that the utilisation of primary health care services was concentrated

among the poor. The concentration index for inpatient care utilisation at the rural health centres was significantly positive (0.0127), indicating that, in rural areas, higher income groups were more likely to use inpatient services at the rural health centres. The researcher of the current study could infer from the findings of Dorjdagva et al (2017:1) that primary health care as first contact is patronised heavily by people with low household income because it is adequately funded by government in Mongolia. On the contrary, the researcher beliefs that primary health care is should not be seen as the health care for the poor in society. In relation to the current study, the researcher beliefs that nurses perceptions would underscore whether PHC services are sought after by rural community members because the assumption is that the services in the rural communities are subsidised by the government of Ghana

According to Novignon and Nonvignon (2017:1) health care centres in Ghana play important roles in health care delivery in rural communities. They provide the first line of services which meet the basic health care needs of the communities they serve. In spite of their contributions, the health centres are under resourced. While health policy makers seek to increase resources committed to primary health care, it is imperative for policy makers to come to terms with and appreciate the nature and inefficiencies inherent in the operations of the health centres. The study carried out by Novignon and Novignon (2017:1) in Ghana realised that, there is need for primary health facility managers to improve health outcomes through effective and efficient resource usage. Average efficiency was found to be about 0.65 and 0.50 for private and public facilities, respectively. Based on these findings, they recommended efforts to improve efficiency should focus on training health workers and improving facility environment and ensure effective monitoring and evaluation exercises. These were based on the facts that on average, facilities could save about GHC 11,450.70 (US$7633.80) if efficiency was improved. Because primary care serves as main entry point in the health system, efficiency must be improved in order to strengthen health care delivery at first point of care. The study employed numerical figures to measure efficiency but the researcher holds the view that efficiency at primary health care facilities as first contact could also be evaluated by the perceptions of the nurses since majority of the nurses are engaged in PHC.

2.3.3.3 Comprehensive, integrated and continuing care

“Comprehensive primary health care (CPHC) is essential health which is based on practical, scientifically and socially acceptable methods. CPHC is made accessible to the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination” (WHO 1978) as cited in (Talbot & Verrinder 2017:21). The CPHC philosophies allow societies to act on the fundamentals for health and address the social-ecological determinants of health which are the causes of health and ill health. The Declaration of Alma-Ata (WHO 1987) provided the foundation for CPHC that was seen as important to achieving a level of health that allowed people of the world to lead a socially and economically productive life. Three major principles stand out in the Declaration of Alma-Ata and which include equity, social justice and empowerment. (Talbot & Verrinder 2017:21). Equity means fairness, while justice implies a commitment to fairness. Empowerment is a process that enables people to participate in a way that improves their lives and achieves social justice. The WHO continues to affirm the philosophy of primary health care (WHO 2011; WHO 20115c) as cited in (Talbot & Verrinder 2017: 22).

2.3.3.4 Family and Community-based

The implementation of community-based services through community health workers will assist to redefine the approach and practice of primary health care (Bennett**,** Marcus**,** Abbott & Hugo 2018:1). Community-Based primary health care is the type of health care delivery in which health care facilities work with communities to improve health outcomes through activities that may be linked with health facilities but which take place in communities. The role of communities and community–based approaches to improving maternal, neonatal and child health is still being dominated by the facility-based health systems and there have been calls for a shift towards an approach in which communities and community–based services are incorporated into health programmes in order to improve the effectiveness of health systems in resource–constrained settings (Black, Taylor, Arole, Bang, Bhutta, Chowdhury, Kirkwood, Kureshy, Lanata, Phillips, Taylor, Victora, Zhu & Perry 2017:1). According to Simon, Abdul-Hakim and Akwetey (2017:1) Ghana launched the Community-based Health Planning and Services (CHPS) initiative as an approach to deliver primary health care to rural communities. The CHPS

was adopted by the Ministry of Health as a national programme that will narrow the gap between remote and urban communities to access to health care. In this strategy, a Community Health Officer (CHO) is resident in the community and supported by the community members, to render some basic packages of primary health care services especially preventive care including home visits, educational programmes and other health promotion activities and not sedentary clinical services at the health facility. Strasser, Kam and Regalado (2016:395) are of the view that rural inhabitants have lower life expectancy and also have poor quality of health services. This in part is because rural areas of developing countries have always had shortage of health professionals at rural communities. In the study by Strasser et al (2016:395) that explored Sub-Sahara Africa in depth concluded that, decision makers should rely on the expertise of communities to identify their health priorities and should develop the capacity that enables the appointment and training of local health workers from marginalised communities to provide quality health care in rural communities. The researcher holds the view that rural participation in good health care service should form an integral part in health policy formulation. This could be achieved through the collation of the views of health care professionals and in some cases; their perceptions would be invaluable to assist policy makers. This is among the many reasons the exploration of nurses' perceptions about PHC in the current inquiry seeks to establish.

Yarney, Buabeng, Baidoo, and Bawole (2016:525) found out that at Kasoa Polyclinic, Ghana, health care professionals of the Polyclinic are familiar with the patients' Charter and also know what it entails. However, patients are unaware of the availability of the Charter and could not talk about its contents. The researcher holds the view that since primary health care targets the community, ignorance on the part of the patients of what must be readily available to them must be investigated from the point of view of nurses who are charged with the responsibility of health education. In doing so, some of the bottlenecks that affect primary health at the rural communities would be established.

2.3.3.5 Emphasis on promotion and prevention

Health promotion was succinctly defined by O'Donnell (2002) as "the science and art of helping people change their lifestyle to move toward a state of optimal health" as cited in Dombrowski, Snelling, and Kalicki (2014:343). The aim of health promotion is directed at wellness by dealing with variable risk factors, such as smoking, diet, or physical activity. This includes all the important matters of health education, nutrition, sanitation, maternal and child health, and prevention and control of prevalent diseases. Through health promotion, communities will gain an understanding of what constitutes a person's health and develop the skills that will improve and maintain their health and wellbeing (Onokerhoraye 2016:29). In the current health care delivery system, health promotion and disease prevention are viewed as the effective strategies to improve care and reduce health care costs. Strong evidence points to the fact that health care facilities that invest in employee health through evidence-based programmes consolidate their bottom line (Dombrowski, Snelling & Kalicki 2014:343).

Roncarolo, Boivin, Denis, Hébert and Lehoux (2017:1) argue that little is known about those challenges that hinder the implementation of a cost-effective PHC, health promotion strategies and preventive programmes that when properly coordinated at the community level it would strengthen PHC. A scoping review by Roncarolo et al (2017:1) concluded that health services (HS) research has been targeted at the ways HS can accept modernisations, but inadequate information is available on the system-level encounters that modernisations should firs tackle. The researcher beliefs that the gap in the identification of some HS challenges would be addressed by this inquiry basing on perceptions using the qualitative exploratory approach. Furthermore, the scoping review did not include evidence-based findings from the field of practice and thus, the current study approach using exploratory design would conclude on the perceptions using thematic data analysis of the information obtained via individual in-depth interview.

Again, Nwankwo, Udeobasi, Osakwe and Okafor (2017:124) conducted a cross-sectional survey about people's perception about primary health care in Anambra State, Nigeria. They found out that PHC matters are no longer top on the agenda of village meetings; PHC centres are rebuilt and supported from community funds; PHC centres are left to dilapidate without maintenance; New PHC centres are not situated closer to the people. The researcher agrees with the findings of the research but thinks that perceptions from nurses would also be relevant

to ensure unbiased appraisal of perceptions about PHC in rural communities basing the setting in another location.

2.3.3.6 Appropriate care

A research carried out by Diniz, Cavalcante, Otoni and Mata (2015:182) to find out how nurses in primary health care perceive the management of the nursing process realised that managers know the relevance of the nursing process, but its implementation was not an urgency. This was because, there was the difficulty and a lack of understanding that the execution of the proper care process should be an inter-departmental action in the local healthcare management. Critical review of this literature assumes that the implementation of primary health care management by nurses was not a priority to health care managers. The researcher of this inquiry holds the view that, appropriate health care could be implemented efficiently when the perceptions of nurses who on a daily basis deal with the challenges they are confronted with in care delivery are taken care of.

2.3.3.7 Active participation mechanisms

In the health system, the outcomes obtained for active participation are not encouraging, partly because not all the people have the same opportunities that allow them to be involved in decision-making processes in health. Because of this lack of citizen participation in health, citizens' involvement in health was officially recognised as a right during the Conference of Alma-Ata, the International Conference on Primary Health Care, organised by the World Health Organization (WHO), in 1978. The *Declaration of Alma-Ata* affirmed participation not only as a right, but also as a duty to be exercised individually or as a group in planning and implementing health care. When this likelihood has occurred, the recipients of participation are not from underserved communities whose voices are to heard (Matos & Serapioni 2017:2). According to the findings of Matos and Serapioni (2017:8) participation in decision-making in health is still incomplete without legal backing and has little manifestation in reality. The researcher argues

that the active participation in health by citizens must be actualised through community engagements like durbars in rural communities in developing countries like Ghana.

2.3.3.8 Sound policy, legal, and institutional framework

The right to health provides moral policy and real-world bases for health care systems development. The aims of the right to health are consistent with those of health systems development, which are about strengthening health promotion organisations and actions that would improve public health (Azétsop & Ochieng 2015:1).

According to Azétsop and Ochieng (2015:1) health care systems development must have democratic characteristics and be grounded in human rights and in decent principles of human self-respect, equality, non-discrimination and social justice. The ideals of health care delivery must form an integral part of a society's vision as a place for multi-level engagements, where government plays its role by equitably resourcing adequately institutions and services that ensure people's welfare. Inter-sectoral collaboration, which seeks conceptual changes in health and public policy, can be helpful in improving health systems through rigorous efforts by government institutions, civil societies and NGOs.

2.3.3.9 Pro–equity policies and programmes

Akhavan (2015:1) beliefs accessibility in primary health care services does not only determine the health status but also ensure the survival of the community after occurrences of illness and increases their life expectancy. Therefore, fairness in access to primary health care must be the basic human right that countries should endeavour to achieve. Societal and structural factors contribute important roles in entrenching inequalities in health and health care. For example, the lack of education, living in a deprived community, and belonging to an ethnic minority are among the factors contributing to inequality in access to and utilisation of primary health care (Akhavan 2015:1).

The study 'promoting equity in primary health care' by Akhavan in Sweden (2015:2) concluded that in order to promote equitable primary health care, it is important for authorities to

understand and analyse the reasons for prevailing inequalities and this must be followed by tactical interventions to create more equitable primary health care. One of the interventions could be that, governments in developing countries must ensure that resources are adequately provided to local authorities to enhance decentralised primary health care. The distribution of resources should be based on the primary health care needs of the identified communities. Furthermore, disadvantaged communities with less health-literate populations and disadvantaged social groups should be resourced sufficiently in ways that will enable them to deliver a better and effective primary health care. This will intend lead to the reduction of times patients spend at health care facilities, ensure the continuity of care and will enable health care managers to engage bilingual staff that will help solve the challenge of language barriers

2.3.3.10 appropriate human resource

According to Willcox, Peersman, Daou, Diakité, Bajunirwe, Mubangizi, Mahmoud, Moosa, Phaladze, Nkomazana, Khogali, Diallo, Maeseneer and Mant (2015:1) the World Health Organization explains “critical shortage” of health professionals as being less than 2.28 health professionals per 1000 population and the inability to attain 80% coverage for deliveries by skilled birth attendants (Midwives). According to Wilcox et al (2015:1) health worker population has improved progressively since 2000 in South Africa and Botswana which already have achieved the WHO targets but health care professionals have not improved in Sudan, Mali and Uganda since 2004. These countries already experience critical shortage of health workers.
Reducing maternal and child deaths are among the aims of public health and which is among the Sustainable Development Goals. Although there are good evidence-based approaches to realise these targets, a major constriction in ensuring them is the inadequate health workers, especially in primary health care (Wilcox et al 2015:1).
In the research by Wilcox et al (2015:10) it was realised that “inverse primary health care law” exists in African countries and this has encouraged governments in Africa to focus on attaining a certain health worker density. In so doing, development partners and funders have focused on training more doctors, nurses and midwives. However, this focus has not caused an improved recruitment and retaining of primary care professionals in some countries in Africa. The number of health workers for a defined population has not improved in the low-income

countries, and thus, those with the greatest need continue to experience poor access to effective primary health care services. Therefore, there is the need to underscore recruitment and retention of skilled staff in training and supervisory roles, who will support the lower level health workers who provide the frontline primary health care services in most countries in Africa. In respect of these findings, the exploration of the perceptions is likely to provide some reasons why there are still challenges in staff retention in rural primary health care facilities.

2.3.4 Benefits of primary health care-based system

Enhanced access is associated with reduced wait times, improved coordination, improved referrals, less duplication of services, reduced mortality, and reduced self-referred emergency department visits (McMurchy, 2009; Shi, 2012; Cowling et al., 2013) as cited in Nova Scotia health authority (2017:6). There is also evidence that access to primary care can lead to improvements in other inter-related attributes, such as continuity and comprehensiveness and access is linked to improvements in health equity for priority population groups in multiple reviews (Shi, 2012; Kringos et al, 2010; Starfield et al., 2005) as cited in Nova Scotia health authority (2017:6).

Over time, continuity of care is associated with appropriate preventative care, fewer diagnostic tests and prescriptions, reduced emergency department usage, improved patient satisfaction, improved provider satisfaction, improved chronic disease prevention and management, fewer hospitalisations for ambulatory care delicate conditions, and reduced health discriminations linked with socioeconomic status (McMurchy, 2009; Hsaio & Boult, 2008; Barker et al., 2017) as cited in Nova Scotia health authority (2017:6).

Comprehensiveness of care is correlated with enhanced quality of care, less disease and death, increased prevention and screening activities, and lower hospital admissions rates and length of stay (McMurchy, 2009; Bazemore et al., 2015) as cited in Nova Scotia health authority (2017:6). As well, individuals with efficient comprehensive primary health care team are more likely to receive disease prevention and health promotion than those who lack the access to efficient primary health care team (Khan et al., 2008) as cited in Nova Scotia health authority (2017:6).

Coordination of care is associated with reduced redundancy in services, greater patient satisfaction, improved chronic disease prevention and management, and improved patient safety (McMurchy, 2009) as cited in Nova Scotia health authority (2017:6). There is increasing evidence in the literature suggesting that PHC is cost-effective, particularly for interventions associated with improved *continuity and coordination* of care and as a result of reduced hospitalisations and emergency department use (Dahrouge, 2012; McMurchy, 2009; Kringos et al., 2010; Shi, 2012; Barker et al., 2017) as cited in Nova Scotia health authority (2017:7).

2.4 INTEGRATED PRIMARY HEALTH CARE

The unavailability of primary healthcare integration has been seen as one of the key restrictions to programmes' usefulness on the African continent. This is particularly related to the Millennium Development Goals, whose health objectives were not attained in many countries at their term in 2015 (Druetz 2018:89). Stein (2016:4) explains integrated primary health care to mean health services that are managed and carried out in a manner that ensures people receive a range of health care services. which include health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, at diverse levels and locations of care within the health care system, and according to the health needs of the people throughout their life course. The World Health Organization (WHO) has defined integrated care delivery to mean "…the management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system (Sifaki-Pistolla, Chatzea, Markaki, Kritikos, Petelos & Lionis 2017:1). This literature supports the principle that integration of primary health care will result in better health outcomes and will minimise the overall health care costs.

According to Alzaied and Alshammari (2016:2) demographic disparities that exist among countries, for example, the different age groups distribution, risk factors, and economic and epidemiological contexts make it impossible to establish a singular primary health care system that fits all countries. For example, in Saudi Arabia, health care services are provided at three levels: primary, secondary, and tertiary. Primary health care is aimed at preventive and curative primary care services, and the patients are referred to secondary and tertiary facilities when

necessary. This approach is similar in developing countries like Ghana and therefore the concept of integrated PHC is essential to addressing the health concerns of rural communities. The study by Alzaied and Alshammari (2016:2) which assessed the status of several primary health care centres in Riyadh city in Saudi Arabia from different perspectives, particularly access and effectiveness of health care service delivery showed that primary health care is well implemented in Riyadh city in terms of effectiveness and accessibility. However, there was the challenge of realising the optimum use of primary health care services by the people. According to Alzaied and Alshammari (2016:2) the fact that majority of patients would not opt for primary health care as their first choice of health care should be looked into and ensure that primary health care becomes the first choice in health care delivery. The researcher holds the opinion that, although the concept of integration cannot be side-stepped in PHC policy formulation in rural communities, emphasise should be placed on robust PHC to attract patients to access primary health care services at primary health care facilities. The renewed interest of integrated primary health care is expected since integrated health care service is recognised as a sound approach to organise a health system in a given country. Integrated primary health care is the sure way to deliver accessible universal broad range of services without compromising its quality. The current challenge of its action is to be clear about what integrated primary health care service should be in different countries and how it can influence the projected health objectives of the people getting the health care. Brown and Oliver-Baxter (2016:149) see integrated care as the health care system that will ensure efficiency in health care and improve patients' satisfaction and health outcomes. Nonetheless, strives towards integrated primary health care, specifically at the primary and community health levels, have not gained the needed attention both in countries and at international fora (Brown & Oliver-Baxter 2016:149). A health system-based definition of Integrated primary health care adopted by the WHO is, a way of health care delivery that seeks to reinforce people-centred health systems through the promotion of a wide-ranging delivery of quality services across the life-course of the people, and which is planned according to the many needs of the community and the individual and delivered by a team of well-coordinated health professionals who work across different health care facilities and levels of care. It should be managed in an appropriate manner to ensure the best health objectives and the proper use of supplies and logistics based on the best available evidence, with response loops that enables the improvement in performance and to address

major causes of ill health and to promote well-being through multifaceted exploits (WHO 2016:4). According to the WHO integration has various perspective:

4.2.1 The user

This dimension of integrated care refers to the ability to empower and engage people in the improvement of their health and wellbeing. The approach supports a wide range of 'service users' example, patients, people living with frailty or physical disabilities and carers to become actively involved as partners in care (Stein 2016:8).

2.4.2 The Provider

Integration of care carried out by health workers and health administrators to patients into a clear process within and/or across professions, such as through the use of common guidelines and policies (WHO 2016:5).

2.4.3 Senior health managers and policy-makers

This dimension of integrated care relates to the extent to which different partners in care have developed a common frame of reference, example, of vision, norms, and values in support of the aims and objectives of care integration (Stein 2016:8).

2.4.4 Organisational

This dimension of integrated care refers to the ability of different providers to come together to enable joined-up service delivery that helps to support professional and clinical integration (Stein 2016:8).

2.4.5 Professional integration

This dimension of integrated care means the presence and advancement of co-operations between health care workers that allow them to work collectively as teams or systems and promote healthier care co-ordination around the needs of patients or the community (Stein 2016:8).

2.5 ELEMENTS OF INTEGRATED PRIMARY HEALTH CARE

2.5.1 Context

Health care systems are multifaceted and dynamic and are influenced by the existing political, economic and social issues. Activities that support integrated care in one location will not certainly support integrated care in another; organisations' locations and environments contribute to their mechanisms of integration. In planning integration, it is essential to consider the location, geographical factors, historical background, management, resources and institutions. Understanding context in integration means one must do assessments of the facilities based on proper methods for organising, analysis, interpretation and the use of information. The more comprehensive the data are across a diversity of sector standpoints, the greater the ability to explain the delivery of more integrated approaches, monitor progress and address quality improvement (Brown & Oliver-Baxter 2016:150).

2.5.2 Governance and leadership

While understanding that context through consistent linked data is beneficial, it is also significant for health care groups to deliberate who their major policy makers and management will be. That is, they should recognise individuals together with organisations who are responsible for the distribution of power and, in particular, those who will be in charge of integrated care. Leadership is central for making a vision, followership and drive that can result in normative integration. Engagement at the governance level, whether it is taking place within the organisation or with state enterprises, is important for controlling actions, for regulation, and to establish cordial relationships that allow management of deliverables, risks and processes, to ensure sustainability (Brown & Oliver-Baxter 2016:150).

