EXPLORATION OF COMMUNITY HEALTH NURSES’ EXPERIENCES ON PRIMARY HEALTH CARE DELIVERY IN NKORANZA SOUTH MUNICIPALITY, BRONG AHAFO REGION, GHANA

BY

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JULY, 2017.
DECLARATION

I, David Dery do hereby declare that this thesis is a record of my own research work. It has neither been submitted in part or whole to any institution elsewhere for an award of a degree. References made to the works of other researchers and authors have been duly acknowledged.
DEDICATION

This work is dedicated to God, Whose wisdom and abundance of grace made it successful.

Glory is to Him.
ACKNOWLEDGEMENTS

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<tr>
<td>CHN</td>
<td>Community Health Nurse</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<td>PHI</td>
<td>Primary Health Care</td>
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<td>HRSA</td>
<td>Health Resources and Services Administration</td>
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<td>MDG</td>
<td>Millennium Development Goals</td>
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<td>SDG</td>
<td>Sustainable Development Goals</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>GHS</td>
<td>Ghana Health Service</td>
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<td>DHS</td>
<td>Demographic Health Survey</td>
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<td>HPO</td>
<td>Health Promotion Officer</td>
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<td>HPA</td>
<td>Health Promotion Assistant</td>
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<td>HEW</td>
<td>Health Extension Worker</td>
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<td>CHPS</td>
<td>Community Health Planning Service</td>
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<td>1Mchw</td>
<td>One Million Community Health Workers</td>
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<tr>
<td>MCH</td>
<td>Maternal Child Health</td>
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<td>MCWM</td>
<td>Maternity and Child Welfare Movement</td>
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<td>BDRA</td>
<td>Birth and Death Registration Act</td>
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<td>PML</td>
<td>Marie Louis Hospital</td>
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<td>PHN</td>
<td>Public Health Nurse</td>
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<td>PHNTS</td>
<td>Public Health Nurses’ Training School</td>
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<td>CHNTS</td>
<td>Community Health Nurses’ Training Schools</td>
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<td>HHS</td>
<td>Health and Human Services</td>
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<td>NLD</td>
<td>Normal Line of Defense</td>
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<td>Full Form</td>
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<tr>
<td>FLD</td>
<td>Flexible Line of Defense</td>
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<tr>
<td>LOR</td>
<td>Lines of Resistance</td>
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<td>VFW</td>
<td>Variance from Wellness</td>
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<td>NSM</td>
<td>Neuman Systems Model</td>
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<tr>
<td>HPSA</td>
<td>Health Profession Shortage Areas</td>
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<td>GDHS</td>
<td>Ghana Demographic Health Survey</td>
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<td>LGA</td>
<td>Local Government Authorities</td>
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<td>CHNM</td>
<td>Community Health Nurse Midwife</td>
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<td>CBSV</td>
<td>Community Based Surveillance Volunteer</td>
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<td>OPD</td>
<td>Out Patients Department</td>
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<td>CWC</td>
<td>Child Welfare Clinic</td>
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<td>CIM</td>
<td>Chartered Institute of Management</td>
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<td>COPC</td>
<td>Community Oriented Primary Care-strategy</td>
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<td>NASHP</td>
<td>National Academy for State Health Policy</td>
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<td>CHNAC</td>
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<td>Integrated Community Case Management</td>
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<td>UNICEF</td>
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<td>TBA</td>
<td>Traditional Birth Attendant</td>
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ABSTRACT

This study explored and described the Primary Health Care experiences of Community Health Nurses (CHNs) in Nkoranza South in the Brong Ahafo Region of Ghana. Four themes served as a guide to investigate the experiences: the factors that serve as hindrances to Primary Health Care delivery, the factors that facilitate Primary Health Care delivery, the methods CHNs use in ensuring optimum Primary Health Care delivery and ways CHNs create rapport with clients in communities. The design of the study was an explorative qualitative one using CHNs in the villages of Nkoranza South. The sample size depended on saturation and was attained on the 16th participant. In-depth interview with the sixteen (16) CHNs, averaging a time of forty-five minutes and using unstructured interview guide enabled qualitative data to be gathered. The data analysis was based on (Teshch 1990) in (Cohen et.al., 2007) content analysis approach. Several findings emerged under the four themes: (1) the factors that facilitate work were put under four subcategories as (a) empowerment of workers, (b) infrastructural development, (c) empowerment of community members and (d) good rapport and community support; (2) hindrances factors to service delivery included inadequate logistics, lack of infrastructure, human resource challenges and community activity related challenges and behavior; (3) ways CHNs deliver health care to reach maximum coverage were categorized into five: (a) use of community visitation and surveillance, (b) use of health education, (c) use of health outreaches, (d) use of community volunteers and (e) referral and finally; (4) ways in which CHNs ensure rapport creation had five sub categories emerging as (a) creating good receptive atmosphere, (b) the use of community resources, (c) home visiting, (d) professional work ethics and (e) provision of health information.

It was recommended that CHNs be offered opportunities for further training; general health education on CHN job is essential, infrastructure and logistics should be improved, electricity should be extended to all health facilities of among others.
CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Community Health Nurses are the frontline health providers in Ghana’s health care system and the world over. Largely they provide Primary Health Care services to the door step of the client or citizenry in communities through health promotion and education, while referring complicated cases.

The Alma Ata conference of 1978 in the United Soviet Socialist Republics (USSR) stated that Primary Health Care Services should be the focus of health-related projects in the developing world. The emphasis was placed on the use of appropriate technology and allied health personnel such as Community Health Nurses, while rejecting the orthodox medical model of disease diagnosis and providing cure to such illnesses diagnosed (Alma-Ata, 1978), report of the International Conference on Primary Health Care.

Since the Alma Ata conference, there have been diversified efforts by countries to improve access to Primary Health Care (PHC) in order to attain a minimum standard quality of life. There have been several coordinated PHC programme improvement efforts; however, the expansion and adaptation of PHC services to serve vulnerable populations such as the poor and rural dwellers remain ineffective.
Community Health Nurses (CHNs) have become the primary providers of health care across the world, since the Alma Ata declaration of 1978. There have been an expansion over the century of the CHNs working force, just as there have been an increase in the populations they serve (Bovbjerg & Ormond, 2013). According to them, the principal factor responsible for this expansion is the population boom in the mid-20th century. During the population explosion, the human clientele health demands started out stepping the medical provider capacity to extend the needed health care services as cited by Health Resources and Services Administration, HRSA, (2007). The United States of America Census Bureau (2012), also reports of an increase in families living in poverty, with one in five families at or near poverty level incomes. It is a fact that there exist a positive correlation between increased poverty and increase in poverty-related diseases but a negative correlation at the same time in access to health care. This therefore demands a need of change in service approach.

Paired with the need for change in health care delivery is also a strong push in the medical system to provide efficient care delivery through various means such as the use of care teams. The change in approach coupled with the use of teams is driven by shortages in the primary medical care working personnel, however, with a simultaneous increase in demand for care.

Meanwhile, the orthodox physician or medical model approach to Primary Health Care leads to high costs, thereby hindering access to primary medical care. These constraints are pushing government and other providers to reconfigure how health services are delivered. The use of Community Health Nurses (CHNs) is therefore seen as the best approach to increase access to health services to reduce costs. It is also seen as the best approach to solve the problem of increasing population with its attendant health problems such as; (1) programme design and sustainability, (2) management of integration, (3) management of primary health facilities and
(4) management of intermediary health care facilities. For instance, Liu, Sullivan, Khan, Sachs & Singh (2011) posited that during the twenty first century, many developing countries were deploying Community Health Nurses programmes because these Community Health Nurses have the ability to identify, refer, and treat illnesses at the household level. They further added that there were however many hindrances in programme design and sustainability as far as management and integration with primary health facilities were concerned.

Confirming the findings of Liu, Sullivan, Khan, Sachs & Singh (2011) about increasing population with its attendant management and integration problems, (Wanjau, Muiruri & Ayodo, 2012) cited over 4,700 health facilities that provide health services in Kenya with the public sector accounting for slightly more than 51 percent of these facilities. According to (Wanjau, Muiruri & Ayodo, 2012), there is a hierarchy for public health facilities, namely: national referral hospitals, provincial general hospitals, district hospitals, and health centres with dispensaries at the lowest end. The provincial health care facilities are intermediaries between the central level agencies and the district level agencies. In Nigeria, they have oversight responsibilities of policy implementation at the district level (Omoleke, 2005). The district hospitals in turn concentrate on the delivery of health care services based on guidelines from the headquarters; while the Health Centres provide preventive and curative services of local needs.

Primary Health Care (PHC) services in Nigeria are composed of the education on existing health problems and their preventive and control measures (Afolabi & Mayowa, 2015). Some of these health promotion measures have to do with food supply and quality nutrition, the provision of good maternal and child health care, and not excluding methods to plan families for better development.
Also, there is immunization programmes to prevent the spread of infectious diseases as well as controlling endemic and epidemic diseases through the provision of vaccine supplies and other essential drugs (Adeyemo, 2005). Despite all the efforts put in place by Nigeria to achieve the Millennium Development Goals (MDGs), such as infant and maternal mortality rate reduction, there are still high rates of maternal and infant mortality as posited by Oyewole (1999) emanating from malaria, cholera and other contagious diseases, due to ineffective Primary Health Care system (Abiodun, 2010).

Ghana’s health care delivery system is categorized into the public and private sectors. However, it is the Ministry of Health (MOH) that is responsible for the overall oversight control of the entire health care delivery system by the planning of policies and monitoring and reviewing the performance of the policies implemented. The Ghana Health Service (GHS) and teaching hospitals have implementation service delivery functions to execute and also constitute bulk of the Ministry of Health institutional bodies. Despite the GHS and teaching hospitals constituting the majority of institutions, there are other bodies which also deliver health care services in the country such as the quasi-government institutions and statutory bodies (Manso, Annan, & Anane, 2013).

Community Nurses programmes have therefore emerged as effective strategies to deploy Primary Health Care (PHC) to the citizenry, particularly the rural communities because these programmes are effective in addressing human resource challenges including personnel shortages and access to health care. Notwithstanding the diversified efforts to provide access to health care for all Ghanaians, the ease of access to Primary Health Care services to reduce cost, particularly in the rural areas still has a huge deficit because rural infant mortality rates still

The Alma Ata conference ratification of health for all has resulted in countries using the Sustainable Development Goals (SDGs)-used to be called Millennium Development Goals (MDGs), especially goals four and five on infant and maternal mortality as the basis for strengthening national Primary Health Care (PHC) systems. These goals have given countries in Africa a united front to focus on methods of delivering care in the most vulnerable populations such as rural communities. This then creates a driving pressure for nations to deploy Primary Health Care (PHC) to the vulnerable populations who are largely village dwellers, in order to meet the Sustainable Development Goals that are normally reviewed at the country’s level of performance.

Primary Health Care is supplemented by secondary and tertiary or specialty care through the hospitals. In order to address the global disease burden with less difficulty, effective existing and proven interventions must be deployed within the PHC system (Liu, Sullivan, Khan, Sachs & Singh, 2011). They therefore indicated that low household coverage of vaccines and supplies for pneumonia, malaria and diarrhea will not be sufficient to improve the situation. In an attempt to address the human resource crisis, PHC system moved toward the deployment of diversified Community Health Nurses personnel, as stated by (Liu, Sullivan, Khan, Sachs & Singh, 2011).

These Community Health Nurses (CHNs) have been touted to be a cadre of workers who provide low-cost health care at community and household levels for the public. An effective CHNs programme, in an effective PHC system promotes care at the household level and serves as an
important link for community members and the PHC system alike. This becomes an avenue for continuum of care across multiple points.

In 2010, the Government of Ghana implemented several community health interventions in an attempt to close the gap in service delivery between the cities and the villages. For instance, several lower cadres of health workers, health promotion officers and health promotion assistants and many others were trained and sent to the districts, sub-districts and communities for the delivery of primary health according to the Ghana Ministry of Health (2014).

The 2010 programme served as a complement to the efforts of the CHNs who are trained and sent to work in the Community Health Planning Services (CHPS) zones and other health posts around the country, in charge of the health care of communities. These cadres deliver community-based health promotion through free basic health screening, preventive health education and minimal interventions such as treatment.

The Ghana’s Ministry of Health and Earth Institute’s One Million Community Health Workers (1mCHW) programme is an effort over the past years to strengthen the accessibility of health service coverage to remote communities (Ghana Ministry of Health report, 2014).

Ghana does not have the required resources in terms of health care professionals such as doctors and nurses for health care services to be delivered to all who need such interventions. In order to fill the gap, the alternative is in the use of Community Health Nurses (CHNs). Ghana, like many other countries in Africa, America or Europe, uses Community Health Nurses as the basic model for Primary Health Care provision. These Community Health Nurses (CHNs) are normally given two years of training in a nursing institution in Ghana.
Community Health Nurses (CHNs) have major health care roles and responsibilities to deliver in big towns and cities of all countries, including Ghana, but this study focused on the experiences of CHNs and the interventions they can deliver in low-income rural communities of Nkoranza South in the Brong Ahafo Region of Ghana, where progress towards meeting the Millennium Development Goals (MDGs) four (4) and five (5) in maternal and infant mortality in health respectively, is most likely to be delayed.

1.1.1 Historical Overview of Community Health Nursing

The history of Community Health Nursing, popularly known as health visiting is tied to the history of Maternity and Child Welfare Movement because the health visitors cared for both the mother and children. The profession originated in Britain in 1782 by the Maternity and Child Welfare Movement (MCWM), during which visiting Community Health Nurses educated mothers on hygiene and the provision of good diet for children, especially the under-five.

This led to the formation of a team of ladies in 1863, whose duty was to distribute tracts, pamphlets and leaflets to the people. The team of professional ladies had difficulty to trace the homes of new born babies and that culminated in the establishment of the Birth and Death Registration Act (BDRA) in 1874.

The failure of the print media education approach led to the kick starting of a system of home visiting by the nurses to educate mothers especially the poorer ones. This outreach approach rather chalked enormous success and hence came to stay.

The ladies group functioned in a hierarchical order with the services delivered. At the district level, a lady senior voluntary worker and a health visitor were responsible in educating and
promoting knowledge on environmental sanitation and hygiene. This served the communities and people’s physical, social, moral and religious needs at the same time. The team of health promotion ladies also organized health talk meetings on personal and environmental hygiene, how to prevent infectious diseases and also care for children.

The health visitors were appointed by the voluntary society up till 1890 when the Manchester and Salford Corporation paid their remunerations. At the same time a Medical Officer of Health was made responsible to supervise and direct the work of the health visitors.

The efforts of Miss Florence Nightingale led to the inception of the first training programmes by North Buckinghamshire Technical Committee from 1891-1892 for health visitors. The content of the Health Missioners syllabuses were similar to modern Ghana course programmes for health visitors. The entire student population for these courses was sixteen women, however, only twelve sat for the exams and only six obtained certificates.

During that era, the local supervising authority in the name of the London Country Council arranged for notification of births by the midwives, and forwarded this information weekly to the medical officer for health. Many countries then adopted the London Country Council style. This led to the enactment of the Notification of Births Act in 1907 and by 1915 birth notification was made compulsory.

In 1909, the London Country Council Act required health visitors to possess a medical degree of three years training as a nurse, and also a certificate of the Central Midwives Board in not less than six months training. To be qualified as a home visitor, the training was also imbued with children and adult nursing.
The first kind of large-scale deployment of Community Health Nurses programmes were in the
1960s in Latin America, Tanzania, Mozambique and China (Liu, Sullivan, Khan, Sachs & Singh
2011). According to them, during that era, China deployed thousands of paid “barefoot doctors”
to the rural populace in order to improve their health. Also, during the 1970s and 1980s, short
term public and private funding support for Community Health Nursing (CHNs) emerged, but
with focus on formally designed interventions.

Push factors such as macroeconomic and political forces, as well as the integrated Community
Health Nurse-driven Primary Health Care (PHC) approach led to the fall out of the Community
Health Nursing concept during the late 1980s and early 1990s. The failures on large scale
deployment programmes were mainly due to lack of technical and financial support for
supervision and refresher trainings. There began a renaissance of Primary Health Care (PHC) in
the 1990s during which communities became integral part of health policies that enhanced the
professionalization, regulation and incorporation of CHNs into the health care system.

1.1.2 The Inception of Community Health Nurses in Ghana

According to a report of the German Technical Corporation (GTZ, 2001) in Africa it was the
missionary bodies and former colonial masters of the colonies who introduced health care to take
care of their health needs. The health care systems in Africa and Ghana therefore have been
bequeathed by the religious organizations with foreign origin or the colonial rulers of Europe-
some three to four decades after those in Europe and the Americas were established.

The hospital based system had high cost, in Europe, America and Africa (GTZ, 2001) and Ghana
as well, hence only few populations were able to afford the cost to attend health care; while the
majority of the people in the low income status group, mainly the disadvantaged rural dwellers could not afford to pay these exorbitant costs to access health care.

At the Alma Ata conference in 1978, the participating countries ratified the declaration of health for all by the year 2000 in an attempt to address the widening health inequity, particularly in the developing African countries, where the quality and access challenges to Primary Health Care are more pronounced. The ratification to close the health inequity gap sought to use Primary Health Care interventions and programmes such as community and individual self-reliance through the use of multi-sectoral and decentralization approaches.

In Ghana, the Community Health Nursing (home visitors) concept started with the formation of the Ministry of Health in 1919. The Board of Education Regulations for this home visiting concept were also passed in the same year. There were two types of courses to train Community Health Nurses for home visiting, namely a full two years duration course for people who had no knowledge or experience in the work of a health visitor and a one year course for trained nurses and others already possessing substantial knowledge or experience.

Since 1925 the Ministry was entrusted with the responsibility of the training of health visitors. In 1928, untrained Public Health Nursing programme started in Ghana and Nurses of the Princess Marie Louis Hospital (PML) in Accra were used in these programmes.

The duties of the Public Health Nurse (PHN) were to visit sick children in hospitals and in their homes. The responsibilities also included the running of Child Welfare Clinic at the hospital as well as the giving of health talk such as on sanitation issues in homes.
During 1929, two assistant Community Health Nurses with no much requisite training skills accompanied the health inspectors in their home visit inspection. From 1929, there were no clinics until 1932 when the British Red Cross Society built clinics at Koforidua and Cape Coast in Ghana, while mobile clinics were also ran in the countryside communities. During the same era of mobile clinics usage, child welfare clinics were also organized in Kumasi, Osu and Kpando, but the Community Health Nurses took care of minor ailments in the form of yaws and scabies as well as malnutrition and antenatal care.

By 1936, Community Nurses Health Visiting was published in the gazette and nurses educated lactating mothers on how crucial it was to monitor growth of the infant and also go through vaccination to immunize the infant against diseases. It was also common to find child welfare clinics in churches, schools, market places and other convenient places. The various interventions on Primary Health Care provision using home visits and Child Welfare Clinics yielded good results and mothers’ interest soared especially in the food demonstration interventions and hence the attendance kept increasing day by day.

It was by 1950 that a trained Public Health Nursing tutor from Britain was recruited for the training of Public Health Nurses in Ghana. In 1951 one of the pioneers of home visiting by name Samara Signge was sent for tutorship training at the Royal College in London. On return in 1952, she began a one year Public Health training course at the Public Health Nurses’ Training School (PHNTS) at Korle Bu. The content of the course was not different from that of the Royal College of Nursing in London. The student population of this course was on the average 10, even though the expected population was higher. This Public Health Training institution was the only one of
its kind in Ghana with only two Community Health Nurses’ Training Schools (CHNTs) at Winneba and Oda (doing pilot training at the time in diploma in Community Health Nursing).

1.1.3 The Establishment of Community Health Nurses Training Institutions in Ghana

In the 1960s, the health care demands in Ghana led to the training of supporters of Public Health Nurses in two years duration, in order to supplement the efforts of the PHNs to bring essential health care to dwellers in the remote and urban areas alike.