2.5.3 Infrastructure

After the requirements and key players responsible for the delivery of integrated care have been identified, valuation of appropriate infrastructure can be considered. This includes physical structures, logistics and a permanent or temporal location where possible to provide space for

the health facility. Suitable structure that encourages meaningful use of resources may also support communication and sharing of information across health care providers. For example, collective integration is improved by shared electronic health records. E-Health provides avenue for information governance, which is an important part of a well-structured integration that enables improved referral processes with electronic transfer systems designed to promote care coordination among health facilities and within health care systems (Brown & Oliver-Baxter 2016:150).

2.5.4 Financing

Committing financial support towards infrastructure as a requirement of integrated care though laudable, the financial systems and the processes in health care delivery sometimes disturbs the capability and readiness of health organisations and private health care providers to integrate their health system with each other. Funding regimes that exist at government levels and other forms of remuneration create the current challenges confronting many primary health care programmes. Improving integration means that, health care providers must acknowledge and address risk-sharing, managerial and funding splits between organisations. Organisations contend with using various sources of funding in the most effective and efficient way. It is important to contemplate how proper integration is likely to be affected if health care partners have multiple funding regimes. Furthermore, in some cases, if partnership will be a challenge, then engagement may need to be incentivised (Brown & Oliver-Baxter 2016:151).

2.5.5 Engagement

Integrated care characteristically entails team activities. Engagement has to do with connecting organisations, clients or patients, health care providers and practitioners, and communities. It ensures the transfer of knowledge, the establishment of trust among organisations, the show of respect and it includes key actors in the health care system in shaping the services they provide. Sustaining engagement involves clear definitions of prospects and the recognition that the process of engagement will need more time, effort and financial and organisational commitments. Partners in integrated care will have diverse urgencies, methods and values and these must be addressed so that there would be the mutual understanding and also agreement about the objectives and roles well-known (Brown & Oliver-Baxter 2016:151).

2.5.6 Communication

For organisations to entrench their integration, it is important that channels of communication remain strong. Open, regular and respectful communication is the foundation of active integrated care. It is not enough to simply involve stakeholders; their involvement must be preserved through ongoing and clear communication. This may take place through direct, one-on-one or verbal connections, written channels, or interacting through electronic health records. Formal communication approaches, such as meetings and conferences allow stakeholders to meet and deliberate population or patient needs and plans to tackle them; there is also support for the value of informal exchanges and tête-à-têtes', which is among the benefits of co-location (Brown & Oliver-Baxter 2016:151).

2.6 MODELS OF INTEGRATED HEALTH CARE

2.6.1 Individual models of integrated care

This is concerned with individual management of care for high-risk patients and people with several health conditions and those caring for them. Individual models of integrated care aim to ensure the proper provision of health care services and avoid the division between providers. The management of care for such patients goes beyond one incident of care, where the organisation of health care between diverse providers is necessary, but also accept the idea of integration across the life-course (WHO 2016:7).

2.6.1.1 Case-management:

Case-management is a supportive process that involves communication and ensures that health care is organised in an effective way along a range of care providers through effective resource utilisation. The objectives of case management include the attainment of optimal health, access to proper care and the efficient use of available resources, whiles ensuring that the patient has the right to self-determination (WHO 2016:7). The key responsibilities of a case manager are thus, to assess the patient's and carer's needs, to design a custom-made care plan for the patient, organise and alter care procedures accordingly, monitor quality of care and keep in touch with the patient and carer (WHO 2016:7).

Important components of case-management include: defining and selecting target patients for which case management is most appropriate, these include patients with several disease conditions, patients who are often admitted to hospitals or patients who need coordination within and across health and social care; patients who need assessment and individual care

plans. There is however, the frequent nursing of patients and when necessary care plans are changed. There has been the evidence that case-management reduces the number of hospital (re)admissions and improves patient satisfaction. An important consideration in developing and providing case-management is that it should be made available to cautiously and carefully identified groups of patients that are most likely to the beneficiaries of case management (WHO 2016:7).

2.6.1.2 Individual care plans

This approach of integrated care targets patients with several disease conditions and are living with chronic illnesses. The objective of this model is to ensure a more personalised and focused care which create a joint care plans that keep the record of the care processes, and express in clear terms the responsibilities of care providers and patients involved in the care process and hold health records about the care for a particular patient. Care plans provide information for any individual care provider involved in an individual's care. Care managers assess the health needs of a patient, and develop care plans and discuss with the patient ways to provide the various areas of care. The success of care plans that stretches to the interface of health and social areas depend on the authority that care planners are given. During the design of care plans, it must be ensured that the plan yields the intended outcomes. Like case-management, care plans are expensive and labour intensive (WHO 2016:8).

2.6.1.3 Patient centred medical homes (PCMH)

This was established and encouraged in the USA as a model for changing the organisation and the provision of primary health care. The interest arose owing to the fact that people lack access to primary care, the challenges in going through segmented care systems and the growing costs of health care. It was promoted by the major primary care physician groups in the country and the principles were recognised and widely tested by many clients, professionals and consumer groups (WHO 2016:8).

In broad terms, patient centred medical homes is a physician-driven group practice that can offer health care which is readily available, non-stop, complete and well-coordinated and is provided in the framework of family and community. The PCMH model adopts comprehensive ways of managing patients with chronic diseases and many disease conditions by offering an

alternative individual model of primary care where clients are given to particular medical homes and physicians. PCMH should not be viewed as a health care facility where care is provided but instead as a complete model of health care system that carries out the essential functions of primary care. The features of PCMH are comprehensiveness, patient-centredness, coordination, accessibility, quality and safety (WHO 2016:8).

2.6.2 Group- and disease-specific model

2.6.2.1 Chronic care model (CCM)

The model was developed in response to the fact that health care systems have failed to address the health needs of people living with chronic disease conditions. It provides a wide-ranging framework for the organisation of health services in ways that would improve the health outcomes for individuals living with chronic disease conditions. CCM proposes to move away from acute, occasional and responsive care towards health care that emphasises longitudinal, preventive, community-based and integrated approaches. It was developed as a result of a systematic literature review and it brings together evidence-based factors and components that are widely documented to have positive impacts on patient health outcomes, quality of care and cost savings (WHO 2016:10). CCM consists of six key areas, these include community, health system, self-management support, delivery system design, decision support and clinical information systems.

The review of integrated health care shows that, when the various health care systems are integrated, there would be improved health outcomes. Also, rural health and urban health should also be integrated to avoid urban bias that has led to low patronage of rural health by the community members who travel long distances to seek health care in urban centres. The researcher also beliefs that the integration of various nurse cadres in primary health care delivery would maximise the skill mix needed to attain optimum health and thus, the choice of nurses as the participants for the current study. The researcher agrees with the models of integrated health care described above and is of the view that when nurses are educated and adequately oriented to take on additional roles to implement some of the models in rural communities, it would improve the primary health care situations in rural communities.

2.7 COMPREHENSIVE PRIMARY HEALTH CARE

Andrade, Costa, Ferreira, Silva, Araújo, Pereira, Assunção, Dutra and Cabral (2015:365) find that the most acceptable explanations that people give to comprehensive care by health care professionals refers to the complete knowledge of every patient, which ensures the non-fragmentation of care provided. According to Andrade et al (2015:366) comprehensiveness is now a principle of the Unified Health System in Brazil and possesses a challenge to health workers, partly because the work of multidisciplinary teams is important to reach its goal. Comprehensive primary health care includes health promotion, the prevention of diseases, treatment and care of patients, community development, and advocacy and rehabilitation (Harfield, Davy, McArthur, Munn, Brown & Brown 2018:3). CPHC can be considered a socio-political philosophy as well as an implementation strategy for improved health equity. As a socio-political philosophy, it emphasises fairness in accessing health care. Its implementation requires both socio-political processes and technological choices (Labonté, Sanders, Packer & Schaay 2017:4). Labonté et al (2017:5) find that an integrated referral system which facilitates the provision of a range of care to patients and communities in the health care system without disruption; and with various health care professionals including community-based health care workers are key to the realisation of CPHC. Five key principles of CPHC include:

• universal accessibility and coverage on the basis of need: in other words support for the principle of equity;
• comprehensive care (which includes the integration of preventive, curative, rehabilitative, and promotive services);
• intersectoral collaboration and action to address the social and environmental determinants of ill health;
• active community participation in program and service planning; and
• appropriate care and use of technology (Labonté et al 2017:4).

A systematic scoping review by Harfield et al (2018:1) to identify the characteristics of local primary health care service provision models found that the culture of the local people was the dominant feature underlying all seven characteristics which were identified, these were accessible health services, community participation, continuous quality improvement, culturally appropriate and skilled workforce, flexible approach to care, holistic health care, and self-determination and empowerment. This finding supports the view that when the culture of the

local people is incorporated into PHC policies at the community level, it will yield better health outcomes in comprehensive primary health care.

Challenges associated with primary health care funding include unreliable national sources of funding, the lack of sustainability of primary health care programmes which are tied to external donors, and misappropriation that leads to the misuse of funds. These challenges confront the implementation of comprehensive primary health in developing countries. When the idea of CPHC is implemented, a certain approach for the administration of health care becomes apparent. There is the balanced system of health promotion, disease prevention, rehabilitation and illness treatment, with the whole system built to meet the objectives of CPHC, thus, equity, social justice and empowerment (Talbot & Verrinder 2017:22). Dealing with the increasing burden of disease globally demands disease prevention strategies for health promotion and disease prevention in rural communities in addition to curative measures to deal with disease management with health care services.

Health system based on CPHC will:

- Reduce exclusion and social disparities in health (Universal coverage)
- Organise health services around people's needs and expectations (collaborative service delivery)
- Integrate health into all sectors (public policy)
- Pursue collaborative models of policy dialogue ((leadership), and
- Increase stakeholder participation (WHO 2008a) as cited in (Talbot & Verrinder 2017:23).

The objective of CPHC is to address the determinants of health, which are the conditions that generate health and cause diseases. On the contrary, Selective primary health care (SPHC) concentrates on treating diseases and ailments. Thus, SPHC is based on illness system and medical model of health care (Walsh & Warren, 1979, cited in Baum, 2008) as cited in (Talbot & Verrinder 2017:22).

Using the definition of Comprehensive primary health care, one could argue that the development of a strong comprehensive health care would directly impact primary health care in a given community. Health promotion, disease prevention, treatment and rehabilitation are

among the numerous roles of the nurses and hence their perceptions concerning rural health is vital. In the rural areas, nurses are involved in disease prevention outreaches, health promotion campaigns and treatment of illnesses but despite all these, rural communities continue to be disadvantaged in health care systems. The researcher holds the view there could be other factors that are undermining rural health and thus, the use of qualitative exploratory design approach in this inquiry.

2.7.1 Comprehensive primary health care versus Selective primary health care

CPHC could be understood to mean the state of complete physical, mental and social wellbeing; and addresses health care discrimination through fairness and social justice measures. Comprehensive primary health care considers the importance of education, proper housing schemes, nutrition and income and acknowledges the impact of community development on the health of the people and recognises the skills of individuals to determine their own health needs.

- It is an intersectoral enterprise
- The socio-ecological determinants of health are considered in all policies
- Social and environmental justice underpin policy development
- Redistribution of wealth through taxation is implemented to enable investment in public goods
- The concept of generational and intergenerational equity is embedded in policy
- Community participation in decision-making is conducted in a way that empowers individuals and communities.
- Policy decisions are based on evidence or the precautionary principle

(Talbot & Verrinder 2017:23).

Rifkin and Walt (1986) as cited in (Talbot & Verrinder 2017:23) argue that Selective Primary health care (SPHC) practice assumes health to mean merely the absence of disease rather than, as in the broader WHO definition. It emphasises the eradication and prevention of diseases and directs action for health within the realms of facility-based health care where specialists are trained to treat disease.

- Through the focus on disease and illness treatment, the need to address the principles of equity, social justice and empowerment which are at the root of many health problems are ignored

- Non-clinical interventions, such as the provision of education, proper housing schemes and nutrition, which have greater impact on health than health services themselves are discounted
- The importance of community development as an approach for improving health is not recognised or used as a means to ensure the increase community compliance with medically defined solutions rather than as a mechanism for community empowerment, thus, intensifying power with health practitioners
- The expertise that the community have with regard to their own lives and the issues that affect them is disregarded

(Talbot & Verrinder 2017:23).

2.8 RURAL HEALTH

The difficulties health care providers are confronted with when delivering primary health care to rural communities include the poor socio-economic status of the people, poor transport infrastructure, lack of access to appointment information, patients' lack of understanding of the benefits of good health and the high cost of seeking health care in the rural areas (Frost, Jenkins, Emmink 2017:1). The research conducted by Frost et al (2017:1) in South Africa to obtain a deeper understanding of the underlying factors contributing to the low patronage of outpatient health care services to allow community driven, directed interventions for the communities found out that improved patient awareness of appointments times, modifications in existing referral systems and the notification of appointment cancellation to patients would greatly address the majority of the reasons for the low patronage of outpatient health services. Knowledge of the underlying causes will help health care providers in planning appointment times for the patients, cut costs and have positive impacts on patients care. The researcher beliefs the findings of the study are compelling and therefore, the perceptions of nursing regarding primary health care in rural Kasoa would contribute to the ways of improving PHC in rural communities.

Fearnly et al (2016) as cited in Burnett (2017: 9) identify the default position for defining 'rural' in relation to health is that, rural is 'not urban' or 'not metropolitan'. There is no clear internationally recognised definition. Issues of poor sanitation, deplorable road infrastructure, lack of potable drinking water, and inadequate health personnel continue to dominate rural health research and there is the need to presently evaluate rural health issues in the bid to find

out what other factors may be undermining the efforts to improve rural health in Africa. According to Klobuchar (2014:2) strong and better health care in rural areas are necessary to every economy, particularly in developing countries. Rural dwellers in African nations are mostly farmers and they produce to feed the urban dwellers and therefore the health status of the rural communities deserve considerations. The researcher beliefs that exploration would help policy makers to understand some of the issues that confront rural health and thus, the current study to explore the perceptions of nurses. Gibbens (2016:3) states that rural health care plays emphasis on public health and improving health outcomes of the people. Allender, Rector and Warner (2014:7) explain community health to mean the identification of the health needs, together with the protection and improvement of the health of the people living in a geographically defined area.

According to Allender et al (2014:7) among the challenges public health practice faces is to continue to be responsive to the health needs of the community. As a result, the structure of public health remains complex. There are currently several health services and programmes, for example, health education, reproductive health services, accident prevention, environmental protection, child health and immunization, nutrition, early periodic screening and developmental testing, school programmes, mental health services, occupational health programmes, and the care of vulnerable groups. Owing to the complex nature of community health, the perceptions of actors, specifically nurses, would be invaluable and thus, the current study.

In the study by Andoh-Adjei, Nsiah-Boateng, Asante, Spaan and Van der Velden (2018:1) to assess the perceptions of care providers and subscribers of the National Health Insurance Scheme under the capitation payment system in Ghana found out that beneficiaries of the NHIS and health care service providers across selected regions of the country have comparatively good perception of the quality of health care in general. However, users of NHIS in Ashanti region were less positive than those in the Central region. The researcher finds this literature relevant to the current study since quality of care of health could be evaluated using perceptions of providers as well as the consumers of health care service. The introduction of the NHIS was to reduce the out-out-pocket payments at health facilities. This initiative [NHIS] contributes to health care affordability and therefore, patients and providers perceptions about the scheme is needful.

This current study focuses on community health and how nurses perceive primary health care in rural communities in Kasoa. The research work by Ugo, Ezinne, Nicole, Winifred and Kelechi (2016:1) to assess the improvement in the quality of care in primary health care facilities in rural Nigeria, after government have provided technical support concluded that, governance support and active community participation contributed towards the quality improvement in primary health care facilities. Similarly, Versteeg, Toit and Coupe (2013:119) investigated the challenges that confront rural health in South Africa and the interventions for rural health. The study was meant to provide opinion towards pro-rural health policy dialogue. In this study data were collected from a panel of rural health experts through interviewing and the findings included: the need to prioritise staffing and support for rural health workers; the engagement of managers with necessary and appropriate skills; a rural responsive national Human Resources for Health plan; and impartial funding plans. The conclusions from the study were that specific plans and approaches are needed to tackle the major rural health care challenges and also authorities must ensure improved accessibility in health care in rural South Africa. The researcher concludes from the two research findings that government interventions in rural health is necessary to improve health outcomes in the marginalised societies. From the data collection point of view, one could opine that it would be necessary for the views of nurses to be included to describe the state of PHC in rural communities since they play many roles in PHC-based health system.

A literature review by Burnett (2017:10) found that distance to care and transportation challenges have been identified to be among the challenges that face rural people in accessing health care. This is usually worsened by fewer numbers of health care professionals stationed within rural communities. Studies exploring rural access from health professional perspectives have identified that geographical location and professional isolation have contributed to the decline in health care providers in rural communities (Curran, Fleet, & Kirby, 2006; Merwin, Snyder, & Katz, 2006) as cited in Burnett (2017:10). The research by Burnett was conducted in New Zealand but the current study identified rural communities in Kasoa as the research setting and is exploring perceptions of nurses. In the current inquiry, the researcher is hoping to identify some of the challenges, the nurses face in their line of duties as primary health care providers. The researcher has observed that rural dwellers in Kasoa travel to urban health care facilities to access health care and therefore holds the contrary view that distance may not necessarily

be a challenge to accessing health care by rural folks. Owing to these contradictory opinions, there is the need to carry out the research that aims at exploring the nurses' perceptions on primary health care in rural communities.

The study population will be nurses and will include community health nurses who were formally posted to serve at rural communities and therefore their input would be upheld to ensure a thorough appraisal of the perceptions of nurses.

Baatiema, Sumah, Tang and Ganle (2016:1) note that the mode of operation and activities of community health workers (CHWs) have gained recognition in global health discourse since the Alma-Ata Declaration in 1978. The recognition that community health workers are important partners in the attempt to attain the health-related Sustainable Development Goals (SDGs) has led to the emphasis on the roles of community health workers. The desire to recruit and retain more CHWs is an admission that the roles of CHWs are important in sustaining the success achieved by the SDGs and in addition, achieving the more recent Sustainable Development Goals (SDGs).

Baatiema et al (2016:2) argue further, that, nonetheless the general concern about the vital roles of CHWs among the global health community, primary health care policy directives to acknowledge and support improved provision of health care by CHWs are lacking, particularly in low and middle-income countries. For example, in Ghana, while a number of research findings and reports have emphasised the activities and importance of community health workers, there exists the inadequate health policy support for them. Baatiema et al (2016:1) however, carried out a scoping literature review in addition to their experiences in working in Ghana to reflect on their professional activities as CHWs in health care delivery in Ghana. It was realised from the study that, nevertheless their contributions as CHWs, they are faced with myriad of challenges which hinder them from being productive. The challenges include the inadequate capacity of CHWs, lack of recognition by the health care system, high rate at which CHWs leave the profession and little supervision of their activities. The study concluded that policy makers in Ghana needed to direct their attention towards CHWs, provide better remuneration packages for the activities of CHWs, create career opportunities and provide motivation packages to increase their productivity which will result in sustained gains

associated with the activities of CHWs. Because CHWs are nurse professionals who also play roles in primary health care delivery, the researcher identifies with the findings and recommendations and beliefs the current study is relevant to seek how they view primary health care in rural communities in Kasoa, Ghana. The consensus underpinning the Community-based Health Planning and Services was to strengthen the scope of CHWs to play key roles in PHC in rural communities and therefore their participation in the current study would be invaluable since the study would include all nurse cadres irrespective of experience.

In South Africa, Visagie and Schneider (2014:1) agree that the concept of primary health care is integrated into the country's health care policy and it provides directions for health care service provision in South Africa. Health care service delivery in South Africa has seen significant growth in the last five years. And it is however, not clear whether the progress have reached remote areas and also whether primary health care delivery is properly realised in these communities (Visagie & Schneider 2014:1). To this end their study aimed at finding out how the principles of primary health care have been ensured in rural communities in South Africa using descriptive qualitative design.

Visagie and Schneider (2014:1) found that there were challenges with regard to client-centred approach to health care delivery, provision of health promotion services and rehabilitation services were some of the challenges in the rural communities, the manner in which health care was provided, the role of the doctor, the attitudes of the health workers, there was the challenge with regards to the existing referral services and how complex conditions of patients are managed. The study concluded that the principles of primary health care have not been implemented well in the rural communities. The currents study is similar to the research above in terms of approach. It is therefore necessary to conduct the current inquiry to find out why the implementation of the principles of primary health care is a challenge at rural communities using the perceptions of nurses.

2.8.1 Community nursing

As a field of nursing, community health nursing combines public health knowledge and competencies to address the health needs and challenges of communities and combines them and directs the health care to communities and group of people that are marginalised. Public health nursing however, combines both public health science and nursing science, which

makes its theoretical underpinning and the nature of its practice distinct (Allender et al 2014:19). Furthermore, community health nursing, as a field of nursing, combines nursing science with public health science to formulate a community-focused and people centred practice (Anderson & McFarlane, 2012) as cited Allender et al (2014:20). Allender et al (2014:26) further elaborate that community health nursing has more professional prospects and also challenges which sustain the interest of the nurse to be involved in a community-based health care for so long. Community health goes beyond preventive care and campaigns to control communicable disease.

2.8.2 Roles of the community nurse

Community health nurses play various roles, including the role of a clinician, nurse educator, advocate, health administrator, collaborator, leader, and researcher. The roles require special types of skills and competencies. The type and number of roles that are practiced depend on patients and the prevailing situation, but the nurse should be able to carry out the roles as and when certain situations are presented (Allender et al 2014:69).

The role of manager is one that the nurse must perform in every situation. This involves assessing patient's needs, planning and organising to address the needs of the patient, assisting and supporting the patient to achieve desired outcomes, and monitoring and evaluating the improvement of the condition to ensure that the objectives and clients' needs are met. A type of comprehensive management of clients that has become known as *case management* is an integral part of community health nursing practice (Allender et al 2014:69).

As a part of the manager role, the nurse must engage in three crucial management behaviours: decision-making, transferring information, and relationship building. Nurses must also use a complete set of administrative skills. These include, human skills which allow nurses to understand, connect, encourage, and work with others in the health care system; conceptual skills that allow them to make meaning from complex ideas and apply them to actual situations and provide solutions; and technical skills that allow them to apply management-related knowledge and expertise to a particular situation (Allender et al 2014:69).

2.9 A BRIEF HISTORY ABOUT NURSING

The growth and progress of the nursing profession are connected to historical influences throughout the ages, dating as far back in the ancient. In under developed communities, the decision to be a health care provider or a nurse was usually decided for a person even before the person can decide for him or herself. In many communities, the delivery of health care was a preserve of female members. This was partly because women nurture children and were expected to carry out those nurturing skills to persons who are sick and injured in the communities. However, in other communities, the care of those who are sick was given to medicine men, shamans, and other male tribesmen. This was because there was the lack of formal education in the care of the sick. The earliest nurses learned the profession through cultural practices handed down to them by older generation, they also acquired the nursing skills from observations of others caring for the sick. Other times, they learned the practice through the process of trial and error (Adu-Gyamfi & Brenya 2016:3).

Available evidence suggests that nurses initially came together to form organised groups during the period when Christianity started. The principles of nursing which are charity, service to others, and self-sacrifice were in direct agreement with the doctrines of the early Christian church. Throughout ancient, the desirable, and mostly, the safest, nursing care was given in one's own home, where one was cared for by the family, tribesmen, or even friends. During this period entered *Florence Nightingale* (who is known to be the mother of nursing). She did not reform nursing as it existed at the time alone, but also laid the foundation for nursing as a profession (Adu-Gyamfi & Brenya 2016:3).

2.9.1 Nursing in Ghana

Nursing in Ghana is a very important subject that finds space in almost every issue in societies particularly in the field of hospital care or health care delivery. To a larger extent, the boundaries of nursing have grown since the time of Florence Nightingale. There have been studies which focused on nursing icons like her. The principles in nursing practice however continue to be a concern to people. The need to emphasise the contributions made by historical figures in nursing practice in recent times as well as the nature of interactions that take place between health care professionals like nurses and clients continue to be a major concern to many across the world and Ghana in particular (Adu-Gyamfi & Brenya 2016:1).

Adu-Gyamfi and Brenya (2016:1) conducted a study in which existing literature on Florence Nightingale and the nature of nursing in Ghana from the colonial times were analysed. In the study also, responses concerning the activities of nurses and their interactions with patients in Kumasi were also analysed. The responses of the participants were thematically pieced together to make conclusions that will be of interest to nurse practitioners, policy makers, health administrators, and educators. The findings of the study were that, the challenges faced by the nursing fraternity and institutions today are comparable to the challenges of the earlier period. The study further, stressed the emulation of the positive ideals of Florence Nightingale to promote the interest of patients, a core objective championed by the revered nurse. The persistent complaints of patients at the Kasoa Polyclinic led to this current study and the researcher beliefs that understanding and describing the views of the nurses who are on the daily basis accused of bad attitude towards clients would contribute to the argument put forward by the authors above that, nurses should emulate the positive ideals of Florence Nightingale.

On the contrary, Toso, Filippon and Giovanella (2015:1) conducted a study to analyse the impacts of increasing nursing activities in primary health care in the English National Health Service and its consequences for professional practice. This qualitative study used thematic data analysis to analyse the findings. During the analyses however, two themes emerged: the expansion of nurses' roles which must include consultation, diagnosis and drug therapy, case management and monitoring of chronic conditions; the other theme was the implications for the user which included improved access to health care, communication and comprehensiveness of the health care, increased times of consultations which resulted in greater compliance. For nurses, there was improved competencies, knowledge acquisition and professional recognition. The health care system benefited in terms of cost savings. The conclusion of the study was that the benefits in expanding nursing roles were visible, hence contributing to primary care quality (Toso, Filippon & Giovanella 2015:1).

These research findings call for a comprehensive assessment of roles nurses play in PHC because in one research finding, the attitudes of the nurses were under attack whiles other research findings argue for the expansion of their roles in PHC. These opinions are ripe for the current inquiry because the understanding and the description of perceptions would assist to shape the discourse in ways that would benefit the nursing profession. For example, positive

perceptions would cause the consolidation of strides made in PHC whiles negative perceptions would encourage the nurses and policy makers to re-examine strategies of PHC in rural communities. The current study would use thematic analysis to analyse and present the research findings. Thematic analysis was the method the authors above used and therefore the adoption of it by the researcher is appropriate for understanding and describing the perceptions of nursing regarding primary health care.

Lanzoni, Meirelles and Cummings (2016:2) posit that, a nurse is considered a unique professional in the delivery of Primary Health Care (PHC). This is due to the fact the nurse possesses unique set of skills which allow them to incorporate health promotion and disease prevention in addition to working closely with several other health workers. However, there have been misunderstandings over nurse leadership. This has stalled collaboration between nurses and other health professionals. To overcome these weaknesses, the strengthening of nurse leadership to provide the opportunity which will enhance the visibility of nursing activities and build a good working relationship is recommended.
Lanzoni et al (2016:2) found in a systematic review that nursing leadership styles and good relationship approaches were linked with reduced adverse events in health care settings, reduced complications and deaths. It also led to improved patient satisfaction. In view of the findings, the researcher agrees and supports the view that if nurses are made to take up leadership roles in primary health care, it would result in better health outcomes in rural communities and thus, the need to carry out this research that would take the views of all nursing professionals.

According to Fraher, Spetz and Naylor (2015:1) health care system is undergoing rapid transformation that places emphasis on public health, quality of health care, and the value of the health care services provided. These transformations provide prospects and challenges to the 2.9 million registered nurses (RNs) employed in the United States. Some of these opportunities and challenges are possible in developing countries like Ghana since nursing profession is a universal one.

According to Fraher, Spetz and Naylor (2015:1) in a restructured health care system, nurses are taking up additional duties for a wide range of patients in ambulatory settings and

community-based care. These duties include new responsibilities for population health nurses, care coordination and interprofessional collaboration. Because of the expanded activities for nurses, nursing training institutions should restructure curricula to include new skill-sets for nursing and also, existing regulatory frameworks should be updated to enhance the contributions of nurses in the transformed care delivery models.

2.10 NURSING ROLES IN PRIMARY HEALTH CARE

According to Shamian (2014:867) the health status of an individual is comprised of various aspects and only 25% of it has to do with the prevailing “health care system”. The other 75% is associated with other factors known as the Social Determinants of Health. These include education, shelter, and job opportunities. Based on this, one could say nurses have unlimited roles to play in health care and thus, their views about the systems they play roles cannot be undermined. The International Council of Nurses, ICN, defines nursing as a process in health care delivery that encompasses independent and joint care of people of all ages, families, organisations and communities, the sick or well and takes place almost everywhere. It includes the promotion of health of the community, prevention of diseases, and care of the sick, physically challenged and those dying. Other important roles of nursing include advocacy, promotion of a safe environment, research, involvement in decision-making processes in health policy and in-patient and health systems administration, and education (Shamian 2014:867).

The American Nursing Association ANA, also defines nursing as the protection, promotion, and improvement in human health and capabilities, prevention of diseases and wounds, intervening in the suffering of individuals through the diagnosis and treatment of diseases, and advocacy in the care of individuals, families, communities, and populations (Shamian 2014:867). Shamian (2014:867) considers that, the prevailing health care challenges and the multifaceted health matters have led to the increased roles of nurses. These are, the drive towards Universal Health Coverage (UHC); high prevalence of non-communicable diseases (NCDs) in some parts of the world; The emerging and re-emerging of infectious diseases such as Ebola, Tuberculosis, Upper Respiratory Illness; Challenges of financing health care ; The need to Integrate health care systems; The use of people-centred approach in health care systems; The rise in natural and man-made disasters; Human Resources for Health as a result of inadequate health care

professionals, migration, and task shifting (Shamian 2014:867). According to Shamian (2014:867) the roles of nurses are clearly recognised in four domains. They include, The area of Nursing itself; The Health Care system; The Regional or country level; The Global context. In the Global context, Shamian opines that the World Health Organization, the World Bank, International Labour Organizations, United Nations Populations Fund (UNFPA) have responsibilities that are directly linked to health. For example, the World bank is recognised as a Bank and therefore what will be its role in Health? In reality, the World Bank is among the biggest lenders and stakeholders in health care system, in poverty eradication, and in building economies. Owing to this, the health of the people, the development of the country, the health care system, and the role of nursing will be affected by the decisions and agreements that the World Bank will have with “Regional and National” governments, which reside in the Regional or National level. The role of nursing in the first and second domains respectively are often understood by the nursing fraternity (2014:867-868). The discussion thus far, corroborates the need to involve nurses in the health care discourse since the roles they play cut across many boundaries. Other roles of nurses in the health sector are enumerated in the proceeding discussions.

2.10.1 Public health nurses

Public health nurses have always played roles in developing, executing, and monitoring programmes to advance the health of communities through health promotion and disease prevention. There has been the recognition that a lot of health problems emanate from the community and are preventable through improved public health programmes. In serving patients and communities, nurses and other health care professionals including health care managers must understand the social determinants of health (SDH) and those factors that influence improved population health. For nurses to be effective in care management and coordination roles, as well as in primary health care in general, they will need to address the effects of the community on the people and how targeted interventions, either for the patients or community at large can improve health outcomes. This perspective demands greater knowledge of disease prevalence and social determinants of health (Fraher, Spetz & Naylor 2015:2).

2.10.2 Care Coordination and Transitional Care

Care coordination comprises working with patients with certain disease conditions to help organise the services they receive from providers and ensure that their right to the proper care and needs are provided and share the patient's health records cross various health care providers, and facilitate the appropriate provision of health care services. Many types of health care interventions come under care coordination, including care transitions, guided care, and collaborative care models. Many health care programmes have proved the value of care coordination, as well as the ability of nurses to plan, implement, and involve in care coordination projects and practices. While transitional care aims at providing continuity of care between health care settings and providers, care coordination involves both health care services and social services, including the physical, behavioural, social, and economic dimensions of care. The use of evidence-based approach to guide system transformation is growing (Fraher, Spetz & Naylor 2015:3).

2.10.3 Use of Data, Evidence, and Other Performance Improvement Skills

Increasingly, nurses have become familiar with data management using information from electronic health records (EHRs) and patient health records to identify unmet health needs of communities and to target population health interventions. Health information technology enables health care providers to access patient and community information readily, as well as supports seamless communication between health care providers. When designed well, they improve care coordination, increase the quality of health care, and reduce costs. Telehealth systems on the other hand allow providers to remotely observe and communicate with clients. This encourages timely identification of developing problems and consultations that are most preferred by patients. Effective use of health data and telehealth systems are considered important for successful care coordination (Fraher, Spetz & Naylor 2015:5).

Nurses will continuously use health information technologies to improve evidence-based practice. Patients information stored in EHRs can be used to swiftly assess the appropriateness or the efficacies of interventions directed at selected patients, as well as to assess broader relationships between care processes and patient outcomes. Nurses can rely on these technologies to better meet immediate care needs of the community they serve and to guide organisation policies toward care improvement (Fraher, Spetz & Naylor 2015:5).

2.10.4 Interprofessional Collaboration

An indicator of an improved health system is the level of collaboration that exists between the health professions, including physicians, nurses, social workers, physician assistants, pharmacists, and medical assistants. Nurses' clinical knowledge and movements across the health care settings will enable them to take responsibility for directing interactions between patients and providers along the range of care provided. They can play a major role in bringing out health care systems that ensure that primary care patients receive appropriate specialist consultations, physiotherapy, nutrition guidance and education, drug reconciliation with pharmacists, and assistance with social and economic issues that affect patients' abilities to care for themselves (Fraher, Spetz & Naylor 2015:5).These roles enumerated by the authors above support the long-held view of the researcher that, when nurses are managed effectively; are given the right education in health care systems with strong policy frameworks and are placed on the frontlines of primary health care systems, improved health outcomes would be realised and thus, the importance of understanding their perceptions about the health care in which they are key actors.

2.11 PERCEPTIONS

To inquire about the world requires that one understands the perceptions and ideas created in the world by individuals, and that this world is largely dependent on perceptions, images and philosophies. Thus, when we want to study something, first we should know where, when and how to meet and learn it (Démuth 2013:13). In this respect, the study focus area is primary health care but focuses on identifying and understanding the perceptions of nurses who are at the frontlines of primary health care delivery and therefore, their selection for participation is apt for the current study. In this case nurses and their perceptions.

Reasons we study perceptions can be sincere interest in understanding why objects or subjects appear the way they look like, or to understand oneself and the world in which one lives. To study perceptions means to study the world which is made of them, it also means to study oneself (Démuth 2013:16). The current study is interested in exploring the views of nurses and describing the views in relation to primary health care in rural communities in Kasoa. Secondly, to understand the phenomenon from their view point and the challenges they encounter in the course of their daily duties as primary health care providers and therefore, perception was identified as appropriate concept to attain the purpose of the study.

According to Lee (2015:3) knowledge is seen to be subjective depending on the individual because the individual can choose what is true for himself through perception. Perception becomes more truthful and thorough as information accumulate and are kept when the receiver of the information perceives the same object repeatedly. Perception after a succession of preceding encounters involves the spontaneous grouping of the objects being perceived into a category. Perception is an immediate phenomenon that occurs only when the observant takes part in the act of perceiving the functional objects (Lee 2015:4). The nurses as the subjects of the current study are every day working with patients and the health care system. They are naturally involved in the health care delivery and therefore what they perceive on a daily basis cannot be undervalued and thus, their perceptions on primary health care in rural communities will be important for policy makers.

Hoffman, Singh and Prakash (2015: [1]) opine that usual selection informs our opinions to be, in the typical case, exact representations of our real world, particularly of those facets of reality that are grave for our existence. Health is critical for our survival and therefore, its description based of the perceptions of those who are involved in its delivery will assist policy makers to improve the health care delivery policy or consolidate the gains they have made through existing frameworks.

2.12 CONCLUSION

This chapter focused on some concepts that would guide the researcher in conducting the inquiry. Published articles were also reviewed and analysed in relation to the current study. The researcher identified some works of researchers that were relevant to the study and identified gaps where possible and also stated opinion where necessary. Some of the concept identified included: primary health care, comprehensive primary health care, integrated health care, rural health and perception.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

The previous chapter discussed some of the concepts and related articles that are relevant to the current study. This was done to situate the study in a context that will allow for proper appraisal of the inquiry. This chapter focused on the methodology and the research design used by the researcher in this inquiry. The chapter also discussed the setting of the research and its characteristics. The chapter also argued for why the chosen research design and method adopted by the researcher are appropriate for the current study. The researcher described in details the merits and the demerits of the chosen design. The data collection tool for the study was also discussed in this chapter. The chapter further enumerated some of the ethical issues that the researcher addressed during the study.

3.2 RESEARCH METHODOLOGY

This study adopted the qualitative research approach. According to Leavy (2014:2) qualitative research is a way of obtaining knowledge that describes the realities of the societies in which we live. Qualitative research methods can be used across the many fields to study a wide range of topics. Qualitative researchers assume a viewpoint that proposes that information gathering is viewed as reproductive and process-oriented. The fact about something is not complete and available to be known by unbiased investigators, instead it is dependent, relative, and several (Saldaña, 2011) as cited in Leavy (2014:3). In this study, the researcher adopted the naturalistic paradigm. Beuving and Vries (2015:15) define naturalistic inquiry as studying people in everyday situations through ordinary means. Naturalistic inquiry can bring out interesting and important views into the happenings of communities, views that cannot be obtained from quantitative studies. It can also make these insights clear and productive for many people (Beuving & Vries 2015:16). A naturalistic inquiry often starts with a fairly open research question

that simply points at a particular research problem (Malinowski, 1978) as cited in Beuving and Vries (2015:17).

According to Beuving and Vries (2015:19) naturalistic inquiry is a kind of qualitative research that is carried out naturally in everyday circumstances, and that aims to disrupt these circumstances as little as possible. It endeavours to blend in and respect people in their everyday activities, and takes their attitudes and experiences seriously, and carefully dwells on them. As a skill, naturalistic inquiry may be recognised as the artisanal core of qualitative research. The current study aims at describing the perceptions of nurses regarding primary health care. The researcher beliefs that the perceptions of the nurses would be well understood and appreciated when studied in the narrative where participants freely talk to the researcher about their stories and experiences. Naturalistic inquiry is necessary in helping to appreciate the world around us better (Beuving & Vries 2015:22). Naturalistic inquiry has the ambition to help researchers come to terms with the problems of society from within; that is in terms of the viewpoints of its members. The researcher seeks to answer the research questions from the viewpoints of the participants and thus, finds the naturalistic paradigm appropriate for the current study.

3.2.1 Characteristics of Naturalistic inquiry

Naturalistic inquiry begins and ends with situations as they naturally occur and unfold in people's lives. In naturalistic inquiry, attention is focused less on individuals and their properties and more on persons and their situation. Naturalistic methods seek to investigate social life as it presents itself to the members of a society under normal, everyday situations. Typically, researchers carry out fieldwork by participating in the very social life they are studying. An important naturalistic ambition is that no a priori boundaries are set for the properties under study (Beuving & Vries 2015:37). The researcher was interested in the meaning nurses give to primary health care and their everyday experiences and therefore, visited them in their natural settings to have a natural encounter with the participants. This natural role that the researcher took enabled the researcher and participants to be in a natural and cordial relationship as characterised by naturalistic inquiry.