The first Community Health Nurse training institution was meant for only females with Middle School Leaving Certificate to be trained in twenty four months duration and was established in Tamale. The second of its kind was established at Akim Oda in 1962, followed by Ho in 1965, Winneba, 1980 and Esiama, 2001. The government planned to establish a Community Health Nurses Training school in each of the ten regions. Several other Community Health Nurses training schools were built, including Navrongo in 2001, Tanoso, 2002, Fomina, 2004 as well as those at Sunyani, Guaso, Krobo, and Jirapa.

1.1.4 The Roles and responsibilities of Community Health Nurses (CHNs).

Community Health Nurses provide two-fold interventions to several categories of clients in communities, namely, health and social services issues. They may have similar personal, socioeconomic and health experiences.

The knowledge about health issues as well as the community connection skills (interpersonal skills and observational skills), give CHNs several roles and responsibilities such as educative
role, individual and group counselling as well as doing conflict mediation for clients, not excluding championing the course of the client through advocacy and engaging in outreach education. They also play the role of community health representatives, according to the United States of America Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA, 2007).

The setting for job delivery of the CHNs could range from open and airy spaces, especially for group health interventions to churches and client homes, and in clinics, for both rural and urban communities. They need resources such as transport, electricity, vaccine fridges and other supplies for home visiting, cold chain management of vaccines to ensure drug life maximum potency. Others are means of transport for the safe transporting of complicated cases to higher hierarchy of the care delivery system just to mention a few.

The roles of Community Health Nurses in the provision of care to clients in communities are put into three, as enumerated by Bovbjerg & Ormond (2013); namely primary or community prevention as in health facilitation for both the public and self and environmental inspection; secondary or clinical prevention as in health risks awareness creation, enhancing access to care and encouraging follow ups and finally, tertiary prevention, as in needs identification and facilitation of access to health care. These roles as enumerated by Bovbjerg & Ormond (2013) fall in line with the Primary Health Care prevention principles as outlined by the theorist, Neuman (1970) whose theory is the framework underpinning the study.

Community Health Nurses are an essential link between acute and community care, focusing on prevention, self-management and providing support to transition patients smoothly across the health and social care services. The Community Health Nurse has several duties or roles to
perform, namely, home visiting, running child welfare clinic, family planning clinic, conducting school health services, collecting information or data from the community, promoting health awareness and keeping records of data, just to mention a few of the responsibilities.

The roles of Community Health Nurses (CHNs) may vary depending on the sector in which they work such as service to the society. The second roles they perform has to do with the services they deliver such as going on outreaches, promoting health through education as well as clinical services and finally the skills and competencies required for the service provision such as communication and cultural competences including training and professional experiences. In all of the roles and responsibilities performance, CHNs’ target the particular needs of their clients and communities.

The roles of the Community Health Nurse could therefore be summarized to be clinician, advocator, collaborator, consultant, advisor, educator, researcher and administrator.

CHNs programmes have a major objective to improve health in rural populations that they themselves live in and work and are adept at building community capacity and ensuring the delivery of culturally competent services. They develop trusting relationships with clients and providers. By contributing to the delivery of primary and preventive care, CHNs facilitate improvements in the health status and quality of life in rural communities. Community Health Nurses are therefore the frontline human resource personnel of Primary Health Care in Ghana.

Notwithstanding the large numbers of Community Health Nurses in Ghana, there are still many communities which lack these professionals for health care delivery to proceed progressively. For effective deployment of Primary Health Care services, there is still the pressing need for
many Community Health Nurses to be recruited to facilitate the process of advancing health care access to all the populace.

According to the Ghana Ministry of Health 2014 report, it is critical to have a population to Community Health Nurse ratio of 500 individuals being served by one CHN. The plan in place to achieving this target has been that by 2014 Ghana would have achieved 20% rural coverage but would have had 40% coverage by 2015, and 60% by 2016. It has been targeted that 100% rural coverage would be attained by 2019. The Nkoranza South municipality has a population of 100,929 (Ghana Statistical Service 2014). The doctor-patient ratio in the health facilities stand at 3,879 patients to one doctor whilst a Community Health Nurse also attends to more than 2,710 individuals (Ghana News Agency 2010). The more than 2710 individuals served by a Community Health Nurse in the Municipality falls far too short of the Ghana Ministry of Health expectation of 500 individuals to be served by a Community Health Nurse.

Going by the varied evidences of successes chalked and the impediments being encountered as far as attempts at providing Primary Health Care for all the Ghanaian citizenry is concerned, the Primary Health Care system is still ineffective. Much needs to be done in order to attain health for all Ghanaians as prospected in the 1978 Alma Ata conference declaration. Community Health Nurses (CHNs), by the roles and responsibilities reposed in them, are the pillars of Primary Health Care in Ghana.
1.2 Statement of the problem

Most often the Community Health Nurse (CHN) is away from home, providing health services in other communities. Community Health Nurses (CHNs) give several health services to people in communities and are usually engaged in health provision to families and communities than their own immediate families. They do home visits in order to provide health education for children, mothers and communities, as well as provide counseling services, while referring complicated cases for further advancement of the health of the client. The Community Health Nurse to population ratio in Nkoranza is more than 1:2710. The Community Health Nurse therefore is unable to perform to full capacity due to several limited resource impediments such as lack of electricity for vaccine-cold chain management, poor road and communication network among several other constraints. Considering the workload of CHNs enumerated, including schedule of home visits and clinical care provision in Nkoranza, these cadres of health personnel are stretched beyond their capacity to provide optimal level of care to the populace. They are often unable to avail themselves for both home visits and stationary clinical services simultaneously. Although they are committed and willing to work away from home, it is difficult without the necessary facilities and logistics. The current study therefore set out to investigate the experiences of Community Health Nurses on Primary Health Care delivery in rural communities of Nkoranza South.
1.3 Purpose of the study

The purpose of the study was to explore the experiences of Community Health Nurses on Primary Health Care delivery in rural communities of Nkoranza in the Brong Ahafo Region. The study therefore aimed to explore both the negative and positive factors impacting on Primary Health Care delivery as provided by Community Health Nurses in the rural communities of Nkoranza South, Brong Ahafo, Ghana, among other factors.

The study also aimed to use the Neuman Systems Model as the theoretical framework to assess Primary Health Care interventions, which could become a guide for other researchers.

1.4 Objectives of the Study

The main objective of the study was to investigate the experiences of Community Health Nurses on Primary Health Care delivery in rural communities of the Nkoranza South Municipality.

In order to realize the main objective of the study, some specific objectives were identified.

The specific objectives of the study were to:

1. Investigate the factors that facilitate Community Health Nurses’ Primary Health Care delivery services in Nkoranza.
2. Assess the factors that hinder Community Health Nurses’ Primary Health Care delivery activities in rural communities
3. Describe the methods employed by Community Health Nurses in delivering equitable Primary Health Care services in rural communities
4. Explore community Health Nurses ways of communication delivery among community members
1.5 Significance of the Study

The information obtained from the Community Health Nurses on their work experiences will enable policy makers, government and other employers identify areas of concern for further advancement of Community Health Nursing practice.

The findings will also contribute towards building future research. This is because topic that was researched is the first of its kind, as far as researching into the experiences of Community Health Nurses and the delivery of Primary Health Care interventions in Ghana is concerned.

Also, the findings will reveal the challenges of Community Health Nursing for the Ghana Health Service and the Ghana Ministry of Health, such as lack of staff motivation due to work overload, non-existing opportunities to climb the ladder of education within the same Community Health Nursing Profession, lack of electricity for vaccine management and poor road as well as telecommunication networks, among several others.

1.6 Definition of terms

Primary Health Care (PHC): It involves the use of referring of health conditions that are complicated and hence beyond the level of the facility and capacity of the Community Health Nurse, thereby enabling the expressed health needs of the community or client to be responded to.

Community Health Nurse (CHN): Is a nurse who has gone through a period of two years training after completing secondary school. By virtue of the training he or she becomes qualified to undertake and champion health promotion and prevention at the community level; while
referring complex conditions to health facilities where treatment can be offered. They are the frontline actors in health care delivery.

**Service delivery:** In this study, this means any health intervention that is provided by Community Health Nurses to community members as a primary health care need.

**Experience:** In this study, experience means the hindrances, facilitating factors and methods adopted by Community Health Nurses to deliver equitable Primary Health Care in communities, including the use of rapport creation with their clients.

**Rural communities:** All communities or areas outside the Nkoranza township in which Community Health Nurses deliver Primary Health Care services and refer cases to the Nkoranza municipal hospitals (Nkoranza St Theresa’s Hospital and Pathmos), where there is a medical doctor.
CHAPTER TWO

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

In this section the theory underpinning the study was discussed and literature was reviewed to put the study into perspective. Various topics such as factors that facilitate Community Health Nurses’ Primary Health Care service delivery, as well as those that hinder service, Community Health Nurses ways of rapport creation and the ways Community Health Nurses deliver equitable health care in rural communities of Ghana are reviewed.

2.1 Theoretical Framework for the Study

The study was based on The Neuman’s Systems Model (1970). This theoretical model views the client as an open system (a system in which there is a continuous flow of input, process, output and feedback), that responds to stressors in the environment. In the systems model according to her, a healthy person follows the systems perspective of organization in which all parts and subparts are in harmony with the whole of the client system. In other words, if some part or subpart is invaded by a stressor, then the whole system is also affected.

Her perspective of health focuses on the individual and the environment as a whole, with emphasis on relationship to stressors. The person (individual) as a client system is seen as a layered multidimensional being, interacting with, adjusting to and being adjusted by the environment. Each multidimensional layer consists of five person variables (subsystems) namely; physiological, psychological, socio-cultural, spiritual and developmental, physiological. Under the current study physiological variable means (how the client genetically responds to the
stressor), psychological (how the client feels and thinks about the stressor), socio-cultural (it is the attitude of the client based on cultural and community belief system which determine health seeking type such as self-medication and resorting to herbal medicine as against orthodox approaches), spiritual (the influence of spiritual beliefs as regards what is perceived to cause illness and therefore determines health seeking behavior, orthodox or spiritual consultations), and developmental (those processes that historically determine the health of the client biologically and socially). Micozzi (2006) posited the blending of spirituality with the tenets of alternative, complementary, and integrative treatments provides the Community Health Nurse an avenue to understand how the variables contribute to the creation of illness and to healing. During the information age, which is gradually giving way to the intuition age, healthcare professionals such as Community Health Nurses need to focus less on logical, linear, mechanical thinking and more on creative, lateral, and emotional thinking (Reynolds, 2001).

The client system consists of a central or core structure that is protected by lines of resistance. The core structure consists of basic survival factors (normal temperature range, genetic structure, response pattern, organ strength or weakness, ego structure (Neuman, 2002). These factors to a large extent determine the health of the client, at either the primary, secondary or tertiary levels and consequently have a telling on which kinds of interventions the Community Health Nurse should adopt in order to provide a better service to bring good health to the client. In other words, it is the duty of the Community Health Nurse to observe, assess and target either preventive, treatment or referral interventions to the client depending on the type of factor the client exhibits to be affecting health.

She describes the environment as the totality of the internal and external forces or stressors (intrapersonal, interpersonal and extra-personal stressors) which surround a person and with
which they interact at any given time. The internal environment exists within the client system such as age, educational background, type of occupation and anxiety proneness). The external (extra personal) environment or stressors exist outside the client system such as psycho social, spiritual, financial and developmental factors that determine health seeking and health status of the client or community. During the process of mobilizing resources in order to fight the stressors, other health challenges might surface such as anxiety feelings that could disturb the emotional state (internal climate) of the client system and influence treatment outcome. This is called the created environment. The interpersonal environment is the environment developed during interaction with other individuals within the community and can be described as the created environment. The created environment is developed unconsciously by the client and is symbolic of system wholeness. In this context, the work of Community Health Nurses is very essential in creating a new environment that influences positive health outcomes. Depending on the type of environment observed and assessed, Community Health Nurses can help create either consciously or unconsciously an environment of good health through promotion and preventive interventions at the primary, treatment and referral levels. In the words of Neuman, (2002), she stated it clearly that the primary concern of nursing is to assess and diagnose the appropriate stress-related situations, and interventions aimed at helping the system to adjust are then made to retain, restore, or maintain some degree of stability among the system variables and environmental stressors.
The three levels of intervention modalities as outlined by Neuman are as follows:

1. Primary prevention.

It occurs before the system reacts to a stressor. Primary prevention then strengthens the person to enable him deal better with stressors. Primary prevention includes health promotion and maintenance of wellness. She describes the primary prevention activities to compose of:

- Immunization
- Health education on topical issues such as environmental sanitation, nutrition, food hygiene and risky life style.
- Home visit
- Screening test or health screening exercises
- Community outreach programmes targeting vulnerable groups

2. Secondary Prevention

It is prevention that occurs after the system reacts to a stressor. It involves

- All measures that are put in place to prevent complications
- Proper observation to identify or detect complication
- Early identification and treatment
- Medical treatments
3. Tertiary Prevention

It occurs after the condition has been treated through secondary prevention strategies

- It offers support to the client and attempts to add energy to the system or reduce energy needed in order to facilitate reconstitution-rehabilitation e.g. exercises and special diet, physiotherapy, lifestyle changes, counseling on change of jobs.

Reconstitution is the determined energy increase related to the degree of reaction to a stressor, and represents the return and maintenance of system stability following treatment for stressor reactions (Neuman, 2002). It may also be viewed as feedback from the input/ output of secondary intervention. Figure 1.1 on page 25 is the Neuman Systems Model.
The main aim of the Neuman Systems Model is to identify risk factors in order to prevent the occurrence of diseases or illness. According to Neuman the Model is a validated nursing theory that offers a global perspective on interdisciplinary health care concerns. The primary concern of nursing is to assess and diagnose the appropriate stress-related situations and interventions aimed at helping the system to adjust are then made to retain, restore, or maintain some degree of
stability among the system variables and environmental stressors, in order to conserve energy (Neuman, 2002).

It is a comprehensive and holistic innovative framework for viewing clients across education and the health care systems across multiple dimensions (Gonzalo, 2011). The attestations by various authorities make the model reliable for the current study in Community Health Nurses (CHNs) experiences.

2.2 Some concepts of the Neuman Systems Model

The usual level of health is identified as the Normal Line of Defense (NLD) that is protected by a flexible line of defense (FLD). In other words, the Normal Line of Defense (NLD) is the client/client system’s normal or usual wellness level, which also represents what the client has become/evolved over time (Neuman, 2002). The NLD, defines the stability and integrity of the client system, its ability to maintain stability and integrity. The NLD is the standard against determining any variance from wellness (Neuman, 2002).

The Flexible Line of Defense (FLD) forms the outer boundary of the defined client system and acts as a protective buffer system of the client’s normal line of defense or wellness state.

The FLD prevents stressor invasion of the client system (Neuman, 2002). When the stressors break through the flexible line of defense, the system is invaded and the lines of resistance are activated for the client to move into the wellness-illness continuum. The Lines of Resistance (LOR) is a protective mechanism that attempts to stabilize the client system and foster a return to
the usual wellness. The LOR contain certain known and unknown internal and external resource factors that support the client’s basic structure and NLD (activate immune system mechanisms).

The lines of defense are threatened by multiple stressors such as lack of knowledge about disease, cultural health beliefs, and maladaptive coping mechanisms, which could contribute to unhealthy lifestyle choices. Socio-cultural factors such as role and relationship conflicts, discrimination, geographic isolation from family members and financial issues contribute to stress or sickness. Community Health Nurses have the responsibility to educate communities through health promotion and health education, thereby creating awareness of prevailing health situations in order for the citizenry to avoid disease risk factors. This results in a positive attitude towards health seeking and avoidance of disease stressors, hence integrating in the communities healthy lifestyle choices.

In the presence of stressors, the FLD is neglected exposing the client to risk for a stress reaction. The ability to return to a normal, stable state depends on the physiological and psychosocial status of the client. If able to cope with the stress, the NLD can eventually return to wellness. If the NLD on the contrary is compromised, the individual can develop health complications as a result of reaction to stressors. When this occurs, the LOR is activated. The LOR assists the client to return to wellness.

According to Neuman (2002) and Gonzalo (2011) health is a condition or degree of system stability and is seen as a continuum from wellness to illness. When the system needs are met, optimal wellness exists. On the other hand, when system needs are unmet or not satisfied, illness exists. In other words, when the human resources required to support life becomes unavailable, death occurs.
When the individuals at risk are found out early it will help alleviate the situation hence the focus of primary prevention should be early diagnosis. Therefore, in assessing the health situation Community Health Nurses are encouraged to be thorough in order to locate all the risk factors including strategies to cope, supporting systems and availability of resources (Neuman & Fawcett, 2002).

2.3 Others’ views on the Neuman Systems Model

The views of other authorities on the Neuman systems theory of Primary Health Care delivery are largely contributions rather than critique, discussed in the ensuing paragraphs.

The intrapersonal stressors include people not having knowledge of and not being aware of a health situation and the attending risk factors such as the relevance of exercising according to Angosta, Ceria-ulep & Tse (2016). Such people usually ignore the health situation and move on with their life (Health Forum, 2003). The ignorance of the health situation normally has adverse effect on decision making about preventing and controlling the situation. Glanz et al (2002) had early on stated this that people who are ignorant of the risk for developing a disease are mostly at the least likely to adopt preventive behaviours.

For Leake, Bermudo, Jacob, Jacob & Inouye (2011) intrapersonal stressors are a people’s believes system and their natural innate abilities to be exposed to the stressors such as susceptibility to shamefulness and societal acceptance. In order for such people to do without such natural susceptibilities, they resort to preserving their image. This could result in psychological and physiological susceptibility to the stress or health situation (Leake et al., 2011).
According to Jacquez (2016), Neuman’s proposition of “intervention as prevention” centres on making strong the flexible line of defense in order to reduce an encounter with vagaries such as sickness. Also, secondary prevention takes place when a health condition prevails and during such the emphasis is on making strong the internal lines of resistance and by that protecting the basic structure through treatment of symptoms. Tertiary prevention occurs after the system has been treated through secondary prevention strategies and focuses making the individual well again and continuing to preserve safety, quality, and wellbeing Gonzalo (2011). Again, Geib (2006), indicated that the stronger and better the quality of the client’s health system, the greater and better the buffer system of the various lines of defense.

The focus of secondary prevention is to treat the symptoms of disease and prevent their progress. There is the need to take very serious and immediate measures at this stage in order for the central core not to get destroyed, according to Angosta et al., (2016). The tertiary intervention assists the clients to keep well once they have been treated to be well through secondary interventions. Such interventions may be assessing likely future health challenges and how the community and familial members can be of help, further education awareness in order to avoid symptoms from worsening.

Neumann and Fawcett (2002) posited that the three prevention methods could be adopted for study purposes simultaneously. The Neuman Systems Model however, has not been used as a guide by anybody in Ghana to assess Primary Health Care interventions.

The central aim of secondary prevention is to stop a disease from progressing to acute levels and is therefore intervened to reduce complications and disability; hence early diagnosis with immediate treatment is the priority. King (1994) adding voice in the tertiary level of health
intervention stated that it starts when a sickness has been stabilized and the main purpose here is to bring back the individual to healthy status and possibly a higher level of functionality.

Community health nursing has been established to be very comprehensive in approach to tackling the Primary Health Care goal of health for all. This is done through delivering services to the door step of the client in a nurse-client collaborative approach and community participation.

### 2.4 Factors that Facilitate Community Health Nurses’ Primary Health Care Service Delivery

The giving to women high positions and decision making authority enhances their accessing health care, just as providing information to women and their families enable them discover complications and access care when they set in. Once complications set in, death could easily occur hence the implication is that care must be easily reachable at either the client’s home or some distance away, yet reachable by a fast means of transportation. Also, it is pertinent for well-functioning care facilities to be available with expert providers readily available.

#### 2.4.1 Training Factors that Facilitate Community Health Nurses Primary Health Care Delivery

When Community Health Nurses are offered opportunity to engage in some kind of further upgrading such as in-service and formal training programmes it gives some positive outcomes to enhance care delivery. Kash, May, and Tai-Seale (2007) indicated that six factors emanate from
training which facilitates CHNs job performance namely the opportunity to advance in career, to enhance earning capacity, enhanced CHN retention, better outcomes, higher CHN status, and improved CHN self-esteem.