3.3 RESEARCH DESIGN

The research design for the study was qualitative exploratory design. According to Manerikar and Manerikar (2014:95) when a researcher lacks sufficient information or experience with what is to be investigated, exploratory study design becomes convenient. The exploratory design provides the grounds for a thorough, more decisive future study to be carried out with an adequate understanding of the nature of the problem at hand. Exploratory research gives deeper perceptions of a given phenomenon or simplifies the research problem.

3.3.1 Nature of exploratory design

Exploratory Research may be a one research investigation or a succession of casual studies planned to offer background information. They should be flexible enough to investigate all inexpensive sources that may possibly provide information to help understand a problem. Exploratory inquiry provides a direction for researchers by gathering evidence on a lesser known topic. Exploratory research is often used to produce new ideas (Manerikar & Manerikar 2014:95).

3.4 RESEARCH SETTING AND POPULATION

3.4.1 Setting

The setting of the research was Kasoa also known as the Awutu Senya East Municipal (ASEMA). The Awutu Senya East Municipal (ASEMA) is a newly created district in the Central Region. It was carved out of the former Awutu Senya District in 2012 and established as a Municipality by Legislative Instrument 2025 with Kasoa being its capital. The reason for the creation was to smoothen government's decentralisation programmes and local governance system. According to the district analytical report (2014:1) the total population in the Municipal stood at 108,422. This constitute about 4.9 percent of the region's population.

Kasoa, the Municipal capital, is situated at the South-Eastern part, about 31 km from Accra, the national capital. The major settlements of the municipal are Opeikuma, Adam Nana, Kpormertey, Ofaakor, Akweley, Walantu and Zongo. The geography of the municipal is characterised by isolated undulating highlands found around the Ofaakor and Akweley area. The nature of the relief has impacted the soil type. The highland and lowland areas have loamy soils and clay soils respectively.

The drainage in the high lands is not intensive as compared to the lowland areas. Okrudu, which is the major river, causes flooding during the rainy season. The Municipal forms part of

the south-west plains of Ghana and is one of the hottest parts of the country. Temperatures are high throughout the year and range between 23°C-33°C. Rainfalls are heavy during the major season between March and September. The average rainfall is about 750mm (District Analytical Report 2014:1).

The major occupation in the Municipal include trading, agro-processing, informal sector service and commerce. Trading and its related activities are the leading economic activities which employ about 35.7 percent of the working population in the Municipality. Livestock production is also practiced in the Municipality but on a smaller scale. The contributions of the private sector remain significant and it employs about 81.9 percent of the working population in the banking and the services sector. There are other economic activities such as manufacturing, wholesaling and retailing, and transport services (District Analytical Report 2014:3).

3.4.2 Population

According to Rijnsoever (2017:3) the overall information sources that are relevant and are capable of guiding researchers to answer the research question is the population for the particular inquiry. On the other hand, Taherdoost (2016:19) explains population to mean the complete set of cases from which research sample is drawn. The population for the study was nurses working in primary health care facilities in Kasoa. The researcher did not limit the study to only a particular grade or rank of the nurses but all nursing professionals and irrespective of the experience and qualification. According to Alvi (2016:10) a target population for a given study consists of all the participants who meet defined criteria specified for a research investigation. The nurses included community health nurses, registered nurses, enrolled nurses and midwives. The researcher took this decision in order to present the findings as pertaining to nurses and not a section of nurses. This also avoided the incidence of bias with respect to the population. These constituted the target population for the study. The target population for the study were all the nurses who are willing to take part in the study.

3.4.3 Sample and Sampling technique

A sample could be defined as a collection of fairly smaller number of people who are selected from a population for the purposes of the research. These members that constitute the sample are known as the research participants (Alvi 2016:11).

According to Alvi (2016:11) the procedures researchers use to pick the participants for the research study from the known population is refered to as sampling. Since it is unlikely to assess all the participants of a population, it becomes necessary to use a smaller set of participants for the research study. Based on the information that will be obtained from the sample, conclusions will be drawn for the study population. The more the sample is characteristic of the population, the more the degree of accuracy of the conclusions of the findings and the research findings could be transferred. The sample for the study constituted 24 nurses working in PHC facilities. The facilities included the Kasoa Polyclinic, New Market health centre, Ofaakor CHPS compound and Opeikuma CHPS compound.

In this study, the researcher selected the participants purposively, which is a non-random sampling method. In a non-random sampling method, participants in the population have equal opportunity to be selected and added in the study sample (Etikan & Bala 2017:1). Non-random sampling is usually used in exploratory or even case study researches design and particularly in qualitative studies. In case studies, researchers use small samples and they are interested in examining real life situations, and they are not concerned about using statistical data to draw conclusions for a wider group (Yin, 2003) as cited in Taherdoost (2016:22).

Etikan and Bala (2017:1) explain that purposive sampling designs are dependent on the decision of the researcher as to who is in the best position to give the desired information that will assist the researcher to achieve the study objectives. The researcher focuses on the members of the study population who possess the same or similar views that are needed to carry out the study and are interested and willing to give them to the researcher.

According to Etikan, Musa and Alkassim (2016:1) purposive sampling is a non-random sampling method that does not require fundamental theories or a definite number of study participants. The researcher chooses what needs to be known and goes out to look for individuals who are capable and are willing to give out the information because of their understanding, knowledge about the study area or experience. It is particularly employed in qualitative studies to find and choose the information-rich cases for the appropriate use of available resources. This includes looking out for and selecting participants or groups of individuals that are capable and possess detailed information about the phenomenon under investigation.

The researcher identified nurses working in primary health care facilities in rural communities in Kasoa as reliable source of data. The researcher found the purposive sampling appropriate because, the study had the sole objective to describe and present the perceptions about primary health care from the nurses' point of view and thus, purposive sampling that targets participants because they meet the set criteria was the obvious choice for the study.

In this study, the researcher wanted to examine primary health care in rural communities and because other researchers have focused on other health care practitioners, the choice of nurses was to situate the research in the nursing field and thus, the purposive sampling approach. Furthermore, the researcher did not intend to generalise the findings to other health care professionals but address the research questions from the nurses' point of view, the purposive sampling was chosen. The sample for the study was twenty-four nurses who were interviewed for the study. The sample size was reached at saturation during the sample collection phase. Saturation in qualitative data collection is the stage where participants' information to the researcher become repetitive.

3.4.3.1 Inclusion Criteria

Inclusion criteria are the major attributes of the population of interest that the researcher (s) will need to address their research problem. Typically, inclusion criteria may include demographic information, clinical, and geographic features of the study participants (Patino & Ferreira 2018:1).

In the study, the inclusion criteria included: all the nurses, irrespective of category, qualification and experience working in Ghana Health Services' primary health care facilities in Kasoa. These criteria were set because it would assist the researcher to attain the objectives of the study. Secondly, the researcher considered these criteria in order not to obtain views of a set of nurse professionals but to ensure sample homogeneity in order to have a thorough appraisal of the phenomenon under investigation. In this study, the target population was nurses and therefore, the criteria set out to include the participants enabled the researcher to easily locate the participants of interest.

3.4.3.2 Exclusion criteria

Exclusion criteria are the characteristics of the possible study participants who possess the criteria defined for their inclusion but have other qualities that could affect the progress of the study or cause an undesirable outcome. Some of the exclusion criteria may include features of

suitable participants that make them possible to be missed during follow-ups, miss appointments times for data collection and provide wrong data (Patino & Ferreira 2018:1).

The exclusion criteria for the study were all the nurses who are not working in Ghana Health Services' primary health care facilities in Kasoa. Anyone working at Kasoa primary health care facilities but not willing to participate in the study. Furthermore, participants who voluntarily abstained from the study were excluded from the study. This was to avoid forcing participants to provide information to the researcher.

3.4.4 Data collection

In-depth individual interview was used to collect the data from participants. This study sought to explore what may be hidden and undermining primary health care in rural communities in Kasoa, the study aimed at understanding and describing the perceptions of nurses about primary health care and therefore the use of the individual in-depth interview data collection approach was not out of place.

Individual in-depth interviews usually take place for long periods. They often involve one-on-one or person-to person conversation between a researcher and a participant. It therefore, tries to establish a particular form of friendship that allows for shared self-disclosure. These forms of interviews involve a more expression of the interviewer's personality than other kinds of interviews. It also encourages dedication from study subjects. In-depth interviewing provides greater benefits, however, there are other risks and hazards. They also require strict ethical considerations (Johnson & Rowlands 2014:2).

Johnson and Rowlands (2014:2) further describe in-depth interviewing as the type which involves a certain amount of common and social conversation. As a common conversation, it is different from the exchanges people often find at market places, seminars, job interviews, during counselling sessions, during summits, or even in intimate relationships. To be real and beneficial, in-depth interviews progress and dwell on familiarity. They are like the kinds of conversations that take place among close friends. The conversation between the interviewer and the participant looks like friendship, even may be a lasting relationship. However, in-depth interviews seem unlike the kind of conversation that take place between friends, particularly because the interviewer plans to use the information gained in the interaction for important activity (Johnson & Rowlands 2014:2). The researcher found this technique useful for the current study because, as explained in this paragraph, the researcher used the stories by

nurses and understood their perceptions about primary health care. During the interview process, the researcher wanted to know some of the challenges the nurses face in their lines of duties. Furthermore, the researcher used this data collection method to verify if some of the nurses are ignorant of primary health care or have little knowledge about the approaches.

Johnson and Rowlands (2014:5) argue also that, in-depth interviewing seeks greater knowledge and understanding. Greater understanding and knowledge imply several meanings in this context. For example, comprehensive views are held by the participants who are taking part in everyday activity or the event under investigation. The interviewer therefore, wishes to gain similar depth of knowledge and understanding as the study participants when they carry out in-depth interviews. When th interviewer lacks sufficient information unlike a member or a participant about the topic under investigation, he or she may use in-depth interviewing as a means to understand and interpret the actions of the participants. The researcher agrees with the opinion for the reason that, the researcher is interested in presenting the perceptions nurses have about primary health care and not the researcher's own perceptions. Again, the current study aims at understanding the views of the nurses who are leading primary health care in rural communities in Kasoa and therefore a deeper knowledge and understanding of PHC in rural communities from the point of view of the nurses would assist in arriving at the aim of the study. The researcher cannot assume the role of nurses in this regard and thus, the need to use the individual in-depth interview.

Furthermore, deep understandings extend beyond every day meanings for and other understandings of cultural practices, actions or occurrences. It starts with common-sense opinions, meanings, and knowledge of existing cultural practices. This may involve empirical explanations and objectives to discover the contextual boundaries of that knowledge or opinion, to discover what is hidden from ordinary view and to delve deeper to find out more insights about the nature of that experience (Johnson & Rowlands 2014:6).

Interestingly, deep understandings allow researchers to come to terms with and articulate the varied opinions, standpoints, explanations of actions, occurrences or communities. Deep understandings can bring out how our common-sense expectations, practices, and ways of talking forms our interest and how we understand them (Johnson & Rowlands 2014:6). These

reasons and others articulated above further support the choice of the data collection method the researcher adopted for the study. The data collection commenced after the researcher obtained ethical approval from the research ethics review committee of the Ghana Health Service. The data collection took place at four primary health care facilities in Kasoa. The facilities included: the Kasoa Polyclinic, the kasoa New Market Health Centre, the Ofaakor CHPS compound and Opeikuma CHPS compound.

3.4.5 Data analysis

In this research, the researcher used the thematic data analysis and field notes. The researcher used thematic analysis to analyse the data obtained from the participants. Alleyne (2017:14) identifies thematic analysis as an established way of analysing narrative in terms of themes, where a researcher brings from her research questions a set of thematic issues to the narrative being analysed. These issues would then constitute a conceptual framework against which the narrative is read.

Hawkins, Hawkins and Hawkins (2017:2) argue that themes go beyond topical reporting, to provide depth of understanding within an interaction, text, or message, often revealing information about a process or processes that are occurring. Thematic analysts make sense of recurring observations found within data in effort to interpret what is occurring within communication. Thematic analysis is not specific to any one research method but is used by scholars across many fields and disciplines. The researcher found thematic analysis as the appropriate qualitative data analysis tool for the narratives that were obtained from the participants. Furthermore, the aim of the study was to understand and describe the perceptions of nurses about primary health care and therefore the similarities in the stories of the participants made the thematic analysis data analysis method suitable for the study. In this study, the adapted Colaizzi's thematic data analysis method in which data were transcribed and categorised into themes for the purpose of presentation using an adapted Colaizzi (1978) seven steps of analysis as cited in Bazeley (2013:65).

Step 1: Acquiring a Sense of Each Transcript

In this step the researcher read and re-read each transcript in order to obtain a general sense about the whole content. The researcher put aside any preconceived ideas about the phenomena under the study, to prevent contamination of the findings.

Step 2: Extracting Significant Statements

In this step the researcher extracted the significant statements that pertain to the phenomenon under the study from each transcript. The researcher recorded these statements on a separate sheet noting their pages and line numbers.

Step 3: Formulating meanings

The researcher formulated meanings from these significant statements. Each underlying meaning were coded in one category as they reflect an exhaustive description. Then the researcher compared the formulated meanings with the original meanings maintaining the consistency of description.

Step 4: Theme clusters

The researcher grouped all formulated meanings into categories that reflect a unique structure of clusters of themes. Each cluster of themes was coded to include all formulated meanings related to that group of meanings. Thereafter, groups of clusters of themes that reflect a particular vision issue were incorporated together to form a distinctive construct of theme.

Step 5: Exhaustive description

The findings of the study were integrated into an exhaustive description of the phenomenon. All emergent themes were defined into an exhaustive description.

Step 6: Statement of identification

The fundamental structure of the phenomenon was described. The researcher checked in the findings for the redundant, misused or overestimation descriptions and eliminated them from the overall structure.

Step 7: Participant verification

The validation of findings in the study were sought from the research participants, through member checking, where data analysed were referred back to participants for review, validation and commentary.

3.5 TRUSTWORTHINESS

Researchers agree that research needs to be trustworthy and should demonstrate both rigour and relevance. Trustworthiness represents the validity of research as done in quantitative research. Rigour represents the process of arriving at the results and relevance represents whether the end-results are relevant or not (Mandal 2018:529). The researcher, maintained trustworthiness through:

Credibility: Credibility refers to the plausibility or the certainty in research findings. To this extent, study participants are given the interview transcripts and the research reports and be asked to either agree or disagree with them. This check tries to ensure the credibility of the findings. Credibility can also be achieved by persistent observation and triangulation of data. Credibility helps in ensuring internal validity of the research findings. (Mandal 2018:529). Credibility is used to evaluate the veracity or the soundness of qualitative research. A qualitative study is trustworthy when its findings, presented with sufficient accounts of background, are recognisable to people who share the experience and those who care for or treat them (Hammarberg, Kirkman &. Lacey 2016:500). To ensure the credibility of the study, the researcher returned the interview transcripts to the participants for verification in order to avoid any biases and to present the findings as the account of the participants. The researcher also conducted the interview in the natural setting of the participants to obtain first-hand information through direct observations.

Confirmability: This implies how one can find out the extent to which the results of an inquiry are a function exclusively of the members of the study and circumstances of the inquiry and not of the prejudices, drives, desires and viewpoints of the inquirer (Guba 1981:80) as cited in Moon, Brewer, Januchowski-Hartley, Adams and Blackman (2016: [2]). To achieve confirmability, researchers must show that the results of the study are directly connected to the conclusions in ways that can be followed and, as a process, replicated (Moon, Brewer, Januchowski-Hartley, Adams and Blackman (2016: [2]). The conclusions of the study were reached based on the findings of the study. The researcher also ensured that the conclusions answered the research questions that guided the study and were not based on other interests.

Transferability: Transferability refers to whether the results obtained from the analysis can be applied to other settings and contexts. This acts as a check for external validity of the findings. In qualitative research, researchers provide a detailed description of the settings and the

context in which research is conducted. This is done to provide the readers adequate information to judge the applicability of the findings to other settings (Mandal 2018:529). Hammarberg, Kirkman and Lacey (2016:500) explain transferability as a description for appraising external accuracy. A study is considered to meet the criterion of transferability when the results can fit into contexts outside the study situation and when researchers view the findings as meaningful and relevant in their own experiences. Using bigger samples in qualitative studies doses not necessarily give greater transferability. Thoroughness of the data is preferred to the sample size. This is because too much data may not allow for proper analysis. Sample sizes in qualitative study are usually small. Saturation is often used to indicate when the sample size has been obtained in qualitative methods (Hammarberg, Kirkman & Lacey 2016:500). This is when the information from participants become repetitive. The researcher abundantly described the study setting and the population for the inquiry to allow the transferability of the findings. The exclusion and the inclusion criteria were clearly stated for the target population. The researcher adopted saturation to determine the sample size of the study.

Dependability: Dependability in qualitative study is similar to reliability as applied in quantitative research. A measure is reliable when independent but comparable measures of the same trait or construct of a given object agree. Reliability depends on how much of the variation in scores is attributable to random or chance errors (G.A. Churchill, 1979) as cited in (Mandal 2018:529). Reliability cannot be checked in qualitative research as it is done in quantitative research. Qualitative researchers ensure dependability by having proper documentation of data, methods, and taking proper decisions about research (Mandal 2018:529).

Dependability of the results assesses reliability of the study. This does not suggest that similar study findings would essentially be found in other contexts, instead, when the same research information is made available to other researchers, similar patterns are likely to be found. Researchers often seek maximum variation in the experience of a phenomenon, not only to illuminate it but also to discourage fulfilment of limited researcher expectations (Hammarberg, Kirkman & Lacey 2016:500). The audio recordings of participants were transcribed to obtain verbatim transcripts of the participants and analysed using thematic analysis to arrive at the codes from the narration. An independent coder was engaged to assist in the analyses of the

verbatim transcripts of the participants and results were refered back to the researcher to validate the codes and correct confounding themes where necessary.

3.6 ETHICAL CONSIDERATIONS

Brann (2017:2) views research ethics are the system of moral principles researchers establish to determine right and wrong research practices. Every day ethical principles often guide researchers in making decisions about what to research, how to do research, and with whom to do research, among other choices (Brann 2017:2). Before embarking on data collection involving participant observation, in-depth interviews, or focus groups, it is important to understand some of the basic ethical dimensions of qualitative research. Like biomedical or quantitative research, good qualitative research is designed and conducted within the parameters of internationally recognised ethical guidelines that emphasise the principles of respect for persons, beneficence, and justice. As defined by the Council for International Organizations of Medical Sciences and the World Health Organization (World Health Organization, 2002, pp. 17–18), cited in Greg Guest, Emily E. Namey and Marilyn L. Mitchell (2017:2).

In this study, the researcher adhered to research ethics. The researcher sought ethical clearance from the Ethics Committee of the Department of health studies, Unisa prior to the commencement of data collection. Notwithstanding this clearance, ethical approval was again obtained from the ethics review committee of the Ghana Health Service. Other ethical considerations were also adhered to during data collection. Some of these ethical considerations are enumerated below:

3.6.1 Beneficence

This means doing good work to benefit others. In research ethics, being beneficent requires researchers to keep the welfare of the participants as a goal of any study. This inherently means that no harm should be bestowed upon research participants. Additionally, though, beneficence seeks to maximise benefits and minimise the hazards associated with the research. What may be difficult, however, is that it is expected that beneficence will be applied to not only the research participants but also society as a whole (Brann 2017:4). Beneficence refers to the moral responsibility of the researcher to increase the advantages of the research and to reduce potential harm. This principle gives rise to rules which require that the dangers of research be

reasonable insignificant relative to the advantages, that the research design must be thorough, and that the researcher (s) have the capacity to undertake the research and to protect the welfare of the research participants (Guest, Namey & Mitchell 2017:2). The principle of 'beneficence', states that researchers should strive to increase the likely benefits and lessen likely harm for the subject, and they should decide whether the benefits measure up to the costs (Toepoel 2017:3). The researcher ensured that the study benefited the nursing fraternity as well as the participants by assuring them that, the findings would be published in journal articles. This means that their opinion would be read and authorities would consider them serious. Secondly, since this is an academic endeavour, the findings would fill identified gaps in literature that would be beneficial to the nursing profession as well. The research findings were also given to the participating facilities to enhance beneficence.

3.6.2 Autonomy

Autonomy concerns the need to respect the freedom of those being investigated. The idea that people should be free to choose for themselves what is best for them, in other words, to exercise control over their own lives (Hammersley & Traianou 2015:2). To respect an independent agent is to admit with proper understanding that, the individual has the capacities and viewpoints and in addition, his or her right to hold certain opinions, to make decisions, and to act in certain ways based on personal convictions and principles (Hammersley & Traianou 2015:2).

Guest, Namey & Mitchell (2017:2) explain that respect for autonomy, requires that those who are capable of deciding about their individual choices should be treated with respect for their capacity for self-determination; and protection of persons with impaired autonomy. It also requires that those who are dependent or vulnerable should be provided security against harm or abuse.

In this study, the autonomy of individual participants was ensured in ways that gave credibility to the information that participants volunteered. Participants were allowed to express their views as autonomous as possible devoid of intrusion from external forces. The interviews were conducted in secluded locations to ensure absolute autonomy of the interviewees. Also, the researcher agreed to the venue choices of the participants.

3.6.3 Informed consent

Informed consent is the permission that a subject of research or recipient of treatment may give upon gaining a full appreciation of the facts and implications of a proposed procedure. It is the responsibility of the researcher to secure informed consent, whenever possible, in accordance with disciplinary and institutional guidelines (Tsao 2014:2). Informed consent is said to require subjects to have possession of all facts relevant to a procedure. In practice, however, it is rare for subjects to possess the full range of knowledge needed to appreciate the contextual implications of a research programme (Tsao 2014:3). Participants must be informed of the fact that they may decline to take part or withdraw their participation at any time. Participants may believe that they can no longer withdraw once they have started the survey and it is therefore important to remind them of this possibility right from the start. Researchers also have to inform the participants about the consequences of withdrawing their participation, for example, whether the receipt of any kind of compensation for their participation is tied to the completion of the study (Toepoel 2017:4).

Informed consent should include a description of the study, explain the purpose of the study, what the participants are expected to do and why the study is important. Researchers must, however, be careful not to give too much information, because this might bias the respondents' answers or behaviour. Furthermore, informed consent should address any potential risks, such as anxiety or stress, and the possible benefits like increasing knowledge on certain subjects or any inducements (Toepoel 2017:4-5). In this study, participants' information sheet and consent form were obtained from the University of South Africa through the Department of Health Studies prior to the data collection phase of the study. Participants were made to understand the benefits of the study and were allowed to voluntarily consent to the request of the researcher. Participants were briefed about the purpose of the study as well in order that the participants made informed decisions about whether to engage or disengage in the research. The participants were given the participants information sheet to go through and were allowed ample time before consenting to the study. Different consent forms were used for the different nurse groups for the study.

3.6.4 Confidentiality

Confidentiality is another right that participants have. They should have the right to know who else will access their data. The rate at which participants respond honestly to survey questions could increase if they are assured of the confidentiality of their answers (Singer et al.,1995),

cited in Toepoel (2017:4). This effect could be even stronger if researchers are able to guarantee anonymity and assure participants that it will not be possible to trace any results back to them personally (Toepoel 2017:4). No participants' name was used in this study.

Confidentiality is similar to the right to privacy. Privacy implies that participants should be allowed the free will to decide the depth of descriptions about themselves they want to provide or withhold from researchers (Siegel, 1979), as cited in Toepoel (2017:4). The difference between privacy and confidentiality is that confidentiality refers to the ways in which information are manipulated, while privacy refers to individuals. Confidentiality refers to separating or altering any personal, identifying information provided by participants from the data. Anonymity and confidentiality are important because they protect the privacy of those who voluntarily agreed to participate in research. In this way, participants may be more comfortable completing a survey or participating in an experiment or interview if they have some assurance that the researcher will not reveal the information provided (Coffelt 2017:2-3). The researcher ensured that participants identity and information was kept safe to avoid breach of data which may have defeated the ethics of the study. Participants were also encouraged to withhold any personal information they considered private to enhance privacy in the study. The ethical issues were considered sacred and adhered to in order to safeguard the integrity of the study. Confidentiality of all participating nurses were ensured throughout the study. One way was; the researcher agreed for the participants to use their phone numbers on the consent form.

3.6.5 No maleficence

This implies do no harm. Joel Feinberg (1984) as cited in Israel (2015:2) defines harm as deviating from the interest of the research study, where the interests of an individual are defined as a number of things in which that individual has a stake. Harm is often understood in physical terms, it is also associated with emotional, social, financial, legal and environmental damage. In the field of social science research, harm is seen to be in the form of mental distress, uneasiness, invasion of privacy or violation of rights than physical injury (Israel 2015:2). The researcher being fully aware of the potential discomfort the long periods the interview would take, established friendly relationship with participants. This atmosphere reduced the anxiety among participants and led to minimal discomfort. The researcher also adopted intermittent breaks during interviewing sessions so participants got relieved of stress. Measures were put in place to ensure the study does not interfere with the participants' official work.

3.6.6 Justice

Justice requires the researcher to treat every research participant in a proper manner, to give each person what has been agreed upon. In the ethics of research in which human participants are involved, the principle simply means distributive justice, which requires the fairness in sharing both the problems and the profits of taking part in a study. Differences in sharing the problems and profits are admissible only if they are based on morally appropriate differences between persons; one such difference is susceptibility of study participants (Guest, Namey & Mitchell 2017:2). In this study, the refreshment package the researcher agreed to give each participating group was evenly shared.

3.6.7 Data Storage, Usage and Safety

The audio tapes of the participants were stored by the researcher for a period of five years in a locked cupboard or filling cabinet for future research for academic purposes; electronic information was stored on a password protected computer. The data were used for academic purposes only, thus the current study. Future use of the stored data will be subject to further research ethics review and approval if applicable. The electronic copies were permanently deleted from the hard drive of the computer through the use of a relevant software programme.

3.6.8 Compensation

There were no monetary payments for the participants, however, since the interview extended beyond one hour the participants were provided with snacks specifically a soft drink and meat pie after each interview.

3.6.9 Conflict of interest

No individual, corporate entity or organisation had interest in this study. This study was solely for academic purposes (the award of master's degree in public health). Therefore, the research had no conflict of interest.

3.6.10 Funding

The research was self-financed by the researcher. No other individual, organisation or entity provided financial contribution for this work

3.7 CONCLUSION

The chapter described the methods the researcher used in the study in detail. The research paradigm was explained and the research design was also stated. The research conducted was qualitative research as opposed to quantitative. The design of the study was exploratory study design. The researcher considered saturation as appropriate means to ensure that data collected were enough as against numbers used in other research paradigms, for example, quantitative research. The setting for the study was Kasoa and the participants included nurses working in rural primary health care facilities or health facilities that provided health care services to rural dwellers. The data obtained from participants were analysed thematically. During the data collection phase, some internationally accepted ethical principles were strictly adhered to. Some of these included: beneficence, nonmaleficence, autonomy, and confidentiality.

CHAPTER 4

PRESENTATION AND DISCUSSION OF FINDINGS

4.1 INTRODUCTION

The previous chapter discussed the research method and design which guided the entire research processes. An overview of the study area and the population of interest were succinctly stated. The researcher also described the sampling approach and the data collection method for the study. Ethical considerations were also described in the previous chapter. This chapter focuses on the presentation and the discussion of the findings from the individual in-depth interview conducted with the participants. The discussion would enable the researcher situate the findings in relevant literature for proper conclusions to be drawn. The main objective of the chapter is to provide critical reasoning and presentation of the results in order to provide foundation for how participants viewed the concept PHC and also the challenges they come across when providing care in PHC facilities.

4.2 DATA ANALSIS

The data which were collected using an unstructured individual in-depth interview were analysed using an adapted Colaizzi (1978) seven steps of analysis as cited in Bazeley (2013:65). The independent coder however, opted to use 8 steps of Tesch's open coding qualitative data analysis method as cited in Creswell (2014). This was agreed upon between the researcher and the independent coder due to the commonalities between the two thematic data analysis steps.

Consensus meeting was set between the researcher and the independent coder in order to discuss and agree on final themes and sub-themes based on the ones which emerged when analysing independently. Table 1 provides the final themes and sub-themes which came out

during the analysis by the independent coder and were agreed upon by the researcher and independent coder which serves as the findings of the study.

Table 4.1 Themes and sub-themes of interview transcripts

Main themes	Sub-themes
1. Participants' interpretation of the meaning of Primary Health Care	1.1 Diverse and analogous meaning of Primary Health Care (PHC) outlined 1.2 Existing PHC services commended 1.3 Outline that PHC's meaning associated with affordable and accessible service 1.4 PHC's meaning coupled with Health professionals involved and type of care provided 1.5 PHC associated with promotion of health self-care abilities and management
2. Existing challenges experienced during provision of PHC services	2.1 Lack of good sanitation, inadequate clean water supply associated with development of various diseases 2.2 Poor infrastructure, shortage of financial, material and human resources a challenge to PHC service delivery 2.3 Negative treatment and abuse of nurses by community members affect service delivery and communication 2.4 Lack of money and transport affect adherence to health instructions by clients and patients 2.5 Lack of adherence to health instructions by patients and clients affect expected health outcomes 2.6 Possession of Health Insurance determines accessibility to best PHC services 2.7 Misconceptions, cultural and religious beliefs interfere with PHC services expectations 2.8 Poor implementation of decentralised PHC services observed
3. Views and perceptions related to PHC provided	3.1 PHC services viewed as satisfactorily with minor challenges that could be addressed

	3.2 Health education and patients' rights provided at PHC facilities viewed as helpful in achieving health outcomes 3.3 Provision of outreach services seems to be acceptable to communities 3.4 Existing referral system at PHC facilities well-structured, clear and acceptable 3.5 CHPS zones viewed as helpful to provide PHC services
4. **Existing PHC services provided in the PHC facilities**	4.1 Explanation of various PHC services provided at the polyclinic outlined 4.2 PHC facilities caters for clients and patients from various communities including urban areas 4.3 Provision of PHC services is through CHPS zones and polyclinics 4.4 Different Health professionals provide care at the CHPS and polyclinic
5. Recommendations towards improvement in the provision of the best PHC service	5.1 A need for government and non-governmental organisation raised 5.2 Improvement plan to maximise CHPS, polyclinics and health centres performance required 5.3 Revitalisation of existing infrastructure raised 5.4 Reviving PHC values by government mentioned 5.5 Intensification of health education for various aspects through different communication modes suggested 5.6 Emphasis on review, correct implementation of policies and PHC services suggested 5.7 Government to address existing health hazard in order to improve health outcomes 5.8 Government to supply resources required for effective implementation of PHC services.

4.3 DISCUSSION OF FINDINGS

4.3.1THEME 1: Participants' interpretation of the meaning of Primary Health Care.

The findings of the analysis showed that participants have diverse interpretations for primary health care. This also shows that the concept primary health care means different to different

participants who share the same profession. This is evident in the sub-themes that emerged from this theme.

Sub-theme 1.1: Diverse and analogous meaning of Primary Health Care outlined.

The findings pointed out that the participants have diverse and analogous meanings regarding the phenomenon under study. Although the participants included nurses, the findings showed that primary health care means different to the nurses who are doing similar work. Other participants understood the phenomenon but attributed different definition to it. This is confirmed by one participant who explained primary health care to mean "***...*** *the essential health care that is given to family and members of their household and the community at the cost they can afford and maintain throughout their life. It should involve the community".* Another participant also sees PHC as "... *I see it to be basically the health care provided to the rural communities. It is an affordable way of delivering health care to the community".* A third participant was of the view that "*I know phc is caring for a person and the family. Caring for oneself, community and family. When it comes to the community it is through the chief".* A forth participant explained primary health care as "… *primary health care is basically the health care that is provided at the community level with their participation. It involves some preventive and curative services*." One of the participants also sees primary health care as health care for those in remote areas. According to the participant "*I think primary health care is the health care that is provided to the people at remote areas. The treatment of minor illnesses, growth promotion."* Primary health care refers to the immediate health care service individuals come into contact with the health system, that brings the health care closer to the people or community. It takes into consideration all the services in the community that support the everyday health needs of the community at every stage of their life (Government of Alberta 2018: [Sp]).

In the view of Osahon (2017:1) primary health care (PHC) is the most important health care delivery system, which allows seamless access to health by the community anywhere around the world. The Canadian Nurses Association, (CNA) (2015:1) posits that Primary health care (PHC) is a concept and approach which forms the basis for advancing the health of the people and the effectiveness of health service delivery in all care settings. Furthermore, White (2015:3) defined primary health care as the most important health care which is made accessible to the community at a cost that is sustainable by the country, with methods that are practical,

scientifically sound and socially acceptable. All citizens in the country should have access to primary health care and be involved in it, as should other sectors of society. This should include community participation and education on existing health challenges, health promotion and disease prevention, provision of adequate food and nutrition, clean water, good sanitation, improved maternal and child health care, family planning services, prevention and control of widespread diseases, vaccination against preventable diseases, appropriate treatment of common diseases and injuries, and provision of essential drugs (White 2015:3). Although these definitions are from different sources, they are diverse and analogous in presentation of what primary health care means. From the above definitions and explanations of primary health care from various authors, the researcher argues that, this supports the sub-theme diverse and analogous interpretations the participants provided for what primary health care means to them.

Sub-theme 1.2: Existing PHC services commended.

Participants commended the primary health care services the health care facilities provide to the communities. One participant holds the view that the communities enjoy their services. For example, the participant said "*They enjoy when they come here because at their places, they do not have them there."* The participant went on to say that "*the village folks enjoy coming here but the urban communities don't like coming here."* The participant further explained that "*We [the health facilities] have many outreach sites. Every area has outreach centre. Because of the service they give them they come. They like what we give them. They [patients] have outreach centres but they say when they go, they do not get chairs to sit on so they come here."* A second participant said "*I would give it 6 out 10 because we have a lot to cover."* Another participant sees primary health care services as good. This is evident in the participant's statement "*I would describe it as good."* A third participant ranked phc above average. The participant stated *"I would give 6 out 10."* Another participant also rated phc 8 out of 10. The statement "*I would rate it 8 out 10"* supports the commendation from the participant. One of the participants who said *"It [primary health care] is poor"* rated phc above average. This is evident in the response "*I would rate phc here 6 out of 10".*

Some of the participants see the primary health care as not doing bad at Kasoa rural communities. One participant said in a response that "*I would say it is doing well. Because I see the community visit this facility. We also have referral services so we refer patients to the*

higher health facilities for some advance care". The participant further said "*I would rate phc 6 out of 10".* Another participant also said that "*it [primary health care] is going on well. They [nurses] have been going on outreach from time to time. Once a week. Sometimes twice a week. They go for school health services too. And those in the communities too access their services. They have been going to their vantage points".* This was corroborated by a participant who said "*in my opinion in Kasoa area here I think phc is good. When you are from your house you see the health centre. Phc here is good."* The participant went on to add that "*when you come, they [patients] do everything. Dressing, antennal and stuff".* The excerpts from the in-depth individual interview transcripts support the sub-theme that, the participants commend the primary health care in rural communities in Kasoa.

Sub-theme 1.3 Outline that PHC's meaning associated with affordable and accessible service

According to Stellenberg (2015:1) research findings, affordability and accessibility may determine how the community members utilise the health care services. Accessibility is not just the distance an individual must travel to reach the health service point but more so the utilisation of these services. Strasser, Kam and Regalado (2016:1) concluded from their research findings that primary health care takes into account accessibility to the health care system; accountability to provide care that meets the overall health needs of the people; coordinated and integrated care that deals with disease prevention, focused care, and the treatment of chronic illness and mental health issues; and the establishment of lasting relationships among health care providers, clients, and the larger community. Scheffle, Visagie and Schneider (2015:10) also identified a well-developed systems and organisation of services can create accessible, affordable and available primary health care services, but do not automatically translate into satisfactory and acceptable services. Primary health care as associated with affordability and accessibility is evident in the research findings and is reflected in the participants narratives. For example, one of the participants said "*Well, I would say it [PHC] is the health care that is provided as first point of care to particularly people at disadvantaged communities. This should be 'affordable and accessible'*. A second participant agreed with this and said primary health care should be affordable and accessible. The participant's view regarding this was expressed in the excerpt of the transcript "*It should be affordable and accessible".* A third participant beliefs that primary health care should be accessible. This is

evident in the statement "*Phc must be made accessible to all"*. Another participant shares in the views of the other participants and expressed the view that "*I would say that primary health care is the health care that is provided to clients at their door step and should be affordable, accessible and involves the community participation"*. One of the participants expressed the view that the introduction of the National health insurance has made the health care in the community affordable. According to the participant "*It [phc] should be affordable and accessible. Here it is affordable because we accept the NHIS so people do not pay for any service we offer".* To improve health care and guarantee universal access to basic health care services to all the citizens and non-citizens of Ghana, the government of Ghana initiated the National Health Insurance Scheme (NHIS). The scheme allows individuals to make contributions into a fund so that when they are sick, the contributors could be supported by the fund to access affordable health care in the health facilities (Dalaba et al 2017:1). The CHPS concept was also conceived primarily to make health care accessible to the rural communities. Dalaba et al (2017:1) explained Community-based Health Planning and services as the kind of health care delivery where low cost of health care services and adequate basic quality of health care are delivered to members of the communities where they live through engaging them in the planning and delivery of services. The researcher could infer that the introduction of the CHPS concept and the NHIS contribute to the affordability and the accessibility of phc and therefore, the participants views of primary health care that it should be affordable and accessible has evidential literature.

Sub-theme 1.4 PHC meaning coupled with Health professionals involved and type of care provided

Some of the participants related phc to the types of professionals who are working in the given health care facility. For example, one of the participants said "*When we say primary health care, the types of nurses that come to mind are the community health nurses because they are close to the rural areas and they deal with patients from the rural areas"*. A second participant also said that "*You know phc involves reducing child and maternal deaths so we organise*

antenatal services. When we go to home visits, we talk to them about the importance of ANC visits and the need to give birth in the hospital and reproductive and child health. We do minor treatment here". A third participant view phc as "*phc is like the treatment of minor illness. The preventive is more than the curative. There are certain thing things we don't do"*.

On the contrary, Galavote, Zandonade, Garcia, Freitas, Seidl, Contarato, Andrade and Lima (2016:1) in their research findings highlighted a distinguished role of the professional nurse in the primary health care service, stating the need to expand the scope of practice of professional nurses in primary health care to include administrative activities. They concluded that the inclusion of nurses in primary health care staff has led to new models in the care production with a new standard for the production of care, which has not simply changed the mode of organisation of the production process, in conformity with the interests of capital, but reverses the core of the care's technology. The researcher agrees with the opinion expressed by the authors above that there should be the expansion of the roles of the nurses who are engaged in phc at rural communities (CHPS) as well as in urban centres. This, the researcher beliefs would boost their confidence and help address some of the bottle necks in health care delivery at the rural communities. The work by Galavote et al (2016:1) also sought to underscore the need to expand the activities of primary health care nurses and therefore, the views of the participants that minor roles and preventive care are limited to primary health care nurses is contrary to the opinion held by Galavote et al (2016:1).