In Iran, factors that enhance Community Health Nurses work have to do with the quality of clinical training. Moonaghi, Heydari & Taghipour (2013), posited that Community Health Nursing being a practice-based discipline implies the quality of students’ clinical training programmes has a major role in developing the profession.

2.4.2 Incentive Factors that Facilitate Community Health Nurses Primary Health Care Delivery

Bhattacharyya et.al (2001) concluded that a multitude of factors influence either positively or negatively CHNs Primary Health Care delivery, and how the factors interplay vary enormously from community to community. These factors were documented as pay that is cherished with its accompanying fringe benefits and also when the nurse expects that there will be a future paid employment opportunity and respect from the client communities, or the skills acquired are very much valued. Others are for the individual’s growth and when there is colleague nurses support, trademarks such as job identification badge and shirt, as well as flexibility of time on the job and at the same time clear role definition on the job, involving communities in CHN selection and training among several other factors.

They further concluded that money also motivates the retention of CHNs, though monetary motives mostly result in problems when in particular the money is insufficient or paid late and most especially when it fails to come altogether at the time most needed.
2.4.3 Collaboration as a Facilitating Factor of Community Health Nurses Primary Health Care Delivery

According to the Ministry of Health (2007), in Ghana the stakeholders do not collaborate to produce and deploy health professionals, even if they do it is inadequate and that creates a gap in programming to produce and deploy certain categories of health professionals like Community Health Nurses. There is therefore the need to provide competent and effectual stakeholder consultation among various kinds of institutions such as public and private sectors which produce the cadres of Community Health Nurses in particular in order to have a synergic and harmonious approaches to training programmes (MOH, 2008). Peer support such as working regularly with one or two other CHNs, frequent refresher training, or even CHN associations can be of great help.

In the planning of training programmes it must be noted that all communities are not the same hence planners must take into consideration the social complexity of communities in terms of health needs according to Redick (2014). Redick (2014) also added that Community Health Nurses become effective when there are community mobilization efforts, championed by both non-governmental and community or faith-based organizations. The effectiveness of health care delivery is also dependent upon careful selection and training, including the provision of continuous adequate support to Community Health Nurses Redick (2014).
2.4.4 Autonomy and Bottom-Up Approach to Primary Health Care Delivery

Frumence et al., (2013) found that if there is increase of autonomy to mobilize funds from local sources and an equally increased authority to decide the usage of the funds as well as an opportunity to use bottom-up approach to plan health issues by involving the community at the grassroots level to identify their local health concerns, the health care delivery will be promoted. Other facilitating factors are when Community Health Nurses are made to be accountable to the local community bodies while also reducing the bureaucratic bottle-necks and transferring at the same time more of the decision making to the local authorities.

The granting of more fiscal powers to the Local Government Authorities (LGA) to levy taxes and the giving of grants to the local authorities to be able to implement social and economic development activities also is very important. They concluded on the facilitating factors by indicating that more capacity building through training of the established decentralized bodies and health facility governing boards and committees; enable them to contribute effectively towards improving the quality of health service delivery. It is intriguing whether same or similar factors also influence Primary Health Care delivery in the study setting.

2.5 Hindrances to Community Health Nurses (CHNs) Health Care delivery

In general, the hindrances relate to manpower numbers, training, service capacity and deployment. For example, the inability of the initial training programs of CHNs to provide the necessary skills in how to engage with the community.

Several studies document the issue of access to care in rural areas. It has been found, for instance, that poor non-metro Americans (three out of five), live in areas where there are
shortages of health professionals with the associating limited health resources (Samuels, et.al, 2002). Compared with the urban folks, rural dwellers report cases of worsening health conditions and suffer chronic conditions such as heart attacks and die. This was confirmed by Larson & Fleishman (2003), who posited concerning access to care in rural areas, that despite their greatest need for health care, people who live in rural areas make little visits to consult their health professionals and consequently are the least to be provided health promotion services.

The key hindrances in the rural areas of Indian Community Health Nursing health care sector are low quality of care, poor accountability, lack of awareness, and limited access to facilities, according to Gramvaani (2013). Kenny and Duckett (2003) stated that conditions that affect rural health institutions capacities to provide good Primary Health Care have to do with maintaining a well-trained and competent community Health Nursing workforce.

Also, Manenti (2011) cited the not having evolved Primary Health Care system of Iran in order to meet the population’s health demands, and that the role of CHNs is weak in the Iranian health system. The Community Health Nursing workforce for instance, is inadequate to serve the overwhelming demands. In addition, the Community Health Nurse has not been seen to be crucial for their functions, since they are seen as supporting the work of physicians and doctors, rather than performing a unique primary health service for the general public. Again, Sadrizadeh (2004) stated hindrances in the Iranian health care system to be poor coordinating functions between sectors, thereby ending up in client and health provider dissatisfaction.

According to Guidry, Heather, Forti, Bushy, Tjandra, and Jackson & Philips (2008) the factors to be considered in deciding Primary Health Care issues have to do with accessibility, insurance, affordability of the care, workforce shortages such as Community Health Nurses and their
competencies with the cultural dynamics of the communities. There are also hindrances in accessing health care unique to the sub cultural as well as multicultural dwellers. These include lifestyle, culture, language, demographic shifts, poverty, and the increasing numbers of uninsured.

2.5.1 Contentions in the work of Community Health Nurses (CHNs)

There is a limited societal understanding of CHNs’ potential contributions to better health and services, paired with CHNs having to cope with health financing. Their immense contribution to improved patient understanding of health and health care, community-based lifestyle changes, greater patient engagement and self-management, higher overall individual and community wellness, and improved social determinants of health, however, have traditionally not been recognized by health care actors, according to Bovbjerg & Ormond (2013).

According to Bovbjerg & Ormond (2013), there are serious divisions between Community Health Nurses whose responsibilities are outside the clinic health care delivery and those health professionals whose work fall within central orthodox medical financing and health care delivery systems, therefore serving as a constraint in the attempt to provide services to all the people. It must however be noted that funding has been a difficulty in both spheres. The functions of CHNs’ in the area of public health also overlap with social services and other efforts to address health concerns such hazards of the environment and advancing the promotion of healthy behaviours, therefore creating contentions. Another area of conflict is that some CHNs are integrated into the traditional medicine and hospital health care delivery in which they have few responsibilities and roles to perform. Also, it is mostly difficult to attribute the success of a
health intervention impact to aspects of a programme, such as improved workload management. Based on these, Liu et al., (2011), stated that evaluation measures are often not able to view CHNs programmes as mechanisms within a dynamic PHC system.

In Canada for instance, Underwood (2003), identified several Community Health Nursing functions that are being undertaken by diverse agencies. There is therefore a concern that Community Health Nursing is a fragmented one in the communities and as a result limits the continuity of care. The consequence is missed opportunities to facilitate community connectedness and this distances the Community Health Nurses from the people. The numerous responsibilities they are expected to deliver in many communities then propel the Community Health Nurse to seek validation and recognition in his or her profession and duties.

In Ghana, although the Community Health Planning Services (CHPS) programmes have shown promising reductions in fertility and child mortality rates, access to care remains uncertain in most CHPS zones. Lack of funding, weak supply chains, and inadequate training and supervision often make CHNs restrict services to the facilities rather than extend these services to the doorstep of the people, as stated by Meltzer (2013).

### 2.5.2 Incentive Factors which Hinder Health Care Delivery

Sanders (2010) outlined some of the constraints in community health nursing that militate against Primary HealthCare service delivery to be salary problems, physical incentives, as well as unfair distribution of motivators among different types of Community Health Nurses.

Unless CHN programmes are owned and managed by the communities, they exist on the fringes of the entire health service provision system and hence are exposed to the vagaries of policy.
swings and can never be sustained. Many CHNs programmes failed in the past due to role conflicts in their duties, messy planning and the undermining of their investment by way of resources and other efforts required to enhance their job performance. There is, therefore, a further underestimation and by extension destruction of the image of the Community Health Nurses ideology, Sanders (2010). This is because the Community Health Nursing programmes operate excellently in communities that support with their mobilized effort. On the contrary, the programmes normally thrive to fizzle out in communities where the Community Health Nurses are given the sole responsibility of the mobilization efforts.

The job definition of the Community Health Nurse is such that they work in communities where established health services are not available and the majority of the residents are vulnerable by income status and health. This then makes the attempts by communities to invest funds in their health complex and challenging at the same time. Hardly do such programmes thrive until they are institutionalized.

2.5.3 Passive Clientele Attitude and Social Distance Creation Hindrances to Health Care

According to Magnis-Suseno (1957), because many communities do not want to engage in conflict since that could disrupt harmonious societies and also because people show respect for prestigious others in society, including Community Health Nurses, it makes patients not open up for certain essential health care services to be provided them, especially during family planning consultations. During family planning discussions, the clients normally are reserved and feel shy and reluctant at the same time to tell their opinions, as well as health concerns in order for the health professional to intervene.
It is only under certain conditions such as norms of the community that people are encouraged by friends, family members as well as self-motivation and personal life experiences, including the support of husbands and friends that the client will be motivated to open up (Kim et.al, 2001). (Kim et.al, 2001), however, indicated that in Indonesia, a broad range of social and educational disparities brings about a big societal distance among clients and their health care providers.

According to the Ghana Demographic Health Survey (GDHS) (2014), women in Ghana cited financial poverty (about 42 percent), long distance (about 25 percent) and expecting someone to accompany them to health facility (16 percent) as adverse hindrances to Primary Health Care access. About six percent said getting permission to access the health service was a serious impediment.

2.5.4 Resources and Infrastructural Hindrances to Health Care Delivery.

Notwithstanding the fact that the Community Health Nurse-patient ratios have progressively improved over the years in Ghana, disparity ratios are still skewed considerably and more unfavorably to the rural communities than to the cities. The nurse-patient ratio in 2006 was 1:1537 but improved to 1:1240 in 2011, according to the MOH (2014). The ratio marginally worsened to 1:1,251, in 2012 according to the Annual Report on the Ghana Shared Growth and Development Agenda (2010-2013).

In a (3rd August, 2016) Joy news featured article titled “My baby came out of my womb on a motor bike”, some of the serious hindrances to Primary Health Care delivery in Ghana were reported. It was reported that family planning services are still unpopular in many rural Ghanaian
communities and that accessing health care is beset with many hindrances. The twelfth time labour of Yibenena, a woman in a remote village of the Upper West Region of Ghana was cited to support the case. Yibenena was going into labour the twelfth time, after she had already lost four children at birth due to distance and lack of means of transport to the health facility. Accordingly, about 400 women die in Ghana for every 100,000 live births as a result of non-motorable road, electricity and health post to provide health care services.

There is also no ambulance to convey pregnant women in labour to the health post (citing Dodoma in the upper west region), six kilometers away from Dornye which has only two CHPS facilities with accommodation. On financial challenges Mi, Heerey & Kols (2008) found that serious financial constraints of the Primary Health Care system is an aggravating factor in health care service delivery since there are logistics and professional workforce provider supply inadequacies. The Primary Health Care system according to them is staffed with Community Health Nurses who serve many provider roles at several facilities such as family planning and health promotion. However, the insufficient training and poorly defined job roles and responsibilities, lack of ethical standards and regulatory bodies among several others are the factors responsible for abysmal and non-consistent performances by Community Health Nurses (Hennessy et al., 2006).

In line with this, Frumence, Nyamhanga & Mwangu (2013) writing on health constraints, stated that decentralizing health care is impeded by inadequate fiscal resources as well as non-speedy disbursement of the central government subventions. They also cited understaffing of the working force, including the fact that there are few of them who are competent to perform their
jobs or serve as supervisors of budgeted activities. All these factors, including transportation challenges serve as impediments to Primary Health Care delivery

The major hindrance of Primary Health Care services in Nigeria is inadequate workforce as well as their acute distribution to either favour certain communities, mostly the urban dwellers. This results in ineffective health care provision since it makes many communities to seek health services elsewhere including resorting to herbal medicines and quacks in the process, Afolabi & Mayowa (2015). The unavailability of or limited health education in rural settings also hinders Primary Health Care services in Nigeria. Similarly, poor health facilities and logistical problems such as rickety and inadequate vehicles for transporting Community Health Nurses for outreaches and home visiting to undertake essential services such as immunization services, inadequate funds for the running of PHC services all affect health care provision Adeyemo (2005).

A study by Van den Boom, Nsowah-Nuamah, & Overbosch (2004), indicated that access to health facilities in Ghana remain a problem and that health facilities are acutely distributed in the country to the advantage of the city dwellers. Similarly, most rural communities in Ghana do not have the basic facilities such as hospitals, health posts and CPHS compounds including the workforce such as Community Health Nurses to facilitate Primary Health Care provision Abdallah, &Vanessa (2009). The study emphasized that the facilities that many Ghanaians can go to and consult either a doctor or Community Health Nurse are some 16 km away averagely. Also, half of the Ghanaian population cannot consult a doctor within 5 km and this is equivalent to a one hour distance of walking. Again, a quarter of the population lives 615 km or more away from a facility where a Community Health Nurse can be consulted.
Maintaining CHPS compounds in Ghana is a herculean task Awoonor, & Nyonator, Frank, Wang, Chen & Schmitt (2013) due to electrical power challenges such as; (1) installing and sustaining solar panel, even with the remuneration of CHN being excluded as well as fuel for running vehicles and other activities such as (2) training costs. The most expensive components have to do with (3) building CHPS compounds and motorcycle procurement for the day by day activities. It was, however, realized that if village volunteers were used for the building of CHPS compounds, as well as traditional materials used for building walls reduced greatly. These costs are a major difficulty for district managers who often lack adequate resources for implementing basic health services to the populace.

2.5.5 Inadequate Training of Community Health Nurses and how that Hinders Care Delivery

The Community Health Nurses have inadequately equipped skills set and the nurses training institutions as well have inadequate capacities to train Community Health Nurses for maximum performance on the job. For instance, according to a featured article of the Ghana (Daily Graphic 2 November, 2011) titled, “Students perform poorly in nurse licensure examination”, less than 50 per cent of 3,223 nursing students who wrote the 2011 licensure examination passed to practice as nurses. Out of the total figure, 1,254 candidates (38.9 per cent), passed, while the remaining 1,969, (61.1 per cent), were referred to rewrite the August 2011 licensure examination.

The quality of training received by Community Health Nurses, non-existing technologies or educational models and improper administrative planning have all affected progress of
community nursing Moonaghi, Heydari, & Taghipour (2013). The need to strengthen the capacities of Community Health Nurses and their training institutions in Ghana may therefore be paramount.

2.5.6 Corruption in the Health Care Delivery

Other important factors augmenting disparities between the Community Health Nurses work delivery and how to apply them in the health care system of Ghana range from corruption relating to giving family members favours and general extortion through bribery and corruption to sometimes tribalism Abdallah & Vanessa (2009). This results from the pay benefits obtained by the health officials through theft and extorting the clients, leading to distortion of health policies and fiscal complications Abdallah & Vanessa (2009).

2.6. Methods Employed by Community Health Nurses to Deliver Equitable Health Care Services in Rural Communities.

In the delivery of health care services in communities, the CHN tries hard to reach the entire clientele. Multiplicities of methods are adopted by this category of health professionals in order to reach everyone.

2.6.1 Advocacy and Health Promotion as Methods of Health Care Delivery

A component of health promotion according to Raingruber (2011) is the concentration on offering health education on concerns bordering accessibility of health care, as well as poverty-related hindrances that do not allow individuals and communities to undertake health promoting
activities. Cribb and Dunes (1993) emphasized that empowering the individuals and advocating for them to assist them engage in health promotion behaviours and make healthy choices is the way to go in the health care delivery system.

For Maben and Macleod-Clark (1995), health promotion is about making healthy choices easy such as lobbying for healthy communities, enhancing accessibility to health care and good nutrition, as well as providing safety in homes, making health care information clear to be understood and involvement of patients in care planning and health care policy changes.

Harris and Guten (1979) described five methods of health protective behaviour, which have to do with individual health practices, safety activities and doing things that will avoid bringing oneself into health compromised situations such as avoiding environmental hazards and harmful substances. Primary Health Care interventions such as health promotion mainly target protecting individuals and communities from disease, thereby increasing health and well-being. Barnett (1993) suggested Community Health Nurses must see the promotion of health as a guide to advocate for involvement of the clients, thereby obtaining social support, and personalized care. Integrating advocacy and bringing on board social support by involving patients in the care planning and providing customized care, nurses are delivering health care to communities.

Casey (2007) agreed that one method to deliver health care in communities is the use of keen listening and involving the patient in the care system from planning and daily care to individual care based on need. Another critical method used to provide health service in communities is the use of mediation and advocacy for the rights of the client’s health concerns with other health care professionals. Community Health Nurses facilitate the achievement of these wide health promotion oriented roles Casey (2007).
2.6.2 Use of Media in Health Care Delivery

Several media methods have been used to promote health care delivery including televising, use of billboards, and social media messages among others, Raingruber (2011). Health promotion does not mean marketing or selling Maben & Macleod-Clark (1995). If health is seen as a commodity or as capital, then it will be seen as not having any value except it generates positive returns such as economic productivity. Such a stance can provide the rationale for denying health care to the less privileged such as rural dwellers, unemployed, or elderly if their years of productive life do not warrant an expensive operation or treatment Williamson & Carr (2009). According to Williamson & Carr, the most effective method used in delivering health care in communities is health education and motivating lifestyle through the social media which is very effective in behaviour change.

2.6.3 Health Education Approaches in Primary Health Care Delivery

There exists a multiplicity of teaching methods in primary health care delivery. The CHN uses one or a blend of some of the multiple teaching methods in the health care delivery approach. The major educational methods include lecturing, demonstrating how to do the intervention, using field trips and visits, according to Ildarabadi, Abbas & Ali (2015). The methods are expatiated below.

The lecture is the most used method by Community Health Nurses in health care delivery, Ildarabadi, Abbas, & Ali (2015). The Community Health Nurse lectures the client at the facility and during durbars and also other media in the delivery of services to the clients. It is a not learner-centred method and hence does not facilitate comprehensive learning in clients.
particularly when the learner does not possess the necessary competencies to educate through this approach. The other methods, namely demonstration, doing, visits and field trips are learner-centred methods and hence, directly involve clients in the practical issues of health care delivery Ildarabadi et al (2015). According to them, in the activity or learning by doing approaches, learners actively participate in the process to acquire critical thinking, self-directed learning, communication, and teamwork skills. The health care process is usually described to the clients in detail. For instance, in teaching a woman how to take pills, the Community Health Nurse is more descriptive so as to help the client learn better.

In procedural services, Ildarabadi, Abbas & Ali (2015) the CHN uses demonstrations to explain and shows in a step-by-step manner how to provide the service, for instance how to put on a condom. The clients watch and see how the CHN performs the service.

These interventions provide improved and low-stress educational atmosphere, and hence increase the clients’ satisfaction with understanding of professional responsibilities.

### 2.6.4 Community Involvement Method of Primary Health Care Delivery

Eldh, Ekman and Ehnfors (2010) indicated there is the need for the client to take part in the health care process that brings health intervention to them because the patient or client has knowledge on health issues and could be a good partner in the health care delivery process. This makes the patient able to share in the decision making to bring quality health care. Also, a discussion of what went wrong in their health and what worked for them in the past needs to be done. In advising a patient on salt intake reduction for instance, it would be helpful to find out whether family members or friends will corporate with the lifestyle adaptation.
2.7 Community Health Nurses Rapport Creation in Community Members

Notwithstanding the CHN’s insight with theorists of learning and models used in educating clients, the fulcrum of health educating individuals and communities is rapport creation by the Community Health Nurse with families, clients and communities. The Nurse is the glue used to grip the relationship with the client and hence it is the fuel for the change process, Rippke, Briske, Keller, Strohschein, & Simonetti (2001). The nurse’s ability to involve all parties develops the trusting relationship or glue needed for the learning to click. It was further concluded that the education process is not facilitated by issuing commanding messages but thrives when a congenial environment for interaction is developed with the client or patient. This according to Sands (2007), means that CHNs have to 1) deal with their own racial and ethnocentric feelings; 2) have sensitivity for group cultural diversity as well as use commonalities of tribal issues to leverage the change process 3) locate the cultural knowledge dynamism 4) learn how social and structural factors affect the behavioral change; and 5) avoid blaming the client for their plight.