Sub-theme 1.5 PHC associated with promotion of health, self-care abilities and management

Practitioners in health promotion point to the advantages of including different relevant settings and stakeholders in the intervention target group to promote competence-based, action-oriented, sustainable health and to avoid serious health inequalities .Promoting health across many settings, and thereby increasing the complexity of strategies, also increases the demand for complexity-oriented means of understanding, explaining and organising the ways in which outcomes are processed, managed and implemented (Grabowski, Aagaard-Hansen, Willaing & Jensen 2017:1). The participants view health promotion at some rural communities in Kasoa as not good. This was confirmed by one participant who said that "*their [rural community] phc is poor, it is not good, it not encouraging… Health promotion is not good there".* Some of the participants also view phc as involving health promotion as well as curative health. This is

evident in what one of the participants said about primary health care "*It also involves some curative care too, health promotion".* The participant proceeded to explain health promotion to mean "*health promotion is about giving health education to the people about the importance of their health and things they should do to prevent illness and promote good health. It also deals with giving information about nutrition, sanitation etc."* However, another participant also thinks that health promotion functions of some nurses are not well undertaken. This is evident in an excerpt of the participant "…*there should be health promotion by the community health nurses about the importance of vaccination, the prevention of diseases, personal hygiene. The community nurses are supposed to do this but some of them don't do this".* Another participant also beliefs that health promotion is not going on well at the rural communities. This is evident in the statement "...*for the health promotion I think it is not going on well. Sanitation is a major concern. Everywhere at Ofaakor is dirty. The place smells. Even this area is dirty how much more the villages".* In the current health care environment, health promotion and disease prevention are seen to be effective ways to improve care and control rising health care costs (Dombrowski, Snelling & Kalicki 2014:1). Health promotion has been part of nursing practice since the days of Florence Nightingale. In the current literature, health promotion is an important part of the nursing roles (Kelley & Abraham, 2007; Mooney, Timmins, Byrne, & Corroon, 2011; Whitehead, 2008) as cited in Dombrowski et al (2014:1). Although health promotion is thought of as primary health care strategy for improving the health of the people, the views of the participants regarding health promotion contradict the existing literature about health promotion.

4.3.2 THEME 2: Existing challenges experienced during provision of PHC services

The thematic data analysis revealed that the participants experience some challenges in the course of their primary health care duties. This theme has eight sub-themes describing the challenges experienced by the participants.

Sub-theme 2.1: Lack of good sanitation, inadequate clean water supply associated with development of various diseases.

One of the participants said the sanitation situation in the community is bad and that drives away some the family members. This is evident in the statement "…*Even here is not neat how much more the whole of Kasoa? People in my house say they will not come to the Kasoa*

polyclinic because the place is not neat. Sanitation is a real problem". A second participant corroborated this when the participant said "*We can talk about the poor sanitation and even infrastructure".* A third participant also said "*We see poor sanitation condition in Kasoa. The community lacks potable water supply. I say this because I know they are part of primary health care".* A forth participant also sees the poor sanitation situation in the rural community as challenging and needed to be attended to. This is evident in the statement of the participant that "*they should let them know the effect of poor sanitation. The biggest problem is sanitation. And then make potable water available. I think the sanitation is the major issue. Because if they are sick and you treat them and they go and live in poor sanitation, they will get sick again".* According to the Swedish International Development Cooperation Agency (2015: [1]) access to clean drinking water and good sanitation is crucial, not only for people's health and wellbeing, but also for poverty reduction and economic growth. The UNICEF (2016:2) also state that among the component parts of a healthy primary health care (PHC) centre's environment are improved and adequate water, sanitation and hygiene (WASH) facilities. The adequacy and quality of these facilities are medical requirements that are essential for effective and efficient healing in the PHCs. In view of these existing requirements by the authors, the researcher agrees with the participants that the sanitation situation in Kasoa and rural communities is affecting phc delivery in Kasoa rural communities and therefore needed attention from policy makers in order to make the PHC a fully functional health care approach in improving the lives of the people.

Sub-theme 2.2: Poor infrastructure, shortage of financial, material and human resources, a challenge to PHC service delivery.

According to Saikia (2014:84) a well-developed health care structure plays an important role in determining good health of the people of a country. However, the health care infrastructure in India is not well developed and, in many respects, India's health care infrastructure is similar to the poor health care infrastructure in developing countries like China and Sri Lanka (GOI, 2012) as cited in Saika (2014:84). Similarly, the thematic analysis of the participants' transcripts revealed poor infrastructure as one of the challenges that confronts primary health care in rural communities in Kasoa, Ghana. This is expressed in what one of the participants said: "…*We can talk about the poor sanitation and even infrastructure. For example, when you come to this*

facility, we have to get proper windows to prevent vectors from trespassing. We have so many mice around. The vectors are not supposed to be living with us. This is why I said poor environment. And what is causing this is because we are lacking the proper infrastructure". A second participant also viewed the lack of logistics as a challenge in phc in the communities. This is evident in the verbatim transcript "…*sometimes too we face logistical supply challenges. Whereby the lack of these supplies affects our work as phc providers".* A third participant also sees the lack of adequate infrastructure as affecting patient privacy. For example, the participant said that "*we do not have enough separate wards so their privacy is not very much guaranteed. There are even times kids are brought here".* This is supported by a forth participant who said that "*there are times when the place gets congested, both males and females are brought here. I do not think this is good phc practice. No privacy is assured".* Another participant also sees staffing issues as among the challenges affecting the work they do as phc providers. This is confirmed by the response "we *have staffing issues too. Less staff is affecting our work",* of the participant. The sub-theme is confirmed by another participant who responded that: "…*we lack some basic supplies to work with. We have staff shortage. We expect the visiting of other health professionals to complement our work but this does not happen".* According to Adepoju, Opafunso, Lawal and Ajayi (2017: 65) challenges hindering health care delivery in selected primary health care facilities in South West Nigeria included inadequate staff, inadequate medical equipment, poorly motivated staff, lack of basic health facilities, unavailability of drugs, poor investment in the health sector and cultural beliefs. However, Chinawa (2015:1) in another study also found out that, adequate supply of basic working items such as gloves, needles, bandages, good access to drugs and medications, a good cold chain system, and full implementation of immunization programmes all exist in PHC centres despite existing equipment and manpower, job security and salary being the challenges in the implementation of PHC. These findings support the sub-theme revealed by the thematic analysis that inadequate supply of logistics hamper the implementation of primary health care services. The findings by Chinawa (2015:1) also revealed that although the supply of adequate logistics may be in place at primary health care facilities, health care providers are still faced with the challenge of salary and job security.

Furthermore, Makwero (2018:3) holds the view that ensuring adequate and proper infrastructure for primary health care facilities and improving access is not enough. Therefore, countries need to commit investments in improving the quality of primary health care,

integrating health facilities and community-based teams, and also consolidate community participation. In view of this relevant literature, the researcher agrees that health care authorities should ensure both the development of health care infrastructure and health systems development at rural communities and also provide motivation packages to the health care providers (nurses).

Sub-theme 2.3: Negative treatment and abuse of nurses by community members affect service delivery and communication.

According to the participants, some of the community members abuse them when they visit the facility.

According to Burke (2016:1) violence, bullying and ill treatment of nursing staff are well known and keep occurring in health facilities. Each of these negative treatments have been shown to have negative impacts on nurse job satisfaction, job performance, quit intentions and psychological and physical health. Most victims are unsure of the best means to respond to these encounters. Sources of each include patients, families of patients, doctors, supervisors and colleagues. Thematic analysis of the verbatim transcripts revealed there are negative treatments of the nurses by some members of the community who visit the health care facility. This became evident when one of the participants was asked: "But do you encounter clients trying to abuse you", the participant responded that "*A lot. They have a problem with the hospital bill. When you tell them to buy drugs, they think they are paying a lot. They do not acquire health insurance. There are times we have to call administration to come in and settle the disputes".* A second participant also said that: "*There have been times that clients abused providers".* Another participant also said it is difficult communicating with some of the patients who visit the facility. This is confirmed in the statement "*It is difficult explaining things to people who are illiterate here and this sometimes results in conflicts here".* A forth participant also corroborated this and said that "*Language barrier is a challenge. Some times because you cannot speak Hausa you are forced to get an interpreter to assist in communication. Sometimes the interpreter will not say exactly what you intend to tell the patient and this leads to conflicts which affects my work as a nurse".* Workplace violence is a serious social and public health problem and there is a need for measures to be put in place to protect nurses and provide violence free workplace environments (Fisekovic, Trajkovic, Bjegovic-Mikanovic & Terzic-Supic 2015:693). Sisawo, Ouédraogo and Huang (2017:1) found that nurses in the Gambia are at a

comparatively higher risk of violent occurrences at work in their study. Quite a greater number of their study respondents (62.1%) reported having been assaulted before at work. These included exposure to verbal abuse, physical assaults, and sexual harassment and was 59.8%, 17.2%, and 10% respectively. Those who ill-treated the nurses included those who accompanied the patients or relatives of patients, patients themselves sometimes assaulted the nurses. Some of the reasons that led to negative treatment of the nurses were mainly attributed to nurse-patient disagreement, inadequate staff, shortage of drugs and supplies, absence of security, and apathy on the part of management to workplace violence. This existing literature confirms the experiences the nurses go through in the course of their nursing duties as expressed in the transcripts of the participants.

Sub-theme 2.4: Lack of money and transport affect adherence to health instructions by clients and patients

The participants revealed that some of the patients do not go to referral centres due to the lack of money. This is evident in what one of the participants said, "*Some of the patients do not go to referral facilities for fear of paying high or exorbitant bills".* A second participant also said that: "*Some of them do not even go when we refer them due to financial constraints".* A third participant also said: "*. I see poverty as some of the causes why some of the community members refuse to come to us because they think we will charge high fees".* A forth participant also beliefs that the lack of money causes some of the community members to practice self-medication. This is evident in "*Some stay home until sickness deteriorates. This is partly because of the poverty level in the community and so majority of them do self-medication". "Due to the poverty level here, some of them do not have NHIS cards and so they do not come to seek health care. Some of the patients do not go to referral facilities for fear of paying high or exorbitant bills",* said another participant. Another participant confirms this when the participant expressed the views as "*Most of the people are poor and so cannot afford the medicines that are not covered by the NHIS".* The lack of money and transportation challenges is further supported by another participant who said that "*Some of the patients come from cottages and so even the money for transportation to this place is a problem. Some drugs too are not covered by the health insurance and the patient has to pay. So financial constraint is making phc difficult here".*

According to Atuoye, Dixon, Rishworth, Galaa, Boamah and Luginaah (2015:1) the unavailability of reliable transport services is defeating the expected positive impact of CHPS on maternal and child health (primary health care services). This literature confirms the perceptions expressed by the participants. However, Atuoye et al (2015:1) concluded that it is necessary for a policy initiative to address rural transport problems in order to improve maternal health. This may be the introduction of a community-based transport strategy with CHPS to improve adherence to referral and access to emergency obstetric services. This conclusion supports the views expressed by the participants that the lack of transport is among the challenges of phc in rural communities in Kasoa.

Aryeetey, Nonvignon, Amissah, Buckle and Aikins (2016:1) assessed the impact of the introduction of the NHIS on health service delivery in mission health facilities in Ghana and concluded that the implementation of the NHIS saw improvement and expansion of services resulting in benefits to the facilities as well as constraints. This research finding suggests that the introduction of the NHIS expanded access to health but the revelations from the participants suggests that the lack of money denies some community members from accessing phc services because they are unable to acquire the NHIS and thus, this challenge is perceived to be affecting phc in rural communities.

Sub-theme 2.5: Lack of adherence to health instructions by patients and clients affect expected health outcomes

According to one participant, relatives of patients do not adhere to visiting hours and thinks that the practice does not only affect them as nurses but also affect the health of the patients. This is evident in what the participant said: "…*When you are working on someone's relative, their relatives do not follow the visiting hours. They do not know what visiting is. We referred a patient yesterday but they just came this morning. So, with this I cannot give good. I can somehow say illiteracy is reason or even if it is not illiteracy they pretend not to know".* Another participant also thinks that some of the religious beliefs of the patients/clients is a leading factor why some do not adhere to health instructions. This is revealed in the responds "*Some churches too do not accept blood transfusion procedures so even if as a midwife you think your clients need blood due to low haemoglobin in pregnancy, you are reluctant to advice because some of the*

pregnant women would not go for the transfusion because of their religious beliefs." A third participant also confirmed this when the participant said that "*Most of the pregnant women stay in churches during their entire pregnancy period. They belief it is a blessing to give birth at church than the clinic. They only come to this facility when they are due to deliver so they get ANC book. When you refer them, they do not go".* A forth participant also expressed the view that some pregnant women do not desist from unhealthy practices that affect the unborn child. This is evident in the verbatim transcript of the participant who said that: "*As a general nurse, I do midwifery too. Sometimes when you go to the labour wards the women are not supposed to do enema, they mix concoctions and do enema before they come for delivery. We tell them to desist from such practice but they tell us that their mothers did enema and made the baby strong. This practice affects the unborn baby. They also mix concoctions and cow dung and smear it around the umbilical stump. They claim it will hasten the healing process. This causes infections to the child".* The researcher identified these narrations as supporting the sub-theme that the patients do not adhere to instruction and which affect health outcomes.

Sub-theme 2.6: Possession of Health Insurance determines accessibility to best PHC services

According to Garba and Ejembi (2015:1) the National Health Insurance Scheme (NHIS) in Nigeria was implemented in 2005 to ensure universal access to good health care services, by protecting families from financial barriers to health care, and ensuring availability of funds to the health sector for improved services. Aryeetey et al (2016:1) argue also that Ghana is one of the countries in sub-Saharan Africa to roll out the National Health Insurance Scheme (NHIS). The analysis of the narrations of participants revealed that the NHIS provides accessibility to phc services. This was evident in what one participant said, "…*In this facility patients who come from rural communities and are holding NHIS cards receive health care free".* On the other hand, some of the participants say that due to the lack of funds/ poor living conditions of the community folks, they are unable to obtain NHIS cards which would afford them better health care. One participant said that "…*they don't come to the CHPS even though we have the CHPS compound. When you ask them, they say they don't have money. Some of them cannot pay to obtain the NHIS. Some people too when they go for the NHIS card they tell them they should go and come sometime or the cards are not available. Even some pregnant women don't come at all, they give birth at home. They don't come for check-up. Some have NHIS but they still*

charge them even at the CHPS". Though the possession of the NHIS card affords the patients the best health care services, there are inherent challenges which the participants acknowledge. Another participant expressed this when the participant said "*At the CHPS level some drugs are not covered by the NHIS".* This was corroborated by a second participant who revealed that the patients prefer visiting private facilities due to the lack of confidence in the CHPS. According to the participant "*the reason is the drugs. With the CHPS compound we have some drugs we serve and in Ghana most people use the NHIS and at the CHPS zones we don't give antibiotics and so if at the CHPS zones you write antibiotics for them to go and buy or they have to pay, they don't come again because they possess health insurance. So, they will go to the private facility or the government hospitals where they would give it to them free so they won't come to the CHPS compound. When you are giving antibiotics at the CHPS they have to pay."* Some of the participants also view the affordability of phc services as due to the NHIS. According to the participant "*. The phc we offer here is affordable and this is due to the insurance [NHIS] policy."* According to Kotoh, Aryeetey and Geest (2018:1) people enrolled and renewed their membership because of NHIS' benefits and health providers' positive behaviour. Fenny, Asante, Arhinful, Kusi, Parmar and Williams (2016:1) also emphasise that the NHIS provides a workable policy tool for increasing access to healthcare through an emphasis on social health protection. These research findings support the sub-theme that the possession of the NHIS card determines the accessibility to the best phc services. The challenge however, is that at the CHPS, the possession of the NHIS cards does not necessarily guarantee the best primary health care services as one has to pay for antibiotics at the CHPS.

Sub-theme 2.7: Misconceptions, cultural and religious beliefs interfere with PHC services expectations

The role of churches and other religious bodies in primary health care delivery in Africa's poor contexts is widely known. The discourse regarding the churches' and other religious institutions' role in health focuses on the spiritual aspects and tends to overlook the physical aspects. This challenge and gap in the activities of religious bodies in primary health care is mainly due to the absence of coherent strategies and approaches to determine the efficacy of the interventions. This calls for the re-examination of the roles the religious bodies play in the provision of primary health care (Magezi 2018:1).

Berglund and Lindmark (2016:1) acknowledge that Maternal health (primary health care service) status before pregnancy is the positive outcomes of pregnancy and could also be a risk factor for maternal and infant complications. Still, maternity care does not start until the pregnancy is established and in most low-income settings not until more than half of the pregnancy has passed, which often is too late to impact outcomes. According to the participants, misconceptions, cultural and religious beliefs interfere in the provision of some primary health care service like family planning.

This is evident in an extract of one participant who argues that "*I see religious beliefs as one of the challenges we face. Some Muslims do not allow their wives to do family planning. Some women say to us, when they do family planning, their husbands would divorce them and marry another woman."* A second participant also said that "*Some also belief in their gods. When they stay here for 4 days and they do not get well, they leave to their gods. I think religion is affecting our work."* A third participant also beliefs that "…*They [some Muslims] belief in the Quran than anything else. They do not belief in health issues as compared to the way they belief in the Quran. They think their religion supersedes health so even when you come and tell them about their health some will not mind.".* A forth participant also argues that "*Certain Christians do not do family planning; some tribes avoid family planning because they think you have to give birth to as many children as you can. Some Christians too do not accept blood transfusion. They belief the blood belongs to the person and no blood is supposed to leave one person to another person. People are so much dedicated to their religion than health."* A fifth participant further explains that the religious beliefs of the community folks is among the challenges they face as nurses in phc services. This is evident in the extract of the transcript: "*Their cultural beliefs too I think it is something we can talk about. For example, some women say their beliefs forbids them to have few children so they do not want to do the family planning".* Other participants belief that the misconceptions about family planning is hindering family planning practices. For example, the participant said "*They have some misconceptions about family planning so some of them refuse when you advise them to do family planning. They are told by quark personnel that they would not be able to give birth again if they do family planning."* Another participant also said "*Some faith-based organisations do not encourage some health care practices like blood transfusion and family planning. This is in part due to the misconception that has been thrown out there by non-health care workers who are selling herbal concoctions to them. Due*

to their illiteracy too, they belief in the stories they tell them. For example, they are told that if you do family planning you will be sick and even get fibroid. This puts fear into them so some do not patronise the practice." According to Gueye, Speizer, Corroon and Okigbo (2015:191) negative myths and misconceptions about family planning are a barrier to modern contraceptive use. This literature is supported by the findings of the analysis which revealed that cultural and religious beliefs and misconceptions affect health expectations. However, according to Aniwada, James, Uchenna, Ekuma and Kelechi (2017:1) high percentage of respondents from their study were familiar with family planning and believe that it is important. However, few respondents agree to the negative implications. Understanding the myths and misconceptions about family planning will greatly influence the knowledge and perceptions as well as bring about behavioural change on family planning with increased uptake. The study by Gueye et al (2015:191) supports the opinions expressed by the participants that misconceptions, cultural and religious beliefs interfere with primary health care services in rural communities in Kasoa. Aniwada et at (2017:1) stressed, education as a way of explaining the benefits of family planning (a primary health care intervention) to the rural communities to increase their patronage of the service.

The research by Magezi (2018:10) revealed that, viewed from a PHC perspective, churches and other religious institutions in Africa play a critical role. The impact of this role was demonstrated by reported experiences of the church and community members on the situation before and after the Salvation Army's intervention. The researcher however, holds the view that, though some religious beliefs and myths interfere with primary health care intervention outcomes, activities of religious bodies in Africa contribute to improving the health outcomes.

Sub-theme 2.8: Poor implementation of decentralised PHC services observed

According to Abimbola, Olanipekun, Igbokwe, Negin, Jan, Martiniuk, Ihebuzor and Aina (2015:2) decentralisation is an administrative system of governance in which the power, authority, resources, and responsibility for PHC service delivery are transferred from a central government to actors and institutions at the local level. With the governance closer to the people, this transfer of responsibilities allows for local initiative, input, and control.

This existing literature contradicts what the participants perceive at rural communities in Kasoa in terms of primary health care delivery. The data analysis showed that primary health care is

properly decentralised in Kasoa. This is confirmed by one participant who said that "*I think the CHPS helps a lot in the community because they are first point of contact before other higher health facility but some things are impeding their work. Example the inadequate funding regime for the CHPS, they lack even some drugs, gloves etc. We are focusing on urban health care and abandoning rural health. I also think the decentralisation programme is not well implemented. Drugs, instruments, gloves all come from the central medical store."* A second participant thinks that the poor implementation of PHC services is affecting the delivery of phc at health centres. The participants suggested that "*I would suggest that the supply and logistics aspect could be decentralised so that we can easily get items when they are out of stock".* The poor implementation of the CHPS (a decentralised concept of PHC) makes some of the community see the CHPS as a hospital and assume the facility should be treating all kinds diseases. One of the participants confirmed this when the participant said in a response that "*The community do not understand the concept of the CHPS compound. They see it as hospital so they expect you to treat almost every sickness they present to you. I also think the CHPS concept has not been fully implemented".* A second participant corroborated this view and argues that "*They think because the building is here there must be someone here and they have to get everything they know they will get from hospitals here".* The participant further suggested that "*The ministry/directorate should at least once a year come through durbars to educate them about the CHPS and it will also help."* The research shares in the views of the participants that if the decentralisation regime is better implemented the community would not expect advance health care at the CHPS since the CHPS is basically for preventive health care as expressed by one participant who said that: "*The primary purpose of the CHPS was not for curative purposes, it was for preventive purposes but they [community] don't see it like that so when they come and they don't meet anyone they will be angry".*

The findings of Seshadri, Parab, Kotte, Latha and Subbiah (2016:1) revealed that there is a need for extensive capacity building at all levels of the health system to genuinely empower functionaries, particularly at the district level, in order to translate the benefits of decentralisation into reality. The literature supports what some of the participants expressed that proper decentralisation strategies will lead to the maximisation of health outcomes in rural communities. However, Bossert (2016:1) found that decentralisation in Fiji, India shows that increasing the capacities of the local people is not necessarily related to increasing the

decision-making capacities of local authorities, and which contradicts previous studies in Pakistan. And, therefore, recommended that future studies should seek to resolve the relationship among decision space, capacities, and health system performance. The researcher opines that as authorities in Kasoa and other health care managers seek to improve the decentralisation in primary health care, measures should be put in place to increase the decision-making space of the local officials.

4.3.3 THEME 3: Views and perceptions related to PHC provided

Based on the participants' interpretations of primary health care and the challenges enumerated by the nurses, the analysis yielded the theme that gave the views and perceptions of primary health care provided in rural communities in Kasoa. This theme has five focus or sub-themes that describes the views and perceptions of the nurses.

Sub-theme 3.1: PHC services viewed as satisfactorily with minor challenges that could be addressed.

The sub-theme revealed that the primary health care is satisfactorily. This is evident in the excerpt of one of the participants who said that "*I would give it 5 out of 10. There is more room for improvement. Our CHPS do not have compounds. The nurses stay at their places and when it is time for outreaches they go. The CHPS live in rented apartments. They are not designed based on phc concept."* A second participant also thinks the lack of logistical support forces them to refer patients to other facilities and thus, the participant perceives the phc as satisfactorily. This is expressed in the extract: *"We do have logistics challenges. So sometimes we have to refer patients due to the lack of the apparatus",* the participant proceeded to say that "*I would give 5 out 10."* A third participant in a response said that: "*The sanitation is bad and nurses too do prescribe. There is no patient privacy here. We use same table for almost everything from vitals to point of care testing like haemoglobin estimation and even malaria RDTs. The place is small so we have issues of congestion".* The participant proceeded to say that "*I would give 5 out of 10."* A forth participant perceives the phc as below average owing to the fact that "*Even weighing books are inadequate and antenatal mothers do not get them. They always prefer the private facilities to us. You as nurse too you cannot use your discretion to buy some and sell for them. it is illegal ". "I would give it 4 out of 10."* The participant said.

Furthermore, a fifth participant description was "*Our logistics are most of the times out of supply and so it affects our work. Our structure is small so there is no privacy here. We have staffing issues. Our staff strength is small. The staff live in the health facility [CHPS] creating inconvenience for the staff. This lowers staff morale. Our skills too are not up to date so that we can handle emerging health challenges."* "*I would rate it 4 out of 10."* The participant rated the phc in the rural communities. On the contrary, other participants view phc as above average. For example, one of the participants said that "*There are times when the place gets congested, both males and females are brought here. I do not think this is good phc practice. No privacy is assured. We have staffing issues too. Less staff is affecting our work. We do not perform surgery here. For example, caesarean section so pregnant women are referred to higher facility. I think if we have a theatre this could be done here. We also have supply and logistics challenges here. There are times that we lack basic consumables like gloves."* On the issue perceptions, the participant described it as above average when the participant said: "*I would rate phc 6 out of 10."* A second participant description was "*The community lack clean drinking water supply and I think since water is key in phc, its absence affects the health of the people living in the communities we serve. I am also aware of the distribution of treated mosquito nets but some of them use for farming. They say it gives heat when you sleep under it. I would rate phc here 6 out of 10."* The participant stated. The challenges identified by the nurses included: Lack of good sanitation, inadequate clean water supply associated with development of various diseases; Poor infrastructure, shortage of financial, material and human resources a challenge to PHC service delivery; Negative treatment and abuse of nurses by community members affect service delivery and communication; Lack of money and transport affect adherence to health instructions by clients and patients; Lack of adherence to health instructions by patients and clients affect expected health outcomes; Possession of Health Insurance determines accessibility to best PHC services; Misconceptions, cultural and religious beliefs interfere with PHC services expectations; Poor implementation of decentralised PHC services observed.

Sub-theme 3.2: Health education and patients' rights provided at PHC facilities viewed as helpful in achieving health outcomes

According to WHO, each country should design its own patients' charter, which must include the rights and responsibilities, in relation to the cultural and social needs to promote and support patients' rights (Masood, Mahmood-ur-Rahman, Mahmood, Nisar & Mohsin 2016:651).

With regards to health education, one of the nurses said health education is done every morning at the facility where they work. This is confirmed in the extract "*We do them every morning. Here is RCH so every morning we do them. every day and its topic. And the clients understand the education we give them. We do education of family planning, even we give them education on the weather, vaccination, the importance of breastfeeding."* A second participant also thinks that the health education will be helpful if done by prescribers and also at th OPD. The participant expressed this view when the participant said that "*I think health education should be more particularly at the OPD since it the entry to the health facility. The doctors too do not tell them [the patients] their disease conditions so sometimes they come here and ask us about the conditions or what is wrong with them".* On the contrary, a third participant thinks though the health education is helpful, some community members do not take it seriously. This is evident from the extract of the interview transcript "*the health education in the community is low. Due to high illiteracy rate, the community members do not see the need to participate in health talks."* Another participant also said "*We have established urban centres that do the health education at schools and the community health nurses who are at the CHPS visit clients during home visits to follow up if clients are abiding by health advise."* Another participant also said that patient rights and responsibilities are displayed but patients are unaware of them. This is evident in the response "*. In this facility I know patient education is done every morning. However, patient rights and responsibilities are available but patients are not aware of them."* Furthermore, some of the participants belief that the health education through the outreach programmes encourages the patients to visit their facilities. This is expressed in what the participant said "*We have many outreach sites. Every area has outreach centre. Because of the service they give them they come."* Fasoranti and Adeyeye (2015:225) explain health education to mean the training and learning strategies which are health related and are designed to help the people and communities improve their health, through the acquisition of knowledge or influencing their attitudes towards issues about their health (WHO, 2008; Johnson, 2010) as cited in Fasoranti and Adeyeye (2015:225). In the study to assess the role of health education as means for effective primary health care services in Nigeria, Fasoranti and Adeyeye (2015:227) concluded that health education at rural communities is likely to create

awareness of health problems and solution which will in turn create more accessibility and participation in PHC programmes. The research by Masood et al (2016:651) to determine the level of awareness among patients on admission at hospitals about their rights to health care found that most of the in-patients are unsatisfied about the level of awareness. Although, majority had good knowledge of right to informed consent but had little knowledge of right to decision making about their treatment. In view of their conclusions, the researcher identifies with the sub-theme obtained by the analysis that health education and knowledge of patients' rights and responsibilities will lead to better health outcomes as perceived by the research participants. Therefore, patients' awareness of their rights through patients' health education and health promotion strategies will improve health expectations in primary health care.

Sub-theme 3.3: Provision of outreach services seem to be acceptable to communities

According to the participants, the community has accepted the outreach programmes they embark upon. This is evident in what one participant enumerated: "*They have been going on outreach from time to time. Once a week. Sometimes twice a week. They go for school health services too. And those in the communities too access their services. They have been going to their vantage points".* A second participant argues that the CHPS is helping in undertaking outreach programmes and this is helping. According to the participant "*Our structure is small compared to the people we serve particularly during post-natal visits and market days we do have congestion problems. This affects the patience privacy. But I think the CHPS is helping in some way because of the school health and the home visit outreaches they do".* A third participant also views that the outreach programmes have been accepted by the community. This is evident in a response of the participant when the researcher asked "*Where you went, do you think the community is accepting you?"* The participant responded "*yes they are! because they always come there before we get there. I think they are utilising our services.* Another participant also holds the opinion that because the community has accepted their outreach programmes that is why they visit the health facilities. This is expressed in the extract "*Sure! The community has accepted us. If they have not, I do not think they would come here. They really belief in the care we give".* According to Nxumalo, Goudge and Manderson (2016:69) the activities of CHWs have the likelihood to fill the gap which neither nurse professionals whose roles are usually facility based, and community or family members are unable to fill through outreach programmes. They [CHW] are better placed to create social

capital and social networks within the communities in which they operate, including trust, which they can leverage to connect householders to resources in a way that facility-based health professionals cannot. On the basis of this conclusion by Nxumalo et al (2016:69), the researcher could infer that outreach programmes by community health nurses and community health workers is an acceptable way of reaching out to community members and addressing their health needs as narrated by the participants.

Sub-theme 3.4: Existing referral system at PHC facilities well-structured, clear and acceptable

According to Ghana's Ministry of Health, majority of the people do not utilise existing referral system due to the lack of knowledge about it or low perceptions about the policy (Amoah & Phillips 2017:2). This is true in the case of rural health care in Kasoa and is revealed by the narratives of the participants. There is the existence of a well-structured referral system but it is underutilised by the patients. This is evident in what one participant said: *"There are many times when you refer patients to higher facilities, they do not provide feedback".* A second participant also views the Polyclinic as the main referral health facility in Kasoa, for example, the participant said that "*Here serves as their main source of health care facility although we have minor health facilities around but they refer their cases to this place and if we think we cannot manage them we refer them elsewhere".* A third participant also argues that due to the lack of some facilities/equipment, they refer some cases which are brought to the Polyclinic. This is evident in the extract: "*when the patient needs to be operated on, we just need to refer them to higher health facility."* Also due to the lack of ambulance at the health facilities, the well-structured referral system is not properly implemented at some health facilities. The participant said that "*Some of the nurses do not call for ambulance for the patients. They let the patient call for the ambulance themselves. I think this is not helping the referral processes because it is part of the nursing we do".* The patients themselves do not abide by referral regime available and so it makes the referral system difficult. One participant expressed this frustration when the participant said that "*some of them [patients] go but some too do not go. When you call to find out they say that their grandparents are into herbal medicine so they went to them. That is why I said they belief in herbal concoctions or medicines."* A second participant corroborated this and stressed that "*We had a case where we referred a patient to a higher facility but she refused and rather said to us that she would visit her pastor rather."* A third participant was of the opinion

that due to fear of huge bills that the patient may incur or the fear of death, the patients refuse to go to the referral facilities when referred. This is evident in the excerpt "*Some of the patients do not go to referral facilities for fear of paying high or exorbitant bills. They have the misconception that when you are referred to a higher facility, it means you are going to die so they choose not to go."* The participants acknowledge the existence of referral policy in Kasoa and is expressed in the response of one participant "*We also have referral services so we refer patients to the higher health facilities for some advance care."*

In Ghana, patients accessing health at health care facilities in the country are expected to access services from primary services incrementally (example, the Community-based Health Planning Services, CHPS, and health centres), through secondary facilities (example, district hospitals) and if required to the highest services (regional and tertiary hospitals). The referral system exists to ensure efficient and appropriate use of health services to benefit both patients and the health care system (Amoah & Philips 2017:2). Their study to examine how the resources embedded in both organisational and perceptive aspects of social relationships influence knowledge of, and adherence to, referral policy indicated that both perceptive and organisational forms of social capital significantly contributed to the ability and willingness of people to abide by the referral processes in health care delivery. This finding agrees with the above sub-theme that there exists a well-structured referral health system. However, patients are not fully utilising it as revealed by the verbatim transcripts.

Sub-theme 3.5: CHPS zones viewed as helpful to provide PHC services

The CHPS is helpful as revealed by the thematic analysis. This is evident in what one participant explained as "*I think it [CHPS] is brilliant idea that government did. And I think it is improving health care because when we go to some CHPS compound they do minor curative there. Before maybe a particular disease or sickness may get out of hand the CHPS may have handled it at their level before they are transferred here."* A second participant also agrees with this explanation and added that "*We are doing the same as the CHPS compound. But the only difference is that the CHPS compound is restricted to certain things. They do not do surgery but we do it here. The main focus of the phc is based on the CHPS compound."* A third participant on the part said "*the phc in Kasoa is delivered through the polyclinics and the CHPS. Here serves as their main source of health care facility although we have minor health facilities around but they refer their cases to this place and if we think we cannot manage them we refer*

them elsewhere. So, I would say phc in Kasoa is through the CHPS zones and the polyclinic." A forth participant views the CHPS as helpful in phc delivery. The participant said that: "*I think the CHPS helps a lot in the community because they are first point of contact before other higher health facility but some things are impeding their work".*

According to Dalaba, Stone. Krumholz, Oduro, Phillips and Adongo (2016:1) Ghana in 2000 rolled out the Community-based Health Planning and Services (CHPS) initiative to ensure improved access to health and family planning services. The CHPS was based on the Navrongo Project, which was conducted in the Kassena-Nankana district (KND) between 1994 to 2003 which showed significant impact on fertility and child mortality. In their study to examine contraceptive perceptions in communities that experienced the Project's service models over the period, and after the implementation of family planning methods at the CHPS found that Community-based services, such as family planning caused the members of the communities to have a positive attitude towards family planning in a traditional sub-Saharan African setting. Continuous delivery of primary health care services that have improved the survival of children has made the use of contraception more acceptable. This exiting literature supports the sub-theme that explains that the CHPS is helpful in providing primary health care services like family planning as identified in the literature cited.

4.3.4 THEME 4: The participants identified and explained the various primary health care services that exist in the various health facilities.

This theme has four focus areas or sub-themes that were revealed in the data analysis.

Sub-theme 4.1: Explanation of various PHC services provided at the polyclinic outlined.

The participants identified and explained the various primary health care services that are delivered at the polyclinic. One participant was of the view that the primary health care is delivered by the CHPS compound whiles they the nurses at the polyclinic do advance health care. This is evident in the extract "*The main focus of the phc is based on the CHPS compound. But when it comes to the Polyclinic and the health centre, we are doing advance health care.* A second participant also said that the polyclinic undertakes some preventive health care services that the CHPS are mandated to undertake. This was reflected in what the participant said to the researcher in a response to the question "What about health education here?", the participant said "*We do them every morning. Here is Reproductive and Child Health so every*

morning we do them. every day and its topic. And the clients understand the education we give them. We do education of family planning.

The preventive services like reproductive and child health are free and even it does not require one to have the NHIS card. This was explained by a third participant and it is evident in the excerpt of the transcript "*If you have the insurance, you are free to go. Even at this place we do not use health insurance. Everything is free from weighing to vaccination. Unless your child is sick. RCH is free."* A forth participants also understand primary health care to include some preventive and curative health care services. Some of these include family planning, vaccination, school health and health education. According to the participant "*It [PHC] involves some preventive and curative services. Some services include family planning, health education, vaccinations, school health. It also involves treatment of diseases such as malaria, diarrhoea, etc. In this community I think PHC is doing well for example community members patronise our family planning services".* A fifth participant support this opinion expressed above by the forth participant. This is confirmed in the extract of the participant "*We also can talk about school health and family planning as some of the activities in phc. The urban centres have been established to do health education while the clinic is responsible for the sick".* Health education is defined as any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes (WHO, 2008; Johnson, 2010) as cited in Fasoranti (2016:225).

According to Kulczycki (2018:9,12) expanding access to family planning and addressing unmet needs for contraception are key goals for improving reproductive health. More optimistically, awareness of the rationale for making family planning programmes a higher priority to African health systems is increasing and several regional success stories and implementation models have emerged. These indicate the potential for addressing unmet need and for scaling up family planning service delivery, despite the complexities involved and the added challenge of sustaining scaling up in the prevailing global economic environment. The researcher finds health education and family planning as important tools in improving the health and the reproductive health of the community and therefore their incorporation into primary health care services is a good step since phc is not all about curative health care as indicated by the participants.

Sub-theme 4.2: PHC facilities caters for clients and patients from various communities including urban areas.

The participants explained that the health facilities cater for patients and clients from various communities and even those in urban communities. One of the participants emphasised that the rural communities enjoy the services the polyclinic provides but the urban community does not like the phc service the polyclinic provides. This is evident in what the participant said "*They [rural communities] enjoy when they come here because at their places, they do not have them there. But we in the urban centres are not happy with the health service. The village folks enjoy coming here but the urban community don't like coming here.* This means though phc facilities are available for both the rural and urban communities, the urban communities do not like the health care facilities.

A second participant supports this sub-theme and is confirmed in the extract "*Those who come to this facility most come from rural areas in Kasoa. Some too come from the urban areas".* A third participant also beliefs that the rural communities appreciate and have confident in the health care they receive at the phc facilities and therefore they visit the place to seek health care. This is evident in what the participant said: "*they have confidence in us. Previously they were not coming but now they come. When it is market day, they bring the children for weighing".* A forth participant also views the CHPS as primary health care facility that benefits the rural communities. The participant expressed this belief when the participant said: "*I think the CHPS is supposed to benefit the rural communities. This is affordable in terms of its operations."*

Sub-theme 4.3: Provision of PHC services is through CHPS zones and polyclinics

The participants perceive the provision of phc services as mainly through the CHPS and the Polyclinics. One participant's account was "*I would say it is working well because of the CHPS compound. You see, the CHPS compound is based on phc".*

A second participant corroborated this when the participant said "*So I would say phc in Kasoa is through the CHPS zones and the polyclinic".* A third participant also said that "*the phc in Kasoa is delivered through the polyclinic. Here serves as their main source of health care facility although we have minor health facilities around but they refer their cases to this place and if we think we cannot manage them we refer them elsewhere."* A forth participant sees the CHPS

and the Polyclinics as doing the same phc services but with some restrictions at the CHPS. The participant expressed this opinion when the participant said "*We are doing the same as the CHPS compound. But the only difference is that the CHPS compound is restricted to certain things. They do not do surgery but we do it here".* The participant went on to say that "*The main focus of the phc is based on the CHPS compound. But when it comes to the Polyclinic and the health centre we are doing advance health care".* Since primary health care involves some activities as home visits, the participants belief the CHPS is filling the gaps that the facility-based nurses are unable to do. This is evident in the extract "*We have established urban centres that do the health education at schools and the community health nurses who are at the CHPS visit clients during home visits to follow up if clients are abiding by health advise."* One participant also views the CHPS as a brilliant idea in primary health care because it does some minor curative care. This was expressed in an extract of the participant "I *think it is brilliant idea that government did. And I think it is improving health care because when we go to some CHPS compound they do minor curative there. Before maybe a particular disease or sickness may get out of hand the CHPS may have handle it at their level before they are transferred here.* According to Kanlisi et al (2017:1) Ghana launched the Community-based Health Planning and Services (CHPS) initiative to further the principles of primary health care in rural communities. The approach was adopted by the Ministry of Health as a national programme to bridge the gap in access to healthcare. In this approach, a Community Health Officer (CHO) is supposed to live in a community and obtain help and support from the community members, to deliver some basic health care services, particularly preventive services through outreach programmes such as school health and health promotion activities unlike facility-based clinical services at the health facility. The perceptions of the participants that the primary health care services are provided by the CHPS finds expression in what Kanlisi et al (2017:1) identified.