The client-Community Health Nurse relationship depends on varied interactions with the client such as mental state and how people feel and act. The client is delivered a better health service if their concerns are fully considered in the relationship building process. Peplau (1952) outlined six (6) characteristics which are very crucial in developing a trusting relationship with the client namely, a Community Health Nurse who is frank and cares for the client, is a friend to the client and is always approachable, has a good ear for the client including a smiling face towards the client which give the client safety and assurance of goal achievement. In the absence of these
factors, the client enters the facility in the initial phase of the therapeutic relationship experiencing difficulties trusting the Community Health Nurse.

Communication is crucial in the development of trust especially in the beginning stage hence; it is foundation of the Community Health Nurse and client relationship. Communicating effectively leads to trust because the degree of trust between individuals is directly related to efficient and effectual communication, Community Health Nurses of Canada (2011).

Effective communication is therefore the foundation of the community health nursing job from the spectrum of health, illness, healing and to recovery.

### 2.7.1 Using Principles of Therapy to Build Rapport

The process of forming, developing, using, and terminating the nurse–client relationship phenomenon is a vital component of care and helps to determine the efficacy of treatment outcomes according to McEwen, Melaine Willis (2011). Therefore, the underpinning rules for engaging in rapport building are all about showing respect and being frank with the client by empathizing and doing active listening to understand client concerns, developing a trusting relationship and being confidential with client information, as stated by McEwen, Melaine Willis (2011). They added that the bottom line in rapport creation is to offer support to the client in order to promote health and make a difference in the client’s state of functionality.
2.7.2 People Centred Approach to Care Builds Rapport

Other factors that may contribute to the problem of inappropriate or bad relationship in the community Health Nurse-client relationship are: a results achievement approach to work rather than having concern for relationship, ethics and rules of conduct at the workplace, and not having sufficient time for the client and at worst not keeping confidential client information as well as stress on the Community Health Nurse job delivery process, Community. Also includes not using empowerment strategies such as mutual goal setting, visioning and facilitation, lack of understanding of group dynamics and effectively using facilitation skills to support group development; not helping individual, family, group, community or system to participate in issue resolution in an effort to address their determinants of health, Community Health Nurses of Canada (2011).

When community Health Nurses are friendly, warm, sociable and approachable as well as develop a trusting relationship with clients and not use more bureaucratic and classical type of consultant-client relationships it leads to quality care, according to Korsah (2011). He therefore encourages social conversation, social relationships and contact with clients. Social contact with Community Health Nurses is seen as the way to form bonds and friendly social relationships, which enables them to feel capable. Another factor that leads to quality of health care according to Korsah (2011) is when nurses show an interest in clients as people. Practices which give clients this impression include listening to and talking with them.
2.7.3 Knowing the Clients Builds Rapport

When Community Health Nurses know their clients it enhances the rapport building process because the clients appreciate the sharing of personal problems about themselves and their families with the nurse. Trust, respect, power and personal closeness are always present and form the foundation of the CHN-client therapeutic relationship, College of Physiotherapists of Ontario (2013). Personal closeness is composed of physical closeness and disclosure of personal information.

For Community Health Nurses, cultural competence is a central ingredient in the development of rapport, collecting and synthesizing information from clients, recognizing personal concerns and developing a plan of care centred around the client as well as being culturally sensitive. If a CHN is not sensitive to the personal differences between individual patients, there exists a possibility of misinterpreting the patients’ behaviours and concerns. Also, the client may misinterpret the CHN services delivered.

The CHN must show sensitivity and respectfulness to the patient’s values, culture and religion. Cultural competence refers to an ability to interact effectively with people of different cultures and socio-economic backgrounds. Cultural competence is made up of four components, College of Physiotherapists of Ontario (2013): (a) Awareness of the CHN one’s own cultural worldview (b) attitude towards cultural differences of the client (c) knowledge of different cultural practices and worldviews and (d) cross-cultural skills. Developing cultural competence results in an ability to understand, communicate with and effectively interact with people across cultures.
Eight ways that CHNs can create rapport with their clients have been discussed by Travelbee (1996). They are: get to know the client, educate them, (using reading materials, suitable linkages such as websites, connecting the client with community resources, providing video resources and permitting them chance to ask questions); being able to think through their concerns of health and following through to create a trustworthy relationship with the client, make other community health nurses to be aware of the client and his or her situation in order to offer help. The rest are calling the clients by their name and offering them attention by listening to them and making contact by looking into their eyes and responding to concerns raised, doing follow ups to find out whether the situation has improved, remaining calm and friendly and the use of on point suitable greetings and interaction closures.

She concludes the rapport process by saying that a Community Health Nurse might be the most experienced and effective in a certain facility or catchment area; however, unless that nurse has a positive relationship with every client she/he deals with, all their efforts will come to nothing.

Facilitating the empowerment process or developing a trusting relationship involves strategies such as respecting the client and empathizing with them as well as developing a peaceful atmosphere for the client and Community Health Nurse to interact Falk-Rafael (2001). The relationship is usually one of cordiality and commonness during which the Community Health Nurse offers assistance to the clients to locate their health objective and also bring on board roles they can play to achieve the objective. The rapport sometimes revolves around advocating for the client’s social, political or personal rights, though for a shortness of period. For instance, Community Health Nurses linking clients to community resources and acting on their behalf to help them attain their health goals.
The process also involves feeding the client with needed information (could be verbal or documented) and enhancing the skills development of the client such as role modeling. The process then allows the client to decide appropriately, actions to champion their health objectives. At other times the rapport process is about building the client’s abilities to do reflective listening and have empathic approach towards issues, thereby helping the client to locate the needed human and material logistics that facilitate the achievement of the health objectives.

Schultz (2015) identifies the roles and responsibilities of the Community Health Nurses to be largely intertwined with rapport or relationship building as briefly explained below.

When CHNs build rapport with the clients, because these CHNs are from the same cultural communities as the people they serve, they are in a position to better develop relationships, build trust, and bridge the gap between patients and the health system Schultz (2015). CHNs are also critical in addressing the social determinants of health that often hinder health improvements such as regularly connecting clients with transportation, health insurance and other social service needs. They provide follow up for clients they have had connection with either in a health care facility or in the community.

They provide educational materials and give presentations via health fairs, street outreach, and social media. In the health facility, CHNs often meet with patients to provide education immediately after clinical staff, thereby spending additional time with patients. Building relationships with other providers: the largest part of the CHN’s responsibilities is education of the client through outreach while linking them with resources they need to improve their health.
They are also expected to develop relationships with medical and non-medical service providers. In all these, there is rapport creation, according to Schultz (2015).

The patient should be viewed as an individual in the health care process. Travelbee (1996) dealt with interpersonal aspect of the Community Health Nurse profession which led to rapport creation. She indicated that to develop a human to human relationship, Community Health Nurses have to go through five phases, namely an opening phase with the patient; making the first impression. This is followed by a phase where both the patient and the nurse show marks of their identity to connect as human beings and make the communication easier.

In the third phase, the Community Health Nurse shows empathy for the patients’ problem or condition. The fourth phase emphasizes that the nurse shows sympathy of the patient situation and finally, the CHN and client establish mutual understanding and contact.
CHAPTER THREE

RESEARCH METHODOLOGY

This chapter discusses the methodological approach, the strategy and design to the study as well as an outline of the research setting, describes the population under study, including the sample size and sampling technique. The data gathering procedures are also expatiated with ethical concerns of the participants addressed. The chapter concludes with a description of the methodological rigor of the data analysis and interpretation procedures.

3.1 Research Strategy

The exploratory qualitative approach was used in the study to identify the experiences of Community Health Nurses Polit & Beck (2008) indicated that this approach is appropriate when little or no information is available regarding the phenomenon under study. Under the current study, little or no research information was known about the experiences of community Health Nurses in the Nkoranza South municipality, where the study setting is located. Polit & Beck (2008) and Creswell (2009) posited that exploratory qualitative research investigates the full nature of the phenomenon under study as it occurs in its natural setting, the manner of manifestation of the phenomenon as well as other factors relating to it thereby providing more insight into the phenomenon for further research and development.

3.2 Research Design

The design was a qualitative descriptive one. Qualitative approach is powerful in enabling people talk about their experiences. This consists of exploring the phenomenon under study with the participants in a particular situation according to Creswell (2009). Maxwell (2013) it is a
research method that is intended to help one better understand (1) the meanings and perspective of the people one studies, seeing the world from the point of view of respondents, rather than simply from researcher’s own (2) how these perceptions are shaped, and shape the respondents’ physical, social and cultural contexts, and (3) the specific processes that are involved in maintaining or altering these phenomena and relationships.

Qualitative research is concerned with in – depth understanding of the issue under examination. It relies heavily on individuals who are able to provide rich accounts of experience, Liamputtong (2013). In order to enable the participants share and express their feelings as well as experiences on their work, the qualitative design was used.

The study aimed at describing in order to understand and explain the experiences of Community Health Nurses in terms of factors that promote their work as well as those that hinder, and also reveal the ways Community Health Nurses deliver equitable health care through effective rapport creation with client community members. The researcher first of all visited the Nkoranza Municipal Health Directorate to seek permission and ethical clearance before access to the participants was allowed. A letter of introduction from the University of Ghana Adult Education Department was sent to the Nkoranza Health Directorate and that facilitated the permission process. See appendix IV, page 177 for sample introductory letter. When the permission was granted, the researcher then visited the various facilities where Community Health Nurses who were the participants in the study could be found. The purpose of the study was explained to the facility heads first and then the participants, following the granting of permission to conduct the interviews. The researcher made it clear to both the facility heads and participants that only Community Health Nurses who had worked three or more years were the target of the study. Both the facility heads and fellow participants of the interview helped to identify the next
participant of target. The participants were assured of confidentiality of their views. During the interviewing, the participants were given the opportunity to withdraw from the process if they so desired after agreeing to take part. The researcher spent about 45 minutes to two hours conducting in-depth interview with each participant to obtain his or her views on a set of questions on their experiences on Primary Health Care delivery in communities. In-depth probing was done to ensure that each participant gave a detailed description of the issues. This then enabled the researcher to learn the meanings of the experiences of Community Health Nurses on their work, as far as Primary Health Care delivery is concerned.

3.3 Research Setting

The study was carried out in the Nkoranza South Municipality. There are twenty two districts in the Brong Ahafo Region, of which Nkoranza is one of them. The Municipality lies within longitudes 1°10″W and 1°55″W and latitudes 7°20″N and 7°55″N. It covers a total land area of 923 square kilometers. It shares boundaries with the Nkoranza North District to the North, the Techiman Municipality to the West (both in the Brong Ahafo Region), the Ejura-Sekyedumase and the Offinso North Districts, both in the Ashanti Region to the South–East and to the South respectively, according to the Ghana Statistical Service, G.S.S, (2014).

The population of Nkoranza South Municipality, according to the 2010 Population and Housing Census is 100,929 representing 4.4 percent of the region’s total population of 2,310,983. The percentage of males is 49.6 percent while females represent 50.4 percent. More than half (52.9%) of the population live in the rural areas.

The indigenous people are Akans. However, the Dagaaba and ‘Fra-Fra’ are also predominant in the rural communities. This means that a Community Health Nurse who speaks either one or
both languages affects Primary Health Care delivery positively. According to local folklore, the Nkoranza state was established by “Nkokora miensa” (three old men). Nkoranza therefore derives its name from “Nkokora miensa”.

More than half of the total population is the Bonos and the remaining population is made up of few other ethnic groups from the northern Ghana. The Majority of the residents are indigenes and the Bono language is therefore the lingua-franca. Since majority of the Community Health Nurses are Akans, this affects the delivery of Community Health Nursing work positively.

The Nkoranza South has a few road networks. Only the roads linking the municipal capital to the neighboring districts are tarred. Apart from that the remaining roads are feeder roads with poor surface conditions due to erosion and non-maintenance. Transporting agricultural produce from farmlands to the marketing centers is often delayed due to the non-motorability of the road network, especially during the raining season. This also reduces accessibility to essential services such as emergency health care.

There are two main Hospitals within the township of the municipality and one Health Centre. These are the St Therese’s and Pathmos hospitals and Nkoranza Health Centre respectively. There are (6) Community Health Centres and (5) Community Health Planning Service (CHPS) compounds operating outside the municipality in various villages and towns, making referrals to the two main hospitals. The total number of Community Health Nurses in both the Health Centers and CHPS compounds is 38. The details are Nkwabeng-4, Ashiayem-5, Bonsu-4, Akuma-5, Ayirede-4, Donkronkwanta-5, Asonkwa CHPS-3, Nsunensa CHPS-2, Dandwa CHPS-2, African Liberal CHPS-2, and Akropong CHPS-2.
Figure 3.1 below is the Map of Nkoranza South Municipality indicating some of the towns or villages where health centres and CHPS compounds can be located.

Fig 3.1: Map of Nkoranza South Municipality

Source: Ghana Statistical Service, 2014
3.4 Target Population

Population according to Burns & Grove (2005) consists of all the elements of individuals, objects or substances that comply with specific criteria for inclusion in a given universe. The targeted population in this study comprised all Community Health Nurses in the rural areas of Nkoranza municipality, working in the Health Centres and CHPS compounds. Community Health Nurses who had worked three years or more and were willing to take part in the study were included, since they have encountered enough of the most recurrent problems and know what factors on the job facilitate or hinder service provision in order to describe these experiences. Community Health Nurses working within the Nkoranza municipality were excluded since they have enough facilities and personnel such as a medical doctor. Those working in the outskirts of the municipality were included since they fall within the rural setting where Community Health Nurses refer cases from their facilities. These facilities total 12.

3.5 Sample Size and Sampling Technique

The purposive sampling technique (a qualitative strategy) was used to collect data from the Community Health Nurses. Polit & Beck (2008) defined purposive sampling as a technique in which the researcher selects the study respondents on the basis of personal judgment about which respondents will be most suitable in a particular study.

In the current study, purposive sampling was used since this involved selection of cases that most benefited the study, based on the researcher’s judgment or interest (Polit & Beck 2008; Creswell 2009). The researcher visited the various Health Centres and CHPS Compounds, explained the research purpose and objectives to the facility heads first, and the participants afterwards. The
participants were offered the opportunity to ask questions for clarification before they consented to take part in the study. A convenient date, place and time for the interview to take place were then agreed on.

As regards the sample size, qualitative research method is said to usually work best with small numbers. According to (Lusardi 1996) cited in Liamputtong (2013) qualitative researchers sample for meaning, rather than frequency. They are not interested in how much, or how many, but in what. This authority also points out that qualitative research aims to examine a ‘process’ or the ‘meanings’ that people give to their own social situations. A total of sixteen (16) Community Health Nurses who had worked for three (3) or more years were interviewed, though saturation of data occurred on the eleventh participant. According to Polit & Beck (2008) saturation is the process of collecting data to the point at which a sense of closure is attained beyond which new data yield only redundant information. According to Burns and Grove (2005) the sample size of qualitative study depends on the concept of saturation. Thus, the recruitment of the participants continued to a point where no new information emerged from the subsequent participants. That is, data was collected to a point when the information being received became redundant or repetitive of what had been gathered from the already sampled population. Of the sixteen participants that were recruited, saturation point was reached on the 11th participant with the five additional participants interviewed to confirm the data that had been gathered from the previous participants. Table 3.1 on page 60 represents the summary of participants sampled for the study.
Table 3.1: Illustration of Data Saturation

<table>
<thead>
<tr>
<th>Interviews</th>
<th>Evidence of saturation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of interviews with emerging themes and categories</td>
<td>11</td>
</tr>
<tr>
<td>Number of interviews to confirm new emerging theme</td>
<td>5</td>
</tr>
<tr>
<td>Total number of interviews conducted</td>
<td>16</td>
</tr>
</tbody>
</table>

The sixteen (16) Community Health Nurses were recruited from Health Centres and Community Health Planning Services (CHPS) in rural communities of Nkoranza in the Brong Ahafo Region. All sixteen interviews were conducted between September 2016 and March, 2017.

A follow up was done to interview participants on two other objectives in January - March 2017. The researcher used both English and Twi (local language) to enable him probe and rule out uncertainties. The interviews were audio recorded with the consent of the participants and afterwards transcribed verbatim into English for analysis. The interviews lasted averagely between an hour and one hour thirty minutes per participant.

3.6 Data Gathering Procedure

Data gathering is the systematic gathering of information relevant to research purpose or specific objective and questions of the study from respondents selected for the research Burns & Grove (2005). The data gathering procedure under the current study involved the use of unstructured interview guide to conduct an in-depth interview of about 45 minutes to two hours with each
participant. Burns & Grove (2005) defined interview as a verbal communication process between the participants and the researcher which enables information to be provided to the researcher. Unstructured interviews provide narrative data for qualitative analysis Polit & Beck (2008). They further stated that most narrative self-report data are collected using guiding questions rather than questionnaires. The researcher in an unstructured interview prepares in advance, a written interview guide, which is a list of questions to be covered with each participant. During the interview, the researcher encourages the participant to talk freely about the phenomenon under study and narrate the stories in their own words to enable the researcher obtain all the information required Polit & Beck (2008).

In order to gain an insight into the experiences of Community Health Nurses, the unstructured interview approach was adopted. The researcher visited the facilities of the interviewees and was granted permission to conduct the interviews; therefore all the interviews took place at a convenient spot at the participant’s work place, decided by them. Face-to-face interaction was used to ensure flexibility of the interview process and to enhance free interaction between the researcher and the participants.

The language of interaction was mainly English, with minimal usage of Twi in order to enable the researcher probe for detail from the participants.

The researcher, after seeking the consent of the participants, used a recorder to record the data during the interview and transcribed them verbatim, immediately from the field, for analysis and interpretation to be made.
3.7 Data analysis and Interpretation

The main objective of analyzing data is to reduce and organize the data to a form that give meaning to it Burns & Grove (2005). According to them, qualitative data analysis comprises of making sense out of the text data. In order to make sense out of the data, the process involves preparing the data for analysis, conducting different in-depth analysis into the understanding of the data and making interpretation of the larger meaning of the data Creswell (2009). Qualitative data analysis goes along with the data collection; hence the current data analysis was done simultaneously with the collection.

The current study made use of the content analysis approach according to Tesch (1990) in Cohen, Manion, & Morrison (2007). The texts were analyzed, reduced and interrogated into summary form through the use of both pre-existing categories and emergent themes. Systematic, replicable, observable and rule-governed forms of analysis were used in order to facilitate the application of the categories, Cohen, Manion & Morrison (2007).

Krippendorp (2004) defined content analysis as a research technique for making replicable and valid inferences from texts (or other meaningful matter) to the contexts of their use. Texts are written and communicative materials which are intended to be read, interpreted and understood by people other than the analysts Krippendorp (2004).

Weber (1990) sees the purposes of content analysis as including the coding of open-ended questions, the revealing of the focus of individual, group, institutional and societal matters, and the description of patterns and trends in communicative content. In the current study, coding was done to reveal the focus of the Community Health Nurse experiences in the transcripts and a description of patterns and trends then made on each participants response to the questions.
There was therefore a continual reflection on the research data, asking analytical questions and writing memos throughout the study.

Tesch in Cohen et al. (2007) provide a systematic procedure for transcribing and analyzing in-depth interview data, which the current study adopted:

1. **Transcription** - The researcher listened to the tapes and transcribed the interview verbatim, adding the identification label for each participant. This stage is crucial in preparing for the data analysis; therefore the researcher ensured accuracy and that the transcriptions truly reflected the views and experiences of the Community Health Nurses.

2. **Coding and extraction of significant concepts and statements**

Miles and Huberman (1984) posit that coding is a process of iteration and reiteration since some codes that are used in the early stages of coding might be modified subsequently and vice versa, necessitating the researcher to go through a data set more than once to ensure consistency, refinement, modification and exhaustiveness of coding (some codes might become redundant, others might need to be broken down into finer codes). Under the current study the researcher therefore read through several times to understand the transcripts, coded and named the units according to the content they represented. The researcher repeatedly read through each of the transcripts and coloured (coded) concepts and statements within the narrative content. The ideas and the underlying meanings of each coloured (coded) paragraphs were written down in the margins of the transcripts.
3. Clustering themes.

For a better understanding of the recurrent concepts and their full meanings, the coded concepts and statements were sorted and listed into topics. Similar topics were further clustered together to form themes. Each significant statement and theme from the interviews were then written down and labeled to serve as the first level of the analysis.

4. Categorization of themes

During this stage, the researcher went back to the data and with the list of clustered themes, searched for commonalities across the participants, while searching for how the themes were patterned and interrelated as well. The appropriate segments of the data from all the participants were then copied and placed under the topics as codes to see what categories emerged.

5. Exhaustive description

During this stage, the most descriptive wording for the topics was found and put into categories by grouping the topics and themes that related to each other. Sub-categories were then drawn between the main categories for easy identification and description.

6. Category labeling

During this stage of the analyses, the supervisor verified the audio-recordings, the transcribed data and levels of coding and analysis of the themes and categories before allowing the final labeling of the categories to be made.
7. Category grouping

The researcher then grouped the categories into major categories with their sub-categories. Each category was then described and supported with the literal verbatim quotations from the participants.

3.8 Ethical Considerations

Ethical clearance was sought from the supervisory team as well as from the Ghana Health Service Directorate in the Nkoranza Municipality before the data could be collected from the participants.

A letter of introduction from the Department of Adult Education and Human Resource Studies, University of Ghana was sent to the Nkoranza Municipal Health Directorate, the Municipal Director of Health Services and managers of the various health institutions within the municipality, explaining the purpose of the study to them in order to seek permission to undertake the study. See appendix II, page 150 for sample introduction letter. The purpose of the study was explained to the participants as well as how the results would be used.

In the entire research process, the participants’ human dignity and rights were protected. This was done through informed consent, anonymity of participants and confidentiality of data obtained from them. The participants were also informed about including some of their comments in the report to be compiled. They were further assured that the research is for academic purpose and would be of use in making a difference as far as Community Health
Nursing policy, practice and quality of health care delivery are concerned. They were given the chance to discontinue the study at any stage, if they so wished.

In the management of participants’ data, they were assured that their responses would remain confidential. The audio tapes, transcribed data and other documented information given by participants were therefore stored under lock and key, made accessible to only the researcher and supervisors. Biographic data were managed to provide anonymity.

3.9 Methodological Rigor/ Trustworthiness

Reliability in qualitative research is essentially dependability, consistency and replicability over time and over respondents.

This research rigor or reliability was regarded as a fit between what the researcher recorded as data and what actually occurred in the natural setting that was being researched Cohen, et.al, (2007), including the degree of accuracy and comprehensiveness of coverage Bogdan & Biklen (1992).

To ensure credibility, the researcher first of all visited the participants at their various health facilities and established rapport with them before the actual interview date. On the interview day, about forty-five (45) minutes to two hours (2) in-depth interview was conducted with each participant at a venue decided by the participant. The researcher then used probing questions and minimal verbal interferences with intermittent clarifications to establish the meanings of the participant’s responses, messages and observations. A voice recorder was used to capture the raw data and responses given by the participants during the interview process to ensure that data
was captured correctly and that no information was left out. The participants’ own words were used to ensure correct representation of their messages.

Multiple data collection methods such as the use of unstructured interview guide questions, review of other studies and comparing and discussing with the findings of the current study were also adopted.

3.10 Dependability

It has been argued that qualitative research strives to record the multiple interpretations of, intention in, and meanings given to situations and events, (Cohen et. al.,2007) citing Brock-Utne (1996). (Lincoln & Guba, 1985; Anfara et. al., 2002) refer to this as dependability and further indicate that dependability involves triangulation, prolonged engagement in the phenomenon under study, persistent observations in the field and independent audits (identifying acceptable processes of conducting the inquiry so that the results are consistent with the data). For De Vos, (2005) dependability is all the efforts the researcher makes to account for the changing conditions in the phenomenon chosen for the study.

In this study, dependability was achieved by coding and auditing the raw data and archiving the data in order to make possible the checking of the findings against the raw data. Consistent checking of data by the researcher and the supervisor was also done.
3.11 Confirmability
It is the objective and neutrality nature of the data gathered and whether the findings can be confirmed by another study (Polit & Hungler, 1999; De Vos, 2005). (Cohen et al., 2007) indicated that same observations and interpretations made by the researcher at different times and in different places, as well as making the same observations of what has been seen or paying attention to other phenomena during the observation of a subject of study, enables the researcher to achieve confirmability. In order to achieve confirmability in the current study, same interpretations were made by the researcher at different times and different places. The same set of questions was also used to interview each of the participants.

3.12 Transferability
It comprises the extent to which the results can be generalized or replicated in other situations or settings.
In a study by (De Vos, 2005) it was indicated that the best approach to achieve transferability was through generalization. To achieve generalization, detailed description of the research setting, transactions and processes were done. That provided the means for other researchers to replicate the study in a different setting.

3.13 Authenticity
It refers to the extent to which the researcher fairly and faithfully displays a range of different realities in the analysis and interpreting of data (Polit &Beck, 2008). The researcher made sure that the participants’ messages were conveyed as reported by them in the study during the recording of the findings.
CHAPTER FOUR

ANALYSIS OF DATA AND PRESENTATION OF RESULTS

This chapter reports the findings of the study. The chapter covers narrative descriptions of the participants or interviewees used for the study. It also covers the data gathered and the findings from the study. The participants were given pseudonyms to personalize their verbatim quotes while maintaining anonymity.

4.1 Description of Study Participants

The participants for the study were Community Health Nurses who had worked up to a minimum of three (3) years. The participant selection criterion was a purposive sampling in the village health centres and Community Health Planning Services compounds (CPHS) of the Nkoranza South Municipality. For the sake of anonymity and confidentiality, the participants were given pseudonyms using the first initials of their names and place of work. Ensuing is a description of the participants:

- AA was a 32 year old married female with one child and her highest level of education being certificate in Community Health Nursing. She had at the time, three years of experience in service delivery as a Community Health Nurse.

- JA was a 37 year old male Community Health Nurse, with no child and had been divorced due to staying too long in the village. He had worked for 7 years and still remained on the rank of Community Health Nurse.

- CB, a married female of 29 years old had no child at the time of interview. She had four years of working experience as a Community Health Nurse with her highest level of education being certificate in Community Health Nursing.
• FA was also a 30 year old female who had never married before. She had a certificate in Community Health Nursing as her highest education and served as a Community Health Nurse for 5 years.

• AN is another Community Health Nurse, a 29 years female who was married with 2 children and her highest level of education was a certificate Community Health Nurse. She had 7 years of working experience as a Community Nurse.

• For NN, another Community Health Nurse, she was 30 years old and married with one child. Her highest level of education was diploma in Community Health Nursing but with 4 years of working experience to boast of.

• SN was a 27 years old who had never being married. She had certificate in Community Health Nursing and had 4 years of working experience as a Community Health Nurse.

• FD, a Community Health Nurse Midwife (CHNMW) was 29 years old and married with one child. With a certificate in Community Health Nursing, she was delivering health care in the rural areas with 3 years of working experience.

• CN, a 31 year old female was married with one child. She was another CHNMW and had a rank of certificate Community Health Nurse but with a whopping experience of 5 years in Primary Health Care delivery.

• As regards AAA, she was 29 years old, but had never married and hence had no child also. She had a diploma in Community Health Nursing and had work experience of 5 years.
• CAN is another female who was 28 years and had never married. Her highest level of education was Certificate in Community Health Nursing with 4 years of work experience to her credit.

• SA was a 26 years old female and never married before and as such had no child. As a certificate Community Health Nurse, she had 4 years of work experience to her credit.

• SAA, another 29 year old female and never married Community Health Nurse had a certificate in Community Health Nursing. Her rank was Community Health Nurse and she had work experience of 4 years.

• KA was also a female, 31 years old but married with 2 children. She had a certificate in Community Health Nursing as her highest level of education but ranked as a Senior CHN with 6 years of work experience.

• GDN is a female of 40 years who is divorced with one child. Her highest level of education was a certificate in Community Health Nursing with a rank of CHNMW, with 6 years of working experience.

• JN was the last participant in the description process. She was 28 years but had never married and hence no child. Her highest level of education was a certificate course in CHN with 4 years of experience on the field.

Appendix II, page 158 gives the profile of the study participants.
4.3: Data Analysis and Generation of Themes

The results of the study are based on themes that were generated regarding community health nurses experiences in primary health care delivery. The themes generated from the data of this study were created through rigorous content analysis using (Tesch, 1990) in (Cohen et.al, 2007) approach to qualitative data analysis. The transcribed data was read and reread by the investigator to grasp an understanding of the experiences of community Health Nurses in primary Healthcare services delivery. The main themes that emerged were: Factors that hinder Community Health Nurses (CHNs)’ health care delivery and activities in communities, Factors that facilitate CHNs’ Health Care Service delivery, ways used to ensure equitable health care delivery and ways in which CHNS create rapport with community members.

Thereafter, subcategories were identified within the main themes. Out of the four themes, eighteen subcategories emerged. The themes and their respective subcategories are shown in Table 4.1, page 73. These themes are described and supported by the verbatim expressions of the participants in the ensuing paragraphs. See appendix III, page 159 for a sample verbatim transcript of interviewee (JA).
Table 4.1: Themes and subcategories generated from the study

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<tr>
<th>Themes</th>
<th>Subcategories</th>
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<tr>
<td>(b) Infrastructural Development</td>
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<tr>
<td>© Empowerment of community members</td>
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<tr>
<td>(d) Good Rapport and community support</td>
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<td>4.2.2</td>
<td>Factors that hinder Community Health Nurses’ health care service delivery and activities in rural communities</td>
</tr>
<tr>
<td>(a) Inadequate and lack of Logistics</td>
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<td>© Human Resource Related Problems</td>
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<tr>
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<td>4.2.3</td>
<td>Ways used to ensure equitable health care delivery</td>
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<td>(a) Community Visitation and Surveillance</td>
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<td>(d) Use of Community Volunteers</td>
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<td>Community Health Nurses ways of rapport creation among community members</td>
</tr>
<tr>
<td>(a) Creating good receptive atmosphere</td>
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<td>(b) Use of community resources</td>
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<td>© Home visiting</td>
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<td>(d) Professional work ethics</td>
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<tr>
<td>(e) Provision of health information</td>
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4.2.1. Factors that Facilitate Community Health Nurses’ Health Care Service Delivery

The first theme that guided the research was to identify what Community Health Nurses in the Ghanaian communities perceived to facilitate their work. Various responses were given and could be put under four subcategories namely: (a) empowerment of workers, (b) infrastructural development, (c) empowerment of community members and (d) good rapport and community support.

The subcategory on empowerment of workers captured factors that seek to develop the workforce of Community Health Nurses including providing them with the necessary logistics required for the successful completion of their work. Under this subcategory, three further subcategories emerged. They include (i) empowerment in the form of motivating Community Health Nurses, (ii) training opportunities and (iii) the provision of logistics required for job performance.

Concerning empowerment as a form of motivation for Community Health Nurses (CHNs), the respondents emphasized there was the need to appreciate and provide Community Health Nurses with the remunerations that they deserve. The Community Health Nurses called for the health sector to appreciate the work of the Community Health Nurse through giving out deserved prizes or plaques of honor as well as remunerations which are sometimes made available by NGOs and government on some projects that the CHNs embark on.

GDN explained this in her response as:

*Everybody wants motivation; even motivation doesn’t mean go and give the person money. If our leaders praise us verbally, say this month CHNs your report that you brought shows that you are really working. That alone would motivate me. Or our leaders should come down with us during our day to day activities,*
occasionally to see where we pass through in order to reach our clients. I would say that, ohh me too I am being regarded.

Also CB commented this way:

*One must love the job, knowing that the community needs help. In addition to loving the job, having the skills set as well as the zeal to work makes one able to deliver effectively.*

FD commented:

*It is the love of the work and my relationship with the clients.*

AN also indicated:

*Proper training and orientation by senior colleagues are the factors that facilitate work as a community health nurse.*

The second subcategory that the participants commented about is empowerment in training opportunities for them as CHNs. The respondents as Community Health Nurses called for the provision of in-service training on specific skills; such as training in community engagement; establishing cordial relationship with community members and new approaches or standards used in work that are critical to delivering as a community health nurse. This was called for as most respondents said the standards of operations is mostly based on what is learnt in school and that sometimes things learnt in school do not meet standard in practice, hence the need for on-the job training. Also, captured under this subcategory is the opportunity to upgrade in the area of pursuing higher education. The respondents believed working for a minimum of three years before an upgrade was too long and hence there is need to reconsider that aspect in order to develop the workforce of the Community Health Nurse. Again, visiting other facilities was a form of training that some respondents indicated was helpful in the work since it offered an opportunity to learn some new things or practice in those places.
JA indicated this in his comment as:

*Periodical on-the-job training in the form of workshops or refresher courses to help one re-echo what one has been doing as well as briefings in new developments, is crucial. In short, sharing of ideas and getting briefed on new developments are some of the factors that facilitate healthcare delivery.*

AAA also remarked:

*Visiting other facilities apart from my facility helps because it helps me as a Community Health Nurse to know what is happening in those facilities. I go to learn from my colleagues. For instance I learnt there was one vaccine that was added and it’s “Men A”, meningitis so last month when I visited my colleagues in other facilities I learnt a new vaccine has been brought.*

This was further supported by CB as:

*Having the requisite skills set as a result of some training or in-service training also enhances the work delivery.*

SA confirmed this in her response that:

*The training gave me knowledge about certain things like how to insert the Jadelle, how to give injection. The Jadelle, if you are not trained on that you would find it difficult to insert. Going for workshops also helps a lot, some things might come new and they would teach you how to go about them.*

AA too indicated:

*Good training helps to know what one needs to do.*

The last empowerment motivation factor is being provided with the required logistics that facilitate the work of Community Health Nurses. This fell in the category of providing the necessary logistics such as fuel, motorbikes, educational leaflets, vaccine fridges, adequate cold boxes and other material items needed to bring work to completion.

JA commented that:

*When the CHN is provided with the needed equipment or logistics to work, healthcare delivery is facilitated.*
CN also indicated:

*We should be provided with items like weighing scales, we want more motor bikes and regular maintenance of the motor bikes.*

Regarding the subcategory on infrastructural development, there was a call to address bad road networks including the provision of electricity. These were considered as two major factors when addressed facilitate the work of community health nurses. These two were seen as core because when resolved will make inaccessible areas accessible and ensure that all clients in those catchment areas are given the services that they need. The electrical output is seen as integral factor in the delivery of good healthcare services owing to the fact that it offers the best opportunity for ensuring drug potency.

KA, a 31 year old Senior CHN, married with two children commented on the infrastructure problem:

*The only borehole just opposite the facility got spoiled two years ago. Now we don’t have one. We don’t have water and the secret is we all go to the stream in the morning and it has been hindering our work. We go to fetch water to wash our utensils but buy pure water for drinking. The ladies do the cleaning and we also go to the streams to fetch water so by the time it is 8 o’clock, sick people are already at the clinic whiles we are not in. When this is fixed our work will run fast.*

The subcategory on empowerment of community members was seen as a way of facilitating the work of Community Health Nurses through certain actions required of community members. This was regarded by respondents as vital because the work of Community Health Nurses (CHNs) benefits community members and hence if the actions of these communities impede the work of CHNs, then there is the need to tackle such for the greater good of health care delivery. This community empowerment concentrated on educating and providing information to debunk certain beliefs that they hold which are seen as a hindrance to health practices.
The move will also see the use of community volunteers in health care delivery to be more acceptable by community members. Some of these negative beliefs cited by the respondents include negative attitude to health seeking where the community members choose work over their health. Also some people believe in self-medication and have some distrust for conventional medicine, as well as in the CHNs, which make the practice of these nurses futile. Due to this, more education which provides more information to community members is seen as a tool that will facilitate health delivery as it helps to debunk some of these ideas.

The use of Community Based Surveillance Volunteers (CBSCVs) is seen as another resource for facilitating health care delivery. These community volunteers are regarded as people who know more about the health issues confronting the community and will be of great help in finding solutions to these problems. The community Based Surveillance Volunteers (CBSVs) are also given some drugs for first aid purposes such that in areas that are hard to access, the clients get some form of help before they get to the CHNs for further assistance. Again, the CBSVs facilitate health care delivery by recording deaths in communities and tracing the causes of such deaths thereby helping to trace the incidence and prevalence of diseases which is the first stage of planning interventions. Again, they are regarded as very forceful in convincing the rest of the community members on some health practices.

JA, in the interview, reported:

*We have to use any available meeting or opportunity to educate the communities, for that matter, our clients. For instance, we do health education at the antenatal level, at the Out Patients Department level (OPD) or at the Child Welfare Clinic (CWC) level. Sometimes, when we go for home visits we do health education including a one-on-one education, and any other opportunity we get to educate them.*
Concerning adult volunteers, some of them go with us during home visiting. Most of them know what to do already so when asked to do something to help, do exactly that, such as weighing of children. I can say that adult volunteers convince the people for us.

It was elaborated by SA as:

When the communities you are working with are not difficult, work is facilitated. You know some people are really difficult when you tell them to do something they do not do it but when you find some community and they are not like that you are lucky.

Another subcategory that was cited as facilitating Community Health Nurses work is good rapport and community support that establish good relationship with community members. This was described as crucial for the health services rendered by a CHN without which not much could be done. These make the services of the CHN easily accepted by the communities, including availing themselves for services to be rendered for them.

AAA indicated that:

What makes health care delivery easy is my relationship with the people. That is I will say, there is a cordial relationship between me and the people or communities. In other words, I am approachable to the people. Also, the way I talk to them and handle them facilitates the work.

Also AA in the interview mentioned that:

What facilitates health care delivery is good community relationship.

Likewise KA indicated that:

The communities serve as a security for me, the assembly woman and some of the opinion leaders serve as father and mother. They have always shared our problems even if they are private. They are much concerned about us.
4.2.2 Factors that Hinder Community Health Nurses’ Health Care Delivery and Activities in Rural Communities

The second theme of the study was the factors that hindered Primary Health Care delivery services of Community Health Nurses (CHNs) in communities. Based on the responses that were given by participants, four subcategories emerged from this main theme. These are inadequate logistics, lack of proper infrastructure, particularly roads and access; human resource challenges and community activity related challenges and behaviour.

For any organization to achieve its goals and vision, infrastructure, logistics and other human and material resources are required to influence the organizational behaviour which will in turn influence job satisfaction as well as social participation. There exists a gap in supply and demand deficits of things needed to implement an equitable and affordable Primary Health Care service in communities. These deficiencies can be traced to the respondents’ expressions as follows:

CB, a 29 year old married Community Health Nurse who has been working for four years indicated:

*Frequent breakdown of our motor bike is the only problem that thwarts our home visiting regarding transportation. When there is a breakdown of the motor bike it makes it difficult to walk several kilometers to reach out to community members for our services. This creates a gap between the monthly immunizations. The same thing occurs when there is shortage of antigens (vaccines) and there is no means of transport to collect them from the district office.*

AN, 7 years experienced community health nurse also remarked:

*There is a frequent breakdown of the only motorbike we have to our service which is a problem.*

Then CN, a 31 year old mother of one child, with 5 years working experience in Community Health Nursing reiterated:
Our main problem is getting to the community. We have one motor bike and if it gets spoiled the authority will accuse us that we are using it for our own personal things so we should do the maintenance ourselves. Regarding fuel, we were told NGOs were supporting us but when we go for fuel the authority tells us it is finished and we have to buy fuel with our own money out of our meager salaries.

Also, JA a 37 year old Community Health Nurse and divorced for being away from her spouse for 7 years in the village lamented:

Truly some of the common problems, especially on administrative issues are about convincing our leaders to provide our needs. Normally it is difficult to appeal to our leaders to provide us with motor bikes and also to maintain those that breakdown, especially if the breakdowns become frequent due to bad roads. There is also vaccine fridges problem to maintain the cold chain for vaccines. Ideally we are supposed to have two vaccine fridges, one for vaccines only and the other for preparing iced packs. For the iced packs, any deep freezer can be used. The vaccine side is not normally a frozen one. Our vaccine fridge got spoiled some months ago and a different one was brought to us. The vaccine side of the current fridge is not working. You can imagine how we are struggling to maintain the cold chain for the various antigens. We are just struggling daily to maintain vaccines and administer them to the recipients at the right temperatures.

AAA, a 29 years old single community health nurse midwife (CHNM) with 5 years of working experience summarized the issues of inadequate and lack of logistics as:

The problem is our motor bike; our motor bike gets frequent breakdowns because of the dusty roads. That is making our work very difficult including the nature of the road. Also fuel to go to outreach is often not enough. You may have a plan for the day but the car or motorbike might be stuck in the mud and that spoils your plan for the day as you will be trying to pull it out and get on the road but mostly a fiasco.

As regards lack of infrastructure, another subcategory that emerged as a hindrance in the work of Community Health Nurses is accessibility to some catchment areas. This encompassed no or poor road networks as well as communication networks making it very difficult to access such communities. Some road networks seemed to be bad especially during the rainy season. There were also poor communication networks and so getting through both road and telecommunication becomes difficult.
Due to these two challenges of certain catchment areas, they also lack Community Based Surveillance volunteers since such areas are far and communication becomes difficult. Also stated by some respondents is the absence of electricity to provide them with light and power to store their vaccines and as such have to travel some distance in order to store these vaccines. CB in her response to the lack of infrastructure remarked:

_Some roads are very bad making movement to the clients difficult. There are two roads in the catchment area that are not motorable, yet we have to be there monthly to attend to women and children’s health needs._

AN also asserted that:

_We have poor road network and the health facility here is unattractive at all as you can see._

AAA emphasized this point as:

_Truly speaking some places you have to leave the motorbike and take your bag. Imagine you are carrying your bag and the vaccines at the same time by the time you get there you will be tired and cannot finish the work you planned of doing. So our roads are not helping in many ways but we are trying our best. We are facing many difficulties on the blind side of our leaders and health authorities._

GDN, a 40 year old Community Health Nurse Midwife (CHNM), described the day to day experience as follows:

_Transportation, because the road is not good, we have hard times to reach areas. Now that we are in the rainy season, if it rains you can’t go because the road is slippery. You would go and get accident. Usually, even motor bikes cannot pass bad roads; we don’t have any way ohh. It’s somebody’s what should I say farm path so you ride the motor, and walk in-between the mud. If you are not careful all your body would, you would have bruises all over your body. Last someone came here to deliver. She was on tractor. She came with tractor. She labored in the house ahhh, and they realized that if they didn’t send her to the hospital she would die. That there was no means and she couldn’t sit on motor, even they had no motor bike, so the only means was to go in for the tractor. And they got the person, and when they came, and God being so good, she survived under my care._
Human resource related problems constitute a major issue in the implementation of Primary Healthcare (PHC) activities. This subcategory captured challenges that are related to the organizational body of the health care system and welfare of Community Health Nurses in delivering health services in communities. There were some subcategories that emerged under this subcategory: inadequate workforce, lack of in-service training and lack of job related motivation.

Regarding inadequate workforce, there was evidence of inadequate staffing at post. Most respondents indicated there was high work load as a result of the few staff available and as such some work is always left undone; especially in places where only one person was at post. This according to respondents led to multiple roles and unrealistic expectations set by the leaders.

On insufficient staffing Mrs FD, a 29 year old Community Health Nurse Midwife (CHNM) with 3 years working experience reported:

*Insufficiency of staffing is a major problem. Maybe I am supposed to go for health talk in the community or schools. I don’t have any person to take charge of the facility, yet I have to be there. So usually, I have to close down the office and put myself in the community till I come back to attend to people who call at the clinic.*

Also, NN a 30 year old CHN with four years working experience interjected:

*There is work overload and shortage of staff.*

Then SN, a 27 year old male CHN with 4 years working experience remarked:

*Inadequate staffing is a key challenge associated with home visiting. The Nsunensa CHPS Compounds has staff strength of two Community Health Nurses. As a result of inadequate staffing, staffs do not take annual leaves as their entitlements. The lack of a midwife contributes to so many home deliveries in the catchment area.*
Furthermore, irrespective of the lack of staffing, the few staffs that do most of the work cited insufficient motivation as a hindrance to their work. They expressed the lack of recognition for them even though they do most of the health care services in communities.

Also SAA a 29 year old CHN with 4 years working experience said:

_Talking about motivation, this motivation is not about our leaders giving us money but rather praising us for the things that we do, if they could appreciate it so that we can put in more effort, ahaa, but they won’t do that, and discouraging us by their remarks such as community health nurses you are not doing your work. This mostly discourages me because they don’t see my effort and let me do it anyhow, as for that we often say._

Mrs CN a 31 year old married CHN with 5 years working experience indicated:

_The challenge at the community level is how to get to people who are hard to reach in order to get the information one needs and also how to convince them on some of the health issues. Another challenge is that we don’t have a midwife and many pregnant women give birth at home or in other facilities. The women come to us for the antenatal service but when it comes to delivery they go to other facilities because they know we don’t have a midwife. It is always hurtful when leaders tell us in the face that we are not performing._

A subcategory on community activity related challenges and behaviour reflected the attitudes and behaviours among community members that hinder the work of Community Health Nurses. This reflected beliefs and attitudes toward health and then the work schedules that conflicted with operational times of the Community Health Nurse’s work. On the beliefs and attitudes dimension, respondents reported that some community members are immune to change and so the health recommendations that are given are almost ignored or not heeded to and so no matter the number of times one tells them about change policies, they do not give an ear. Also other respondents indicated that some community members have their own health beliefs and so distrusted Community Health Nurses and would rather self-medicate or take their own approaches to health. There was also the issue of timing. In other words, the visiting time of the Community Health Nurse conflicted with the time of work of community members who are
predominantly farmers. It was the belief of the Community Health Nurse that the community members value their work more than their health and so even if they are aware of a health activity, will leave for their farms very early in the morning and return very late at such a time that the Community Health Nurses would be returning to their facility or homes by then.

JA points this out as;

*Timing has been the biggest problem. Before one starts a home visit, one must know what time the people are available or always at home since as Community Health Nurses, we don’t normally inform the community members the time we make visits. Normally, by the time we get to our catchment area, the people are not always available. It is only when we have clinics or durbars that we inform them of our visits, if not we will keep them waiting and they may not be happy with that.*

This participant JA continues this further by stating that:

*Upon all advice, one can still meet a mother whose child was supposed to take a particular vaccination within a certain month and yet the mother failed to bring the child just because this particular mother was not coming for Child Welfare Clinic (CWC) and therefore did not get information to come for the other vaccination. So these are some of the hindrances. Another problem is that others report to the facility late when they are sick.*

CB also in her comments mentioned that:

*We always preach to them about environmental cleanliness, some of them don’t change.*

AN also lamented that:

*There is lack of trust and respect by community members and hence they do self-medication.*

AA, 32 year old CHN, married with a child and 4 years work experience also indicated that:

*Understanding of the community members, what we say to them during the outreach program, they don’t seem to take it. Also there is low availability of community members due to farming activities.*

It was further expressed by SA, 26 years old single CHN with 4 years working experience as:

*One problem associated with home visiting includes unavailability of persons due to work such as farming.*
4.2.3 Ways Community Health Nurses Ensure Equitable Health Care Delivery of Health Care Services in Communities

The last but one theme was to explore the ways Community Health Nurses deliver health care to community members to reach maximum coverage. This was answered by the Community Health Nurses and the reports can be grouped into five subcategories, namely: (a) the use of community visitation and surveillance, (b) the use of health education, (c) the use of health outreaches, (d) the use of community volunteers and (e) referral. The subcategories are further discussed and quotes that emphasized these are cited to elaborate on them.

In the first subcategory which is Community Visitation and Surveillance and how Community Health Nurses use that as a way to deliver equitable health care, the report indicates that a number of visits are embarked on to the assigned catchment areas. These visits were described by many of the respondents as also core of the job description they were expected to perform. The form of visitation varied, cutting across individual home visitation to targeted group visitation such as schools, churches and clubs in the community. The main activities during visitation are observing the health status of the community and also disease surveillance in order to have a fair idea of community health status and risk, as well as identify areas of target for health education and outreach. This subcategory was therefore regarded as core to health service delivery to the communities and clients.

The surveillance was also done at the health facilities level to keep track of the cases that are reported frequently. Some responses that emerged on questioning the work of a Community Health Nurse in line with this subcategory are indicated.
YA reiterated;

*We do disease surveillance which is in the form of home visits.*

In his expression JA also put it across that;

*We do monitoring for instance on teenage pregnancy during our antenatal attendance and also during home visits. In terms of disease prevailing conditions such as malnutrition, diarrhea under five, we also go by that, since it is the same conditions people will bring to the facility level. When we suspect the cases are becoming predominant, any instance one gets one speaks to the community and emphasizes on that, for instance sicknesses which we suspect to result from negligence.*

The second subcategory under the ways Community Health Nurses ensure equitable health care delivery is health education. The reports indicate that health education is seen as core to ensuring delivery of health service. This involves educating community members on core preventive practices with the focus on improving health outcomes. This category captured several areas of concern for health promotion and preventive practices. These include nutrition, reproductive health, personal and environmental sanitation and preventive care from malaria.

The health education is reported to take two forms, namely planned and spontaneous. The spontaneous usually takes the form of one on one or individual health education, given to individual members of the community when the need arises. With the planned education, a date is set and premeditated and the target group is met on the set date for such discussions to be made on the topic of interest. An example of this given by respondents is health education in a school, church or at durbars. The spontaneous kind is in the form of Community Health Nurses being approached by community members on an area of concern and the client is educated on it, or the Community Health nurse observes a deficit during visitation and the client or individual is
educated instantly in that area. These were usually done when there was a disease outbreak or the need for an awareness concerning high incidence on specific disease or health concern in the area or country. They are time bound education done as and when the need arose.

Furthermore, health education takes on different approaches in terms of method. The most used ones include discussions, talks, demonstration, flip charts, local information centers and Community Based Surveillance Volunteers (CBSV).

SN in his words stated:

We go to their houses and educate them, if they fall sick the appropriate steps they have to take and sometimes we go to the churches or mosques and other places to give health education. Sometimes clinical care when we come to the clinic, we gather them and give them information about their health and how to prevent disease and if the disease occurs how they are going to cure it.

YA another participant also commented:

We have leaflets for that, given to the CBSVs to talk more about to the communities. When people see these pictures or leaflets they are self-educative.

Another participant JA verbalized:

In terms of disease prevailing conditions such as malnutrition, diarrhea under five, we go by that, since it is the same conditions people bring to the facility level. When we suspect the cases are becoming predominant, any instance we get we speak to the community and harmer on these cases, for instance sicknesses we suspect to result from negligence. A case in point is the Kantankani community, during my antenatal outreach; I realized that hepatitis B was becoming predominant among the youth and pregnant women. We had to organize a durbar and explain to them what hepatitis B is and how it is transmitted from one person to the other.

FA, 30 years old, single CHN with 5 years working experience also put out her dimension of education as:

If I planned to talk about malaria during home visits and I realize that the surroundings are very dirty, I rather take the opportunity to talk about sanitation.
We also do education during durbars such as when there is an outbreak of a disease such as chicken pox. I talk to them about how to prevent it.

The third subcategory on the theme of equitable health care delivery methods is health outreaches. This was described as meeting community members and the community members bringing their health problems so that help is offered them by the Community Health Nurse. These outreaches are also done in response to some observed conditions that are prevalent in certain community areas in order to help these communities deal with the situation. Also, when there is directive from the Ministry of Health regarding immunization against certain diseases, outreaches are used to ensure the delivery of such services.

One respondent JA, said:

*We have outreach (immunization) schedule, where there are schools we also have school outreach schedule, as well as going by the prevailing health related conditions of the community. It becomes part of our agenda when we are embarking on these schedules.*

AN, commented:

*We go for outreaches in these communities and the communities bring their health problems and whatever help we can offer we do. If we are unable to help on that day, we give them another day in order to serve their needs.*

KA also described this in his words as:

*We mainly use outreach method, community durbars and home visits. These are the three methods we use. Any time we want to do community entry we use one or two or all of these methods provided we are able to reach the means by doing it.*

In terms of the use of community volunteers in delivering services in the client communities, the Community Health Nurses see this as another strategic way through which health services are equitably delivered to the client. These community volunteers are seen as core to some of the approaches used as well. The volunteers are made up of members of the community that are trained on basic health concerns as well as “first aid” to act as first point of call for community
members before access is made to Community Health Nurses, since not all catchment areas are easily accessible by the Community Health Nurse.

AA also put his views across:

*The community volunteers are there. They live in the community with the people. In the absence of the CHNs, the volunteers represent us. They are other community health workers who also help in case of any emergencies before the Community Health Nurses arrive to help.*

Also AN indicated:

*We use the volunteers who live with the people in the village communities, they call us when the need arises and we go there to help.*

The last subcategory on ways of equitable health care delivery methods is referral.

It was found that referral of cases or client community members and calling for help from the district level is seen as a measure for ensuring maximum coverage of health care delivery. The respondents asserted this means is resorted to because some cases are beyond them and so referring will endure optimum health. Also, there are occasional backup calls for support from other personnel such as disease control officers when there is an outbreak of disease in some catchment areas; all in an attempt to help bring the situation down.

In a statement by FD, she asserted:

*During epidemics, we call for help, for instance our Disease Control Officers to come and assist.*

Likewise KA commented:

*Sometimes we refer cases that are beyond our level to ensure the clients obtain the health care service they need.*
4.2.4 Community Health Nurses’ (CHNs) Ways of Rapport Creation with Community Members

The last theme of this study was to explore the ways in which Community Health Nurses ensure rapport creation between them and community members. This was queried in the interview and five main subcategories emerged. They comprise (a) creating good receptive atmosphere, (b) the use of community resources, (c) home visiting, (d) professional work ethics and finally (e) provision of health information. These subcategories are explained and quotes that reflect these categories are used to elaborate on them.

Creating good receptive atmosphere was the most cited by all interviewees for the creation of a good relationship for carrying out duties. This was regarded as things or activities done in order to make community members feel at home, loved and open to discuss their health problems so that the problems can be easily solved through collaborations. These include activities such as greetings, offering of seats, sharing jokes with the community members, sharing life experiences that align with their problems and asking about the client’s general wellbeing. Other activities cited include allowing community members to join the CHNs morning devotions if the clients were present before work begins and asking about their general wellbeing. Also cited under this category is the communication style and tone that is receptive and engaging rather than commanding. The following were used to elaborate on the subcategories.

According to SA:

*The way I take time, greet and communicate with the client leads to great rapport. Showing concern about the client is the biggest rapport creation process.*
Also YA stated:

*If the person is rather coming to the facility, the moment I see the person approaching I have to mention their name and welcome them with warmth and smile. I let the person sit down when he/she arrives, and ask how they are faring including their family. I then have a good communication with the person. This makes them feel at home and could reveal any secret concerning their situation of health. There should also be a good environment. That is when the person is coming to me and I know that they are coming to me; I do not usually pretend to be busy with other things or my work.*

SN, 27 years old single CHN with four years working experience interjected in interviewing him:

*I usually create some jokes when I see the clients approach me or the facility.*

Concerning the use of community resources as a subcategory to create rapport among community members, the participants indicated using community volunteers and opinion leaders like the assembly men and women, chiefs, elders and institutions in the communities. This according to the participants helped greatly in creating rapport among the Community Health Nurses (CHNs) and community members, alike. This gave the CHNs confidence that they as CHNs are accepted as key stakeholders of development in the community. The community leaders authenticate and build trust in the activities of Community Health Nurses in these communities, according to the findings. Again, getting involved with already established institutions in the communities creates avenues for community members to get to know about Community Health Nurses in the communities such that if there was a later encounter, the client communities members will open up for further interaction.

This was expressed by CN as:

*For me the CHN must win the hearts of opinion leaders in the community including visiting churches that the CHN doesn’t attend.*
AN, stated:

Even before I go there, I should have had some discussion with the chief of the area and other opinion leaders such as the assemblyman, informing them the purpose of the visit and their support.

Also, JN, 28 years old single CHN, with 4 years working experience put it that:

We have volunteers and so when we want to enter communities, our volunteers take us to the chiefs and assemblymen and then we inform them of the reasons of our visit before we are allowed to meet the entire communities at durbars or even the individual clients, to give say a health talk. Normally the chief asks that they beat the gong-gong to gather all the community members for us to meet them.

On home visiting as another subcategory, most participants indicated that rapport is built through home visiting which could be in the form of just checking up or following up on some clients who have defaulted or reported at the unit with some health needs. This according to the respondents gives opportunity for getting to know about the community and building connection with community members such that they feel loved and that you are concerned and available. Also, following up on clients who have been to the unit with some health concerns make the clients see you as one of them and will be willing to come to you with their health problems. Furthermore, they expressed that visiting established groups within the community can be very helpful. This subcategory was clearly seen in the narratives of CN.
According to (CN):

*The main approach is through home visiting. Supposing you don’t know me and we meet for the first time or they tell you I am going to be in charge of your health. You will accord me some respect. As soon as the CHN gets to the clients houses, they don’t know you and do not expect to see you at their house. In the community there are various groups of people and tribes such as dressmakers association, boys peer groups etc. when I attend or visit such groups; it is the beginning of the rapport creation, since they recognize me as part of them. Follow up is also an essential part of the rapport creation since during the home visiting one could do a follow up in the form of defaulters tracing to find out why. When one identifies the defaulter, still maintain your calmness and ask why the client failed to return to the facility to give a feedback.*

The last but one subcategory is professional work ethics. This subcategory captured participants’ responses that reflected core competences that are required to successfully carry out the work of Community Health Nurses but are also good for rapport creation. The ones mentioned include competency which has to do with being on top of issues in order to give out the required help that community members approach the CHN with. This was regarded as something that helps the Community Health Nurses to gain respect from community members thereby boosting these community members’ confidence in approaching the CHN subsequently. Also, the ability of the Community Health Nurse to keep secret what the client does not want to be divulged opens the client up to share personal problems. That is when Community Health Nurses are able to assure the community members that whatever that they as clients share will be kept a top secret, it opens up relationship for better healthcare service delivery. However, if confidentiality is breached, the community members might not put trust in the issues of the Community Health Nurses.
FD puts this as:

You need to create some form of confidentiality, not that you go and sit somewhere and talk about the client. This leads to the development of trust between the CHN and the client.

According to YA:

In the communication process let the client know that no one will hear about the discussion between you, that is create trust of confidentiality between you and the client.

SA also put it this way:

I have to be alert with anything and they will have confidence in me, meaning the person is coming to me and I can provide confidence in the client that I am capable of helping them.

Also considered as one of the ways through which community health nurses ensure rapport is through the provision of health information to community members. This was described as giving out health advice to aid individual decision making as well as entire community enlightenment. This according to participants made them feel you are concerned and will regard you as a friend and will likely come to you for further service. That is the previous encounter with them gives them some confidence to approach you as they believe in you after such encounter that the Community Health Nurse is able to provide some form of solution to their problems. This theme was captured in statements that were made by some of the participants.
This was stated by SN as:

**What we do to create constant rapport is that, for instance, if I am dealing with client insurance and the client insurance is expired, I have to give drug and advise in addition for the client to go and do the insurance. With such help, the client feels like you are a friend and hence when they have a problem they can say, let me go here, they are my friends, I will get what I want. We also give them education or enlightenment during our visits and sometimes we organize the whole community to enlighten them on important issues concerning their health. All these create rapport between us and as a result, they always come to us for more.**

This chapter analyzed the results generated from the participants based on themes and subcategories. Chapter five which follows discusses the findings.
CHAPTER FIVE

DISCUSSION OF FINDINGS

This chapter presents the discussion of the results in relation to the experiences of CHNs in Nkoranza South. The discussions are based on the themes and subcategories of the results.

The various themes under which subcategories are discussed include factors that facilitate CHNs’ health care service delivery, factors that hinder Community Health Nurses (CHNs)’ health care service delivery and activities in communities, ways CHNs ensure equitable health care delivery and finally, ways in which CHNs create rapport with community members.

The Neumann Systems Model being the theory underpinning the study is used as the main theory to explain the results. The findings were also contrasted and compared with other studies from literature which confirm or disconfirm what the Neumann’s theory indicates, in order to build upon the ideas and make recommendations for action by policy makers as well as other parties such as researchers, who may be interested in the recommendations and findings.

Community Health Nurses have become the front liners in health care delivery in Ghana and in the globalized health care system. The experiences of these category of health professionals is very crucial if health interventions will be equitably delivered to all the citizenry, especially for the rural populace in Ghana, who are challenged by distance, transportation, resources and information, just to mention a few.

How essential the responsibilities and activities of the Community Health Nurses (CHNs) are have been stated by (Liu et.al, 2011). The Community Health Nurses have been touted to be a cadre of workers who provide low-cost Primary Healthcare (PHC) services at the community
and individual levels promote public health thereby serving as a crucial link between community members and the PHC system. This serves as an avenue for continuum of care across multiple points of care.

There are some critical factors which facilitate the work of the Community Health Nurses. These factors were captioned under a major theme as factors that facilitate Primary Health Care service delivery of Community Health Nurses.

5.1 Factors that Facilitate Primary Health Care Service Delivery by Community Health Nurses

Regarding the theme, investigating what Community Health Nurses in some communities in Ghana perceive to facilitate their job performance, the results or findings obtained could be put under four main subcategories namely: (a) empowerment of workers, (b) infrastructural development (c) empowerment of community members and (d) good rapport and community support. The factors outlined by the participants can be said to come under primary health risk prevention, according to Neuman, (1970).

(Rippke et al., 2001) offered some highlight on Primary Health Care risk prevention measures. According to her, in Primary Health Care risk prevention, both the populations at risk and the populations of interest are target of study. This makes studying both facilitation and hindrance factors relevant.

Primary prevention measures according to (Rippke et al., 2001) are normally implemented before a problem develops promotes health and protects against health threats. It also reduces
exposure to risk factors and susceptibility, promoting protective factors and resilience. It targets essentially well populations (populations of interest).

This position of (Rippke et al., 2001) had already been stated by Neuman (1970), that primary prevention strengthens the person, group or community to deal better with the stressors as it occurs before the system reacts to stressors. She described primary prevention to be composed of health promotion and maintenance of wellness. The activities which fall under health promotion and maintenance of wellness according to Neuman are immunization, health education on topical issues such as environmental sanitation, nutrition, food hygiene and risky life style, home visiting, screening test or health screening exercises and community outreach programs targeting vulnerable groups.

The resistance lines are activated by the invasion of the defensive lines of environmental stressors (Neuman, 2002). This implies that if there are no environmental stressors, the client system will continue to be healthy or well and therefore will not go through instability. Community Health Nurses have the responsibility to put in place interventions to strengthen the lines of defense in order to avoid future invasion. This is where factors that facilitate Community Health Nurses’ functions and activities, the second theme of the current study reflects or features. The facilitating factors help maintain and strengthen the flexible line of defense as well as the normal line of defense, which together serve as a buffer for the core structure. The combined effect of the buffer system is that the lines of resistance are protected and as a result they do not get activated or invaded by stressors. Geib (2006) agrees with Neuman on the issue of the lines of resistance serving as buffer for the client’s system of health. Geib asserted that the greater the quality of the client system’s health, the greater protection provided by the various lines of defense. By extension, the facilitation factors of Community Health Nurses’ Primary Health Care
delivery activities and functions enhance the delivery of better health care services to communities and the individual client. In other words, if these factors are well exploited, they could enhance the course of Primary Health Care services as delivered by Community Health Nurses, which in turn lead to healthy communities. In short, there will be quality and maximum coverage of health services to the communities. For this reason Neuman, (2005) posited that, the NLD is the standard against determining any variance from wellness, since it defines the stability and integrity of the client system.

5.1.1 Empowerment of Workers as a Way to Develop Workforce of Community Health Nurses

This subcategory captured factors that seek to develop the workforce of Community Health Nurses as well as provide them with the necessary tools required for the successful completion of their work. Under this section, three subcategories emerged. They include (i) empowerment in the form of motivating Community Health Nurses, (ii) training opportunities and (iii) the provision of logistics required for carrying out their job.

Wachira (2011) indicated that deviant behaviours emanating from financial or status gains among public servants (McCormack, 1997) is now prevalent especially in Africa and has its own effect on the ability to enhance service delivery effectiveness. The current study agrees, to a large extent with Wachira’s findings.
Concerning empowerment as a form of motivation for Community Health Nurses (CHNs), the participants emphasized there was the need to appreciate and provide Community Health Nurses with the remunerations that they deserve. They called for the Ghana Health Services and Ministry of Health to appreciate them for what they do through giving out prizes or plagues of honor when they do well and also receive remunerations which are sometimes made available by Non-Governmental Organisations (NGOs) and government on some projects that they the CHNs embark on.

(Bhattacharyya et al., 2001) concluded that a complex set of factors affect CHNs motivation and that how the factors play out vary considerably from place to place. The following were found to be facilitating factors: satisfactory remuneration (material incentives/financial incentives) or possibility of future paid employment and community recognition (showing respect or appreciation for the work done by CHNs). The findings on motivation of workers as demanded by Community Health Nurses in the villages of Ghana are in line with the Bhattacharyya et.al, (2001) workforce motivation factors.

Touching on training opportunities as a kind of Community Health Nurses (CHNs) empowerment, the participants lamented about the limited training opportunities available for them. There was a call by most respondents for the provision of in-service training on specific skills (such as training in community engagement; establishing cordial relationship with community members and new approaches or standards used in their area of work). This was called for as most people said their standards of operations are mostly based on what they learnt in school which sometimes do not meet standards in their practice.
(Singh, 2015) encouraged the integration of continuing education with regular supervisory processes, individual performance monitoring for effective empowerment of workforce. Continuing education when administered correctly will keep CHNs abreast of best practices as well as increase relevant clinical knowledge. It also serves as a professional development opportunity that can motivate and improve job-related performance. Studies such as those of (Singh, 2015) found that skills and knowledge are quickly lost if regular refresher training is not available. Thus continuing education and in-service training should be anticipated as integral components of CHNs subsystem maintenance and be appropriately funded.

Also, this study findings are in line with those of Neuman & Reed (2007), who indicated that the 21st professional care-giving requires high levels of caregiver knowledge, commitment and skill to foster caregiver partnerships for mutual care planning and implementation. They also added that it will be imperative that Community Health Nurses consider intrapersonal and cultural concerns.

Also captured under this subcategory is the opportunity to upgrade in the area of pursuing higher education. Respondents believed working for a minimum of three years before an upgrade was too long, including also the lack of opportunities to progress to the highest heights of academic laurels within the Community Health Nursing profession. Some participants commented that the highest academic laurel a Community Health Nurse could ever attain was a midwifery certificate. Even though one male expressed the enthusiasm to become a mid-husband, for many other females, if given different progression opportunities apart from midwifery, they would opt out to be trained as a midwife.
(Bhattacharyya et al., 2001), identified acquisition of valued skills by Community Health Nurses, personal growth and development; accomplishment, status within community and community involvement in the selection and training of CHNs to be very critical variables in the empowerment of Community Health Nurses.

According to the Chartered Institute of Management CIM (2002), carrying out your duty as professional includes applying expertise and judgment; the enthusiasm and direction of others and support to the achievement of the objectives of the organization. This essentially ensures that organizations- empower their employees with competencies, skills and attitudes needed to go about their duties and that the right employees are rightly deployed at the right time. The demand for training opportunities by Community Health Nurses in this study, in order to be better equipped with the skills set for self-growth and job performance seems to be in the right direction, agreeing with the findings of CIM (2002) and (Bhattacharyya et.al., 2001).

The third and last empowerment motivation factor is being provided with the required logistics that facilitate the work of Community Health Nurses. This falls in the category of providing the necessary logistics such as fuel, motorbikes, educational leaflets, vaccine fridges, adequate cold boxes and other material items needed to bring their work to completion. Many participants asserted that the logistics availability is very crucial in promoting healthcare delivery and that their shortage, lack of or break down would stall work or bring to a standstill job execution. (Bhattacharyya et.al., 2001) again stressed that appropriate job aides such as counseling cards and regular replenishment of supplies can help ensure that CHNs feel competent to do their jobs.
Sanders (2010) summarized the factors that empower Community Health Nurses to be able to contribute effectively to healthcare delivery as: they require substantial increases in support for training, management, supervision and logistics.

5.1.2 Infrastructural Developments which Facilitate Health Care Delivery of Community Health Nurses

The results of the current study indicate that the participants called for the addressing of bad road networks and the non-existence of power in many health posts and CHPS compounds, which they consider to be the main infrastructural challenges when looked at, will facilitate the work of Community Health Nurses.

The study findings about the need for motorable roads in the village communities confirm the report of the Ghana Statistical Service (2014). The report indicates that the Nkoranza South has a few road networks. Only the roads linking the district capital to the neighboring districts are tarred. The remaining roads are feeder roads with poor surface conditions due to erosion and non-maintenance. Transporting agricultural produce from farmlands to the marketing centers is often delayed due to the non-motor ability of the road network, especially during the raining season. This also reduces accessibility to essential services such as emergency health care.

This study results that the existence of motorable roads and electricity will lead to effective Primary Health Care delivery in the rural communities are also confirmatory with a Joy news documentary. Joy News (2016) indicated that about 400 women die in Ghana in every 100,000 live births as a result of non-motor able road, lack of electricity and health post to provide health care services. There is also no ambulance to convey pregnant women in labor to the health post.
(citing Dodoma in the upper west region), six kilometers away from Dornye which has only two CHPS facilities with accommodation.

5.1.3 Empowerment of Community Members for Effective Primary Health Care (PHC) Delivery

This was regarded by participants as vital to facilitate the work of Community Health Nurses (CHNs) because, the work of CHNs benefits community members and as such if their actions impede the work of CHNs, then there is the need to tackle such for the greater good of health care delivery in the communities. This community empowerment concentrated on educating and providing information to debunk certain beliefs that they hold (such as self-medication and distrust for conventional medicine and CHNs), which are seen as hindrances to health practices. The most effective method used in delivering health care to communities is health education and motivating lifestyle through the social media which are very effective in behaviour change based on a careful understanding of the patient’s situation, economic resources, educational background, social supports, cultural beliefs, and environmental factors within the community Williamson & Carr (2009). They further stated that in order to motivate the individuals, families, and communities to make lifestyle changes, it is necessary to understand the factors that keep them from changing as well as those that prompt them to adopt new behaviors. One must also understand the perspective of the client or the community with whom one is interacting. The point that has been made to enhance community empowerment for them to be receptive to the Community Health Nurse (CHN) health care services is that there should be an opportunity for both the client and consultant to interact and educate each other.
The community will get to know with time what the CHN demands of them, likewise the CHN will get to understand reasons why the clients have trust in what they believe in. On the contrary, Evans and Stoddart (2003) in Gregg (2015), concluded that social and economic factors are far more impactful on health than individual behaviors and attitudinal beliefs. These could be the reasons for the negative attitude of the community towards service providers, such as CHNs. On the contrary, (Rippke, Briske, Keller, Strohschein, & Simonetti, 2001), suggested that to implement effective behavioral or attitudinal change for communities, one should apply the principles of adult education and learning. These principles involve altering knowledge, attitudes and behaviors of adults because they are self-directed and will change when the need arises. The most effective methods will likely be highly interactive, allowing the clients a high degree of discretion in how the health provision could be implemented.

(Maeseneer et al., 2007) , also found that the use of Community Oriented Primary Care-strategy (COPC) will lead to optimum health care delivery. In the COPC, the direct action of the Community Health Nurses team and the inter-sectorial networking will enhance social cohesion in the community. According to them, both the actions of the Community Health Nurses and the increased social cohesion in the community will lead to empowerment of the people either at the physical, psychological, social, or cultural levels. The empowerment of the population will in turn decrease the vulnerability to factors that may contribute to health inequity. This confirms the power of community empowerment and the effect on Primary HealthCare delivery.
5.1.4 Good Rapport and Community Support which Facilitate Health Service Delivery

Another factor that was cited by the participants as facilitating community work is rapport creation and community support to establish good relationship with community members. This was described as being crucial for the health services rendered by a CHN, without which much could not be done.

The existence of rapport implies a high level of mutual understanding, a high level of positivity or warmth, and a high level of behavioral coordination, i.e., a more synchronized behavior both in terms of form and timing, (Iglesias, 2010), citing Tickle-Degnen, Rosenthal & Rosenthal (1992). Rapport can be categorized into: speech-unrelated nonverbal rapport, speech-related nonverbal rapport and verbal rapport.

What the participants described as critical for availing community Health Nurses’ (CHNs) health care programmes to the communities to advance their health care are in line with what Rippke, Briske, Keller, Strohschein, & Simonetti (2001) asserted that: irrespective of the CHN’s familiarity with learning theories and health education models, the core of health education is a therapeutic relationship that develops between the nurse and individuals, families, and the community. Nurses are the cement of the process and serve as catalysts for change by delivering humanistic care. The capacity to involve all client parties or individuals sets up the trust or “cement” necessary for learning to happen. Educating does not begin with the first instructional word but rather starts with establishing an atmosphere conducive to learning.
5.2 Factors that Hinder Community Health Nurses’ Health Care Delivery and Activities in Communities.

There were four subcategories generated under this major theme ranging from inadequate and lack of logistics, lack of infrastructure, human resource related problems to community activity related challenges and behaviours. These are the factors the CHNs consider as infracting upon the smooth running of Primary Health Care services in communities, especially as far as the study setting is concerned.

Under the Neuman Systems Model, these factors as enumerated by the Community Health Nurses can be considered as stressors at the secondary level and therefore the Primary Health Care interventions here should focus largely on secondary prevention strategies. According to Neuman, (2002) secondary level of prevention is that prevention occurs after the system reacts to a stressor. The intervention measures all focus on: first of all critical observation in order to detect or identify the stressor. The second measure is to do early identification which then enables early treatment to be done. Third, avoid complications and forth, go for medical treatment if complications set in.

In the current study, there were four subcategories that served as stressors in the work of Community Health Nurses, namely: inadequate and lack of logistics, lack of infrastructure, human resource related problems and community activity related challenges and behaviours. In other words, these are the factors the CHNs consider as infracting upon the smooth running of Primary Health Care services in communities, especially as far as the study setting is concerned. The stressors are in existence and impacting on the health of the client, hence secondary
prevention measures should be adopted. Confirming the position of Neuman, (1970), Rippke, Briske, Keller, Strohschein, & Simonetti (2001), highlighted some factors which constitute secondary prevention as: detecting and treating problems at their initial stages and curbing any serious or long-term effects while protecting others from being affected. Secondary prevention detects and modifies or treats risks before they become serious. After a problem begins, Secondary prevention is applied. It seeks out those with common risk factors for early detection and treatment. This restores the clientele to the Normal Line of Defense (NLD) Neuman (2002). If adequate energy is restored through reconstitution, restoring the normal line of defense can either be below or above the previous level. From the various analyses made, it could be said that for Community Health Nurses Primary Health Care delivery services to proceed explicitly, the hindrances factors need to be addressed with urgency.

5.2.1 Inadequate and Lack of Logistics Impediments to Primary Health Care Delivery

The first impacting difficulty has to do with logistical challenges. These were stated as required resources which enable the daily activities or work of Community Health Nurses to be executed. The logistical challenges include inadequate or partly functioning motor bikes, syringes, fuel for running the motor bikes, educational leaflets, vaccine fridges, cold boxes among other things listed as required for the smooth running of the day by day activities.

Neumann (1970) outlined that for Primary Health Care interventions to promote and maintain wellness, several activities were necessary, including immunization, health education on topical issues such as environmental sanitation, nutrition, food hygiene and home visiting as well as community outreach programmes targeting vulnerable groups just to mention a few.
Accordingly, these Primary Health Care interventions usually occur for the client or person to avoid interacting with either internal or external environmental stressors or forces (health situation or disease). These stressors could be physiological (physicochemical structure and function of the body), psychological (mental processes and emotions), socio-cultural (relationships and social/cultural expectations and activities), spiritual (the influence of spiritual beliefs), as well as developmental (those processes related to development over the lifespan). The availability of logistics and equipment will strengthen the performance of health promotion activities, thereby strengthening the client or patient to deal better with stressors and maintain good health or wellness.

The current findings are congruent with those of Adeyemo (2005) as well as the activities identified by Neumann (1970) as essential for health promotion and maintenance as indicated in the ensuing paragraph. Adeyemo (2005) found that the hindrances to effective Primary Health Care services (stressors) which could hamper health needs of the client or have the potential for dissatisfaction of health care services (Neuman, 2005) are deprived amenities and equipment such as inadequate vehicles or vehicles in deplorable state used in transporting Community Health Nurses for immunizations and insufficient funds for the administration of PHC services.

5.2.2 Infrastructural Hindrances to Primary Health Care Delivery

Another subcategory that emerged as a hindrance in the work of Community Health Nurses is the inability to access some catchment areas due to bad roads, including the absence of electricity to provide light and power for the storage of vaccines so as to avoid travelling some distance in order to store these vaccines.
Owing to the road and communication network challenges, the Community Based Surveillance volunteers (CBSVs) in certain catchment areas are unable to work effectively. The findings are in congruence with the Ghana Demographic Health Survey (GDHS) (2014) findings which stated that about one in four (25 percent) of women in Ghana cited distance to a health facility as a major hindrance for not obtaining Health Care service. A Joy News documentary (2016) stated that about 400 women die in Ghana for every 100,000 live births as a result of non-motorable roads from communities to health facilities. Also, other factors indicated to impede health care delivery is lack of electricity for the storage of vaccines and unavailability of health post in certain communities which necessitate clients having to walk far distances to other health care facilities in other to access health service. The villages in the study setting, Nkoranza south, are not the exception in the impediments to accessing Primary Health Care services in Ghana, with some as far as 18 kilometers, away from the district hospitals -the Nsunensa CHPS compound is a case in point. This consequently affects the work of Community Health Nurses because poor road networks make home visiting very difficult, hence the needed education and other services may not reach the clients. The lack of electricity for instance could affect the potency of vaccines if such vaccines have to be transported from the municipal centre to these villages.
5.2.3 Human Resource Related Problems of Community Health Nurses Primary Health Care delivery

This subcategory captured challenges that are related to the organizational body of the health care and welfare of Community Health Nurses in delivering health care in communities. Some subcategories that emerged under this section are inadequate workforce, lack of in-service training and lack of job related motivation.

The current study agrees with Sanders (2010) who outlined major factors that militate against Primary Health Care service delivery to compose of inconsistent remuneration, unfair distribution of incentives among the various types of Community Health Nurses (CHN), insufficient refresher training, excessive demands/time constraints, gross disrespect from health facility staff, and unsuitable selection of CHNs and the absence of community participation in CHNs selection, training and support. The finding by Sanders did not however, include the issue of multiple roles and unrealistic expectation set by superiors due to comparison with other places that have the required number of CHNs at post, which the current study revealed.

The issues of inadequate staffing or workforce and related low motivation for work leads to multiple roles and unrealistic expectation set by superiors because of comparison with other places that have got quite a number of CHNs at post.

The lack of a midwife in many Community Health Planning service (CHPS) compounds for instance is reportedly the largest contributor of many home deliveries. These home deliveries have potential infections for both mother and new born, due to unhygienic surroundings. In most cases, the birth attendants are also unqualified because they lack the requisite training in birth deliveries and hence ignorant of the signs of complications, which could cost the life of either the
mother or fetus or both. It is clear that if any job can be done well, sufficient human resource personnel is very much required, added to the fact that the workforce must be very skillful in order for the job to be properly executed. Even though some facilities have the required number of Community Health Nurses at post, other facilities are seriously under staffed to the extent that the few at post cannot even go on their annual leave due them. For the facilities that have only one midwife or CHN the same person goes on outreaches. During outreach, the compound or facility is closed down. The effect is that other clients who come to the facility will not be attended to and at best have to seek for health care in other places, mostly from herbalists, quack birth attendants, including resorting to self-medication. This finding is in consonance with other findings as far as the effect of inadequate workforce is concerned. It confirms the finding of Afolabi & Mayowa (2015) who posited that lack of or insufficient workforce renders less effective the health care service system and some communities try to find health care services somewhere else including the use of herbs and sometimes quacks in the process Omoleke (2005).

Closely related to the inadequacy of staff in terms of numbers at post is the issue of the few staff not being motivated to perform as a result of work overload and drudgery, including lack of appreciation from leaders and authorities in the Ghana Health Service and the Ghana Ministry of Health for Community Health Nurses’ efforts in the advancement of the course of Primary Health Care. The CHNs complain that they do majority of the work regarding health care delivery in larger health care systems but usually are unrecognized or at most accorded the least motivation due them both externally and internally, such that they are unhappy to put in their best for health promotion to be advanced to its maximum in the country at large.
The last constraint in Primary Health Care service delivery relating to workforce issues has to do with lack of or little opportunities available for Community Health Nurses to upgrade themselves through some kind of in-service training or full time training programmes. The Ghana Health Services Code of Ethics and Conditions of Service which compel the Community Health Nurses to be at post for at least three years without breaking before furthering one’s education was seen as too long, since it leads to rustiness of the personnel with regards to knowledge and skills set crucial to job performance. This makes the personnel not be abreast of the times within the profession, in terms of knowledge.

In concluding the section on constraints to Primary Health Care services delivery, insufficient training and preparations, improper job description and eroding standards and governing frameworks for formal practice among others back the poor and unreliable Community Health Nurses’ performance, confirming the findings of (Hennessy et.al, 2006).

5.2.4 Community Activity Related Challenges and Behavioral Problems of Community Health Nurses Primary Health Care Delivery

Another subcategory that focused on hindrances to the efforts of health service delivery by Community Health Nurses is the attitude and behaviours of the community members that Community Health Nurses serve. These reflect beliefs and attitudes toward health as well as work schedules which the CHNs feel conflict with operational times of work. It is the belief of some of the CHNs in the current study that the community members value their work more than their health and so even if they are aware of a health activity, will leave for their farms very early in the morning and return very late at such a time that Community Health Nurses would be returning to their facility or homes by then.
In Neuman (2002), the Normal Line of Defense (NLD) indicates the clientele has evolved with time and the standard for defining any change in wellness. The NLD describes the client system’s stability and integrity, that is, its ability to preserve its stability and integrity. Primary prevention focuses on detecting risk individuals as early as possible. In line with this, there should be comprehensive assessments aiming at finding risk factors, support systems, coping mechanisms and the availability of resources (Neuman & Fawcett, 2002). The attitudes and behaviours of these community members have the potential of exposing them to the forces of illness.

According to (Rippke et al., 2001), self-motivated strategies such as training and apprenticeships including use of persuasion strategies to implement and maintain study groups, resulted in great transfer of knowledge and norm change. Conversely, none of the strategies such as distribution of printed material which require minimal effort led to a substantial change in knowledge and norms.

The current findings on attitude and behaviours toward health seeking by the communities as clients agree with what Larson & Fleishman (2003) also found that although the health care needs of rural dwellers have increased, they have less contacts with medical personnel and barely get the recommended preventive services, (at risk clients or individuals Neuman (2002). This therefore makes the current findings stronger.

Still on the attitude and beliefs of community members, other participants indicated that some individuals in the community have their own health beliefs, to the extent that they distrust Community Health Nurses and would rather self-medicate or take their own approaches to health care provision. Again Neuman, (2002) described such persons as at risk individuals of possible
attack of stress). Abbaszadeh et al., (2013) in their findings indicated that village dwellers have unruly attitude toward change relating to health seeking behaviours. It was found that four categories emerged as constraints to Primary Health Care provision, namely: (a) alteration in characteristics of the rural society; (b) increased health care process complexities; (c) decreased efficiency of the workforce; and (d) decreased health care propensity. The current findings concerning Primary Health Care delivery constraints in rural Ghana agree with the character or attitudinal change in the rural culture and decrease in workforce efficiency as established by Abbaszadeh et tal, (2013). Williamson & Carr (2009) for instance exposed an interesting finding relating to attitude and behaviour change, which could be relied upon as solution to the lack of or lukewarm attitude to health seeking of community members which is impeding attempts at attaining maximum Primary Health Care for all. According to Williamson& Car (2009) the most effective method used to deliver health care in communities is health education and motivating lifestyle through the social media which is very effective in behaviour change centered on understanding carefully the patient’s condition such as financial status, social supports, educational background, belief systems and environmental factors in the community. In order to instigate lifestyle changes in the communities, families and individuals, it is essential to understand the restraining and factors keeping them from adopting change and compelling factors that cause them to take up new behaviors. One must also understand the patient or the community’s perspective during interactions. These attitudes of the client will not auger well for extending Primary Health Care services to all the populace, particularly the rural dwellers. The earlier something was done about it the better it would be for all.
5.3 Ways Community Health Nurses Ensure Equitable Primary Health Care Services Delivery.

The last but one theme of the study was to explore the ways Community Health Nurses deliver health care to community members to reach maximum coverage (optimal health for all people) by eliminating all health care disparities. Neuman (1970) outlined the methods of Primary Health Care delivery to be health promotion through immunization, education and sensitization.

In the current study, the various ways of equitable Primary Health Care delivery were given by the Community Health Nurses and their reports can be put into five subcategories, namely: (a) the use of community visitation and surveillance, (b) the use of health education, (c) the use of health outreaches, (d) the use of community volunteers and (e) referral.

According to Clary (2015), during federal leaders State Health Policy briefing convened by the National Academy for State Health Policy (NASHP), health equity was defined as being certain of the necessities of optimum health care for all the populace. In order to obtain equity in health one needs to value all persons and communities in equal terms, including also the recognition and correction of all unfairness in the past and providing resources according to need. It is expected that when equity in health care accessibility is achieved, then the inequities in obtaining health care too will be done away with.
5.3.1 The use of Community Visitation and Surveillance to Deliver Optimum Health Care

According to Sr (2017) surveillance describes and monitors health events through ongoing and systematic collection, analysis, and interpretation of health data for the purpose of planning, implementing and evaluating public health interventions.

Community visitation is one of the subcategories that emerged as part of the ways Community Health Nurses ensure that optimum health care is delivered to all communities. Most participants opinionated that they embarked on a number of visits to their assigned catchment area mainly to observe the health status of the community and also do disease surveillance in order to have a fair idea of their health status and risk, as well as identify areas of target for health education and outreach. Community visitation and surveillance was regarded as core to health service delivery to the communities and clients.

The study findings agree with many other findings, as far as the job description of Community Health Nurses (CHNs) involving visitation and surveillance are concerned. Surveillance is embedded in the Community Health Nurses Association of Canada CHNAC (2002) draft standards. Schoneman (2002) reinforced this aspect of Community Health Nursing in her description of the nature of surveillance as a nursing intervention within three urban community-nursing centers. Chambers, Ehrlich and Picard (2002), pointed out that Community Health Nurses and other public health practitioners must incorporate epidemiology into their practices. That the nurse in the community often is the first to know that there is a health issue and is in a good position to collect additional information for ongoing monitoring/surveillance, which can lead to developing appropriate actions. For this reason, nurses in the community are likened to
the canary bird in the mine shaft- they are the first to know when there is a health issue in the community.

Talking about community visitation and surveillance, Perry (2013) also stated that Community Based Surveillance Volunteers, for that matter, Community Health Nurses in Malawi provide health education, promote sanitation and hygiene, and conduct outreach clinics, including immunizations and are being trained in Integrated Community Case Management (ICCM) and the diagnosis and treatment at the community level, childhood pneumonia, diarrhea, and malaria. The Malawi and Canada examples are not different from what happens in Ghana, as can be found in the participants report.

5.3.2 The use of Health Education to Deliver Health Care in Communities

Health education is concerned with activities that seek to inform the individual on the nature and causes of health/ illness and that individual’s personal level of risk associated with their lifestyle behavior, Whitehead (2004). Health education seeks to motivate individuals to accept a process of behavioral change through directly influencing their values, beliefs, and attitude systems. Health education in this study according to the participants is composed of enlightening community members on core preventive practices with focus on improving health outcomes. This category captured several areas of concern for health promotion and preventive practices, including nutrition, reproductive health, personal and environmental sanitation and preventive care for malaria. The health education was reported to take two forms, namely planned and spontaneous. Furthermore, different approaches in terms of method are used, including
discussions, talks, demonstration, flip charts, local information centers and Community Based Surveillance volunteers (CBSV).

A number of studies indicate there are multiplicities of teaching methods in Primary Health Care delivery. The current results are in consonance with what Ildarabadi, Abbas & Ali (2015) posited that the Community Health Nurse (CHN) uses one or all or some of the multiple teaching methods in the health care delivery approach, depending on the situation. Three domains of learning, including cognitive, affective, and psychomotor are usually considered simultaneously; since each domain needs an appropriate method of delivery because the learning objectives determine the teaching methods. (Ildarabadi.et.al, 2015) outlined the main categories of educational methods to include lecture, demonstration, doing, visits and field trips, and readiness, based on the facilities, services, and own capabilities.

However, Robertson (2001) and Tones (2000) argued that health education is a component of health promotion. Health education is an integral and essential part of health promotion, as they indicated that achieving health is not just about being educated or coached to change one’s behaviour by a health care provider. For Robertson (2001) and Tones (2000), often times patients would have attempted to alter a health-related behaviour before talking with a health care provider. In such situations, talking with the patients and developing a comprehensive understanding of what the patients want to change, what they previously tried, and their barriers to change are all vital, not just educating them.
5.3.3 Health Outreaches as a Means to Deliver Health Care in Rural Communities.

Another subcategory that was used by respondents in this study to ensure the delivery of Primary Health Care in communities is health outreaches to catchment areas. This was described as meeting community members and they bringing their health problems so that help is offered them. These outreaches are done in response to some observed conditions that are prevalent in certain communities as well as when a directive from the Ministry of Health regarding immunization against certain diseases is given and during outbreaks.

In defining outreaches, Rippke, Briske, Keller, Strohschein, & Simonetti (2001), indicated that outreach locates populations-of-interest or populations-at-risk and provides information about the nature of a health concern, what can be done about it, and how services can be obtained. In line with this, De Roodenbeke, Eric & Sev (2011) outlined two main outreach strategies for delivering health care in rural clients. They are physical and virtual, both of which rely on the involvement of Community Health Nurses from better-served areas. For physical strategies, Community Health Nurses go to the field to provide services, while for virtual strategies Community Health Nurses run the services without moving from their workplace. In both cases, Community Health Nurses dedicate a portion of their time to serve underserved populations. They further stated that outreach activities can be considered as a modality of service delivery for any type of service to any type of population, particularly rural and remote areas. The current study agrees with the physical type of outreaches but not the virtual type.

There is however, concern that the public health and home visiting nurses are not able to better coordinate their activities to meet the needs of people living in the community more effectively.
For instance (Underwood, 2003) expressed that there are ongoing struggles to maintain health promotion and disease prevention services while supporting a growing need for medically oriented home visiting services. It is further argued that emphasis on home nursing could diminish the recognition of Community Health Nurses’ roles, including concerns about services within home care.

5.3.4 Using Community Volunteers to Support the Delivery of Equitable Health Care

The use of community volunteers is one way through which the Community Health Nurses ensured equitable delivery of Primary Health Care services. These are made up of members of the community that are trained on basic health concerns as well as first aid to act as first point of contact for community members before access is made to Community Health Nurses. In Nigeria, they are called Voluntary Health Workers (VHWs), and who they are has been outlined by the One Million Community Health Workers Technical Taskforce (1mCHWTT), according to Singh (2015). A programme of trained VHWs and traditional birth attendants (TBAs) was developed to address the importance of rural outreach services and community involvement in the provision and delivery of health care. As members of the community themselves who are known, accepted and trusted by their communities, the VHW provide a link between facility-based services and the community. VHWs provide health care services to remote areas where access is difficult and help where there are cultural and other reservations to changes in health behaviour.
5.3.5 Community Health Nurses Using Referrals to Ensure Maximum Health Care Delivery.

Referral is an arrangement for services by another care provider or agency that the former provider was unable to deliver. Sr (2017) asserts that referrals assist individuals, families, groups, organizations, and communities to utilize necessary resources in order to prevent or resolve problems or concerns. In the current study, it was found that referral of cases from client community members as well as calling for help from the district level is a measure for ensuring maximum coverage of health care delivery.

Under the Neuman Systems Model, tertiary level of health care risk prevention occurs after the condition has been treated through secondary prevention strategies. Tertiary level of prevention offers support to the client and attempts to add energy to the system or reduce energy needed in order to facilitate reconstitution, for example using physiotherapy and lifestyle changes.

In the current study, tertiary level of risk prevention occurs at a point when Community Health Nurses need to make referrals of health conditions which are beyond their level of care. During such cases, the care given to the client before the referral could be described as care that prevents further complications. In other words, this type of care offers support to the client by trying to do everything possible to add some energy or reduce energy which will prevent further complications before the client gets to the next agency for further treatment. According to Rippke, Briske, Keller, Strohschein, & Simonetti (2001) in Primary Health Care, preventing everything might not be possible but in everything too, there is something that can be prevented. So this is what Community Health Nurses do during referral of cases. They try to prevent the preventable in order to avoid the health situation of the client from worsening.
Tertiary prevention limits further worsening effects of a problem. It alleviates the effects of disease or injury and restores the patients to their optimal level of functioning. Tertiary prevention takes place after a health problem such as injury has occurred. It targets populations who have experienced disease or injury. Tertiary prevention keeps the already happened problems from worsening, for instance, collaborating with health care providers to assure periodic examinations to prevent complications in a health situation such as limb amputation.

According to the participants in this study, before referral of any case to the district hospital is made, the Community Health Nurses in the rural communities collaborate with the care providers at the district level. First of all there is usually some intervention in the patient’s health situation by giving the necessary first aid in order to avoid further complications before the client is dispatched. Follow-ups are made to find out the client situation. Sometimes the client is referred back to the Community Health Nurses after the necessary treatment has been given for monitoring and medications to be continued. For instance, according to one participant, hypertension patients are allowed to take their medications at home while they go to the Community Health Nurses for monitoring. The clients are also allowed to dress wounds with the Community Health Nurses. At this level, there is collaboration in the Care delivery between the community level where community Health Nurses operate and the district level where the District Health Management Authorities also operate to offer the client optimal health care.

There is much evidence in literature on issues that Community Health Nurses have to offer collaborations with their higher agencies in the hierarchy of the health care delivery in order to provide maximum coverage of care for their clients. Health care delivery in India for example, is envisaged at three levels namely primary, secondary and tertiary. The secondary level of health care essentially includes Community Health Centres (CHCs), constituting the First Referral
Units (FRUs) and the Sub-district and District Hospitals are the next levels of Referral units (Nabi, 2012). According to Nabi, the CHCs were designed to provide referral health care for cases from the Primary Health Centers level and for cases in need of specialist care approaching the centre directly.

(Maeseneer et al., 2007) described Primary Health Care (PHC) as the point of access to medical care for the whole community and functions as “navigator” through secondary and tertiary care and other sectors. According to them, the vast majority (over 90%) of presented problems are managed at the inexpensive primary care level. Difficult or uncommon problems are referred, which lead the patients through the medical maze of specialists and procedures, thus making sure that the patients receive the most appropriate care. This leads to better health outcomes and at the same time makes health care much more cost-effective. Maximal access to Primary Health Care with optimum referral opportunity decreases health inequality and the differences in vulnerability.

In Ghana, the first referral Unit according to the participants in the current study is Community Health Nurses. They are the first point of contact by the client in the rural communities, after which if the health needs of the client are not met, the client will subsequently be referred to the second level for continuity of care to take place. The referral of cases is one way that Community Health Nurses ensure access to quality health care for the client, either as an individual, family or community. The current findings agree very much with the Indian system of primary health care as far as referral of cases is concerned.
The Community Health Nurses (CHNs) are equipped with kits to carry out home visits to each household in their catchment areas. They are available daily at either the Health Centres or Community Health Planning Services (CHPS) compounds during certain hours to provide health services for care-seeking individuals, including referring health conditions beyond their capability to the sub-districts for continuity of care.

5.4 Community Health Nurses Ways of Rapport Creation with Community Members

The definition offered by Buist (2007) is that rapport is a close and harmonious relationship characterized by affinity and empathy, in which there is a clear and common understanding. The existence of rapport implies a high level of mutual understanding, a high level of positivity or warmth, and a high level of behavioural coordination, i.e., a more synchronized behaviour both in terms of form and timing, Iglesias (2010), citing Tickle-Degnen, Rosenthal & Rosenthal (1992). From the two definitions of rapport, it is clear that Community Health Nurses’ ability to create a good rapport with their clients will facilitate the identification of the health situation of the client and hence be able to champion same. This is owing to the fact that rapport built will lead to a close and harmonious relationship, or a more synchronized behaviour, which in turn opens up health related challenges thereby enabling the Community Health Nurse to facilitate the health care delivery process.

The first step of the Neuman Systems Model of nursing is assessment, according to (Neuman &Fawcett, 2002). According to them, assessment is similar to rapport building, which is one of the themes for the current study. The use of the model in the perspective of rapport was expatiated as follows: in Community Health Nursing, the nurse focuses on obtaining a
comprehensive client data base to determine the existing state of wellness and actual or potential reaction to environmental stressors. Diagnosis follows assessment during which consideration is given to five variables in three stressor areas, namely: Psychological, physiological, socio-cultural, developmental and spiritual variables interacting in the primary, secondary and tertiary stressor areas. The role of rapport building in the assessment and diagnosis phases is to create harmony with the client and the consultant thereby facilitating understanding of the client’s health situation which therefore leads to the development of interventions and implementation strategies in order to resolve the health challenge. In fact, rapport building runs through all the three stages of Primary Health Care intervention levels- primary, secondary and tertiary, but with more emphasis on the assessment phase.

In relation to exploring ways in which Community Health Nurses (CHNs) ensure rapport creation between them and community members, the participants (CHNs) explained various approaches which have been documented as: (a) creating good receptive atmosphere, (b) the use of community resources, (c) home visiting, (d) professional work ethics and (e) provision of health information. The five approaches are examined in the ensuing paragraphs.

5.4.1 Creating Good Receptive Atmosphere for Health Care Delivery

The creation of good receptive atmosphere was regarded as activities carried out in order to make community members feel at home, loved and open up their health problems so that the problems can be solved through due collaboration. These include activities such as greetings, offering of seats, sharing jokes with the community members, sharing life experiences that align
with their problems and asking about the client’s general wellbeing. Also cited under this category is a receptive, rather than commanding and engaging tone of the nurse.

There are certain foundational principles if ignored greatly reduced the opportunity of rapport occurring, but if employed very well could greatly enhance the opportunities for rapport to be achieved, Buist (2007). They are: develop an attractive personality, become genuinely interested in the other people, aim to meet the other person’s crucial needs, become an excellent communicator, be like the other person, understand and adapt behavioral style and cultivate trust and trustworthiness, since trustworthiness is at the heart of rapport.

The current findings fall in line with these fundamental principles as ascribed by Buist (2007) and as such make the findings more credible