Sub-theme 4.4: Different Health professionals provide care at the CHPS and polyclinic

The participants revealed that different health professionals provide primary health care at the various phc facilities. These included the community health nurses, registered general nurses, midwives and enrolled nurses. This is evident in what one participant said "*we have physician assistants, midwifes, enrolled nurses, the community health nurses and the public health nurses. Sometimes where there is no midwife, the general nurse function as the midwife."* A second participant also confirmed this and said "*When we say primary health care, the types*

of nurses that come to mind are the community health nurses because they are close to the rural areas and they deal with patients from the rural areas." Some roles of the registered nurses at the primary health care facilities include: Maintain a safe and therapeutic patient care environment; Undertake the last offices for deceased patients and give relevant information to relatives/carers; Advise on the promotion of health and prevention of illness, teaching patients and their relatives where appropriate; Undertake assessment, planning and implementation of interventions for addressing patient care problems; Evaluate patient responses to interventions and modify plans as needed. The roles of the enrolled nurses at the primary health facilities include: Provide patient care under the direction of a Registered Nurse; Provide direct contact with patients and their families as well as the performance of indirect patient care activities such as providing a clean, efficient and safe patient care environment; Contribute to the safe and efficient delivery of nursing care in the ward/unit; Assist with the assessment, planning, implementation and evaluation of patient care and make changes as necessary; Assist the patient with feeding, drinking, ambulating, grooming, toileting, dressing, and unit specific technical skills; Safely administer prescribed medication and monitor the effects.

The midwives at the phc facilities, assist with the organisation and delivery of antenatal care to clients; Assist with the organization and delivery of postnatal care to clients; Contribute to the provision of key services during the antenatal period to improve health outcome for clients; Provide counselling to clients on birth preparedness and complication readiness; Conduct spontaneous vaginal deliveries for clients.

The community health nurses are responsible for assisting in developing caseload/catchment population profile and identify, prioritise and implement programs of care, planning and carrying out MCH activities; Assist in the immunization programme to ensure maximum possible protection against disease; Participate in health education activities; Assist in the running of family planning, post-natal and child welfare clinics; Counsel individuals with special problems during child welfare clinics and refer to the appropriate person; Conduct school hygiene inspection.

4.3.5 THEME 5: Recommendations towards improvement in the provision of the best PHC service

The participants having identified some of the challenges they face during their phc responsibilities, outlined some measures that when put in place will make phc in rural communities in Kasoa a better one. This theme revealed seven focus areas or sub-themes.

Sub-theme 5.1: A need for government and non-governmental organisation raised

The participant identified the need for government and non-governmental organisations to scale up their contributions towards primary health care in order to improve its delivery in rural communities in Kasoa. This was indicated by one participant who suggested that they need governmental and non-governmental supports. This is evident in the excerpt "*I think we need governmental support and non-governmental support".* NGOs have played a larger role in providing basic services such as health services and sanitation. Their effectiveness in establishing sustainable primary health care (PHC) systems have increased community participation in health care, their activities are mainly targeted at the poor, being flexible and working with dedicated staff. NGOs in health care working to fill the gaps in public programmes that countries have failed to perform or withdrawn (Ibrahim 2017:3). There are other studies that have shown success in NGO health care provision. For example, in their study, Loevinshn and Hardins (2005) as cited in Ibrahim (2017:4) suggest NGOs as a means to improve health-care delivery and help achieve the health care related Sustainable Development Goals (MDGs). Evidence from their study suggests that, contracting with NGOs to deliver primary health or nutrition services seems to be very effective and impressive improvements can be achieved rapidly. This study proves that the recommendation by the participants is doable and therefore governments should explore these possibilities to improve phc in rural communities in Kasoa. The study by Kress, Su and Wang (2016:216) to assess the primary health care system performance in Nigeria found that adequate health care infrastructure and sufficient health workers are essential but not satisfactory for a robust primary health care-based health system. Other factors like government policies, sustainable health care financing, efficient supply system, and service delivery capacity play a major role in strengthening primary health care systems. In this regard, governmental support for improved phc is necessary as suggested by the participants.

Sub-theme 5.2: Improvement plan to maximise CHPS, polyclinics and health centres performance required

According to the participants, the CHPS concept is not well understood by the communities in which they are situated and therefore should be explained to the communities so they take full participation of the programme. This is indicated by one of the participants who said "*I think the CHPS concept should be properly explained to the community. The CHPS compound workers should be included in the decision making by opinion leaders here. I also think that we should invest in preventive health care."* A second participant also recommended the review of the CHPS concept to allow for some services like laboratory and scanning for antenatal clinics. This is evident in the extract of the participant "*they can review the concept and add some services to the operation of the CHPS for example scanning serves for antenatal clients, or even the labs."* A third participant also held the view that due to the high attendant rate of the Polyclinic, authorities should change its status to the status of a hospital to accommodate the rising numbers. This was expressed in the excerpt of the participant "*also I think the polyclinic should be changed to a hospital. They attendance and the demand are very high."* The participant further suggested that measures should be implemented to allow the CHPS, the Polyclinics and the health centre to function smoothly. According to the participant "*I think they should put in place measures that will ensure the CHPS, polyclinics, heath centres are working smoothly to prevent situations whereby items will run out of supply."* A study by Oyekale (2017:1) to assess the primary health care facilities' service readiness in Nigeria concluded that to ensure equity in access to health care facilities, quality of services at Nigeria's health care facilities should be improved. This could be achieved when mechanisms such as proper inventory of medical services is put in place, increase of health care financing and proper management of health care resources. This will help address the challenges of unavailability of basic medical equipment and lack of some basic and essential drugs. The researcher argues that when the supplies and proper stock management practices are put in place, it will assist to maximise the performance of the health care facilities as indicated by the literature cited as also suggested by the participants.

Sub-theme 5.3: Revitalisation of existing infrastructure raised

The participants were of the opinion that the existing infrastructure should be revitalised. This is because, the infrastructure is in bad shape and need facelift. Among the participants, one indicated that some CHPS are operating in rented facilities and that is not based on the concept. According to the participant "*The CHPS live in rented apartments. They are not designed based on phc concept."* A second participant also beliefs that when the infrastructure is improved, the community they serve will have confidence and belief in the service they provide them. This is evident in what the participant expressed "*. They have to renovate some of the health facilities. When they come and see we have all the items and work efficiently they would belief in us. But when they come and you do not deliver your services well due to lack of basic items, they would not belief in the service we deliver to them."* Another participant also emphasised that if the infrastructure accommodated the staff, they would be available to provide 24-hour services and this will translate in improved health care. According to the participant "*If we have accommodation here the nurses will be here 24/7. If there is any emergency, they [nurse] will attend to them. But if the nurses stay far away and there is emergency, maybe before the nurse comes, something may have happened to the person. So, I think accommodation is fine."* The elimination of infrastructure challenges in health care will result in better services, improve accessibility, availability and quality of health services. This will be as a result of assuring the availability and functioning of the required technical medical equipment (Scholz, Ngoli & Flessa 2015:9). Therefore, the revitalisation of existing infrastructure will help in better health care services as recommended by the participants.

Sub-theme 5.4: Reviving PHC values by government mentioned

The participants perceived that the values of primary health care have been abandoned and they call for its revival. One of the participants suggested that "*I see that we have abandoned the values of PHC so I would say that government should revisit these values."* A second participant also thinks that the ideas underpinning the CHPS concept are now not been adhered to by the community due to the lack of the understanding of its operations. The participant said "*They do not understand the CHPS operation. The community does not support our work. We weed the place when bushy ourselves. We do not get their support. No volunteerism. Now volunteer demand money before they offer help."* A third participant also opines that health authorities should take the initiative to educate the communities through durbars about the CHPS in order for the communities to understand and participate in its operations. According to the participant "*…if the community understands the CHPS well, that would be the best*

solution. The ministry/directorate should at least once a year come through durbars to educate them about the CHPS and it will also help." In so doing the researcher beliefs that the value of community participation will be enhanced.

The development of community-based primary health care services started primarily due to traditional health services being unable to effectively meet the health needs of local communities who often do not benefit from traditional health services and are also marginalised. Among some of the solutions put forward was to establish community specific primary health care services, for and managed by local or rural communities. The reasons why community-based primary health care services are more likely to improve the health of communities they serve than traditional health care facilities include the fact that they usually deliver comprehensive programmes such as treatment and management of diseases, prevention and health promotion, as well as addressing the social determinants of health (Harfield, Davy, McArthur, Munn, Brown & Brown 2018:1). The researcher beliefs that the reviving of primary health care which includes, community participation and the improvement in the CHPS concept will help address some of the challenges that were identified by the participants.

Sub-theme 5.5: Intensification of health education for various aspects through different communication modes suggested

The participants upon identifying some challenges in primary health care, suggested that health education should be done frequently at heath care facilities. According to one participant, health education should be intensified at the OPD since it is the entre point of the health facility. The participant further suggested that prescribers should do well to explain the outcomes of diagnosis to the patients. The participant indicated that "… *health education should be more particularly at the OPD since it the entry to the health facility. The doctors too do not tell them [the patients] their disease conditions so sometimes they come here and ask us about the conditions or what is wrong with them."* According to a second participant "…*health education on radios will be a good way to reach out to the people we serve. Counselling too would help."* A third participant also suggested that *"[they could] use videos demonstrating some health practices at the health facilities because some people are visual learners. This would improve the communication in health education. Frequent community durbar involving the communities to educate them about phc and good health practices."* The researcher observes that by

adopting the community durbar approach, the community will be involved in the health care services which will translate in better health outcomes. A forth participant also supported the idea of improved health education as among the various ways to addressing the minor challenges they encounter. According to the participant "*I also think health education should be intensified in the community."* Fasoranti et al (2015:1) recommended that governments should put in place policies to ensure that health education and well-trained health educators form part of medical team for effective PHC services. This is because, the practice of primary health care services cannot be effective without proper implementation of health education. This existing literature shows that health education is associated with effective primary health care. This literature supports the argument by the participants that health education be intensified to improve primary health care services in rural communities.

Sub-theme 5.6: Emphasis on review, correct implementation of policies and PHC services suggested

The participants stressed the need to review the CHPS policy to allow for broader services that will benefit the community they serve. Furthermore, the participants also observed that the CHPS concept is not fully implemented and drew the attention of the policy makers to it. This finds expression in what one of the participants expressed as "*they can review the concept and add some services to the operation of the CHPS for example scanning serves for antenatal clients, or even the labs."* This was supported by a second participant who indicated that "*the lack of laboratory services causes low patronage by the community we serve. The community does not understand the concept of the CHPS compound."* The participant further stressed the need to fully implement the CHPS concept to realise its full potential. According to the participant "*I also think the CHPS concept has not been fully implemented."*

A third participant held the view that their competencies are limited by virtue of the facility in which they operate and this is affecting the health services they provide and therefore a review of their job description will help address this challenge. According to the participant "*Our competencies are also limited. This is because you can do some procedures or administer some drugs but the CHPS level prohibits you from prescribing some medication. I think this is affecting our health care services."* In the views of a forth participant, the nurses working at the CHPS are not involved in the decision making at the community they serve and are calling for inclusion so they contribute their knowledge in terms of health care. This is evident in the extract

"*I think the CHPS concept should be properly explained to the community. The CHPS compound workers should be included in the decision making by opinion leaders here. I also think that we should invest in preventive health care".*

Sub-theme 5.7: Government to supply resources required for effective implementation of PHC services.

According to the participants, the lack of some basic supplies and other items are affecting the work they do as phc providers. The participants identified the shortage of some of reproductive and child health drugs such as the vaccines and their diluents are among the challenges and therefore recommended that government should improve its medical items supply mechanisms. This was indicated by one of the participants who said that "…*we have problems like out of stock and when we go to the district, district too would not have them so you have to wait until they get some from regional office before they supply us with them"* and therefore, the need to ensure regular supply of the items. The participant indicated that "*I think the supply of logistics should be looked at."* A second participant also expressed similar view and said that "*I would suggest that the supply and logistics aspect could be decentralised so that we can easily get items when they are out of stock."* A third participant recommended same and said "*The supply of logistics too should be looked at".*

Table 4.2 Selected participants' demographics

Participant	Gender	Age	Profession	Facility
1	Female	25	RGN	Polyclinic
2	Male	26	RGN	Polyclinic
3	Female	31	RGN	Polyclinic
4	Female	39	RGN	Polyclinic
5	Female	35	RGN	Polyclinic
6	Female	28	MW	Polyclinic
7	Female	24	MW	Polyclinic
8	Female	36	MW	Polyclinic
9	Female	24	MW	Polyclinic
10	Female	28	MW	Polyclinic
11	Female	24	EN	Polyclinic

12	Female	26	EN	Health centre
13	Female	25	EN	Health centre
14	Female	27	EN	Health centre
15	Female	32	EN	Health centre
16	Female	24	CHN	Health centre
17	Female	26	CHN	Health centre
18	Female	25	CHN	Health centre
19	Female	38	CHN	Health centre
20	Female	33	RGN	Health centre
21	Female	36	EN	Ofaakor CHPS
22	Male	29	CHN	Ofaakor CHPS
23	Female	26	RGN	Opeikuma CHPS
24	Female	33	CHN	Opeikuma CHPS

RGN: Registered general nurse

EN: Enrolled nurse

MW: Midwife

CHN: Community health nurse

4.6 CONCLUSION

The chapter presented the findings of the study and discussed them in relation to existing literature where applicable. The researcher also described the steps followed to obtain the various themes using thematic analysis. The major themes of the verbatim transcripts were discovered in the coding analysis and were presented in this chapter as well as the focus areas or the sub-themes which described the major themes. During the discussion of each sub-theme, the researcher identified existing literature that supported the sub-themes discovered or contradicted them. This was done to ensure that the findings of the study were situated in contexts to aid appropriate conclusions to be drawn which proceed from this chapter. The

category of nurses who were purposively selected for the study were provided in table 2 of this chapter.

CHAPTER 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter summarises the study. The previous chapter dealt extensively with the study findings and discussed the themes in relation to existing literature where necessary. This chapter concludes the study based on the themes and the sub-themes that are linked to the research questions, purpose and objectives of the study. The chapter will also describe the recommendations which were outlined by the participants.

5.2 SUMMARY

The purpose of the study was to explore the perceptions nurses have on PHC in rural communities in Kasoa, Ghana. To achieve this, the researcher used qualitative exploratory research design. This approach was deemed appropriate since the researcher had limited

information on the phenomenon under investigation and to obtain a deeper understanding of what PHC means to the nurses. The study objectives included:

- To understand the perceptions nurses, had with regard to primary health care delivery in rural communities in Kasoa.
- To describe the perceived factors that hindered primary health care delivery in rural communities in Kasoa.
- To identify measures that can be put in place to promote primary health care services.

To attain the objectives of the study, the researcher formulated the following research questions:

One grand tour question was used to explore the nurses' perceptions on primary health care in rural communities in Kasoa, Ghana. The grand tour question that the nurses were asked entails: What is your understanding of Primary Health Care in Kasoa? Follow up questions were used dependent on the participant's responses and in line with the objectives. Some of the questions covered were as follows:

What challenges did primary health care nurses faced in the course of their work?

What were the challenges, if any, in the implementation of the PHC services that made the patients to complain about the nurses' attitude?

5.3 CONCLUSIONS

5.3.1 Participants interpretations of primary health care

The participants' interpretations and meanings of primary health care were diverse and analogous. The participants interpreted primary health care to be the health care that should be affordable and accessible. Some of the participants also associated PHC with the kinds of health care professionals involved. The participants also identified health promotion as among the strategies that primary health care uses to achieve better health outcomes. However, the poor sanitary situations at some rural communities is affecting the health promotion strategies of primary health care in the communities. The participants however, commended the existing primary health care services.

5.3.2 Participants' perceptions of primary health care in rural communities in Kasoa, Ghana.

The purpose of the study was to explore the perceptions of nurses about primary health care in rural communities in Kasoa, Ghana. The participants' views and perceptions about primary health care in rural communities in Kasoa were satisfactorily with minor challenges that could be addressed. The participants further perceived health education and patients' rights provided at PHC facilities as helpful in achieving health outcomes. The participants had the perception that the provision of outreach services seems to be acceptable to communities and the referral systems at PHC facilities are well-structured, clear and acceptable but underutilised by the communities. The participants also perceive the CHPS zones as helpful in providing PHC services.

5.3.3 Challenges participants face during primary health care delivery in rural communities.

In the study, the researcher sought to identify some of the challenges that primary health care nurses face in the course of their work. The participants outlined a number of challenges they face during their daily work as PHC service providers. These challenges became evident and were clearly outlined in theme 2.

According to the participants, primary health care in rural communities in Kasoa is faced with some challenges which when addressed, primary health care in rural communities will be improved. Among the challenges were: The lack of good sanitation, inadequate clean water supply associated with development of various diseases; the challenge of poor infrastructure, shortage of financial, material and human resources affects PHC delivery in rural communities in Kasoa. Participants also complained of negative treatment and abuse of nurses by community members and this affect their work as PHC service providers. Lack of money and transport affect adherence to health instructions by clients and patients; Lack of adherence to health instructions by patients and clients affect expected health outcomes. The nurses also pointed out the following challenges: The participants perceived also that the possession of Health Insurance determines accessibility to best PHC services. There are also misconceptions, cultural and religious beliefs that interfere with PHC services expectations. The participants further observed that decentralisation of PHC services is poorly implemented.

The researcher further found out from the participants what challenges, if any, in the implementation of the PHC services that made the patients to complain about the nurses' attitude. The views of the participants with regards to this were the lack of adherence to health instructions by patients and clients and this affect expected health outcomes. Also due to the misconceptions, cultural and religious beliefs PHC services expectations are interfered. The participants perceive that due to these, patients complain about their [nurses] attitudes.

5.4 RECOMMENDATIONS

The participants (nurses) having been playing pivotal roles in primary health care identified the challenges they face in their work and further posited some recommendations to policy makers. In the views of the nurses, when the recommendations are implemented, PHC in rural communities in Kasoa, Ghana will improve. The recommendations are as follows:

- The need for government and non-governmental organisation raised to scale up investment in PHC in rural communities in Kasoa.
- Improvement plan to maximise CHPS, polyclinics and health centres performance required.
- Policy makers should revitalise existing PHC infrastructure.
- Reviving of PHC values by government.
- Authorities must intensify health education for various aspects through different communication modes.
- The nurses emphasised review, correct implementation of PHC policies and services.
- Government to supply resources required for effective implementation of PHC services.
- The researcher also recommends that future study be carried out in similar locations elsewhere but using different health care professionals.

5.5 LIMITATIONS OF THE STUDY

The limitations of the study included:

Purposive sampling did not make the data representative enough and therefore the findings could not be transferred to other locations.

Some nurses had little knowledge about PHC and therefore their perceptions about it were scanty. This affected the comprehensive appraisal of the findings.

The researcher focus was nurses and since primary health care involves all actors in primary health care service delivery, the researcher identifies this as a limitation of the current study.

The researcher asked leading questions which the independent coder viewed as a gap.

5.6 CONCLUSION

The chapter summarised the study and concluded the inquiry based on the findings and in relation to the research purpose, and the objectives. The chapter enumerated the challenges the nurses face during their work as PHC providers. The recommendations that the participants outlined were also stated clearly in the chapter. The limitations of the study were also pointed out by the researcher.

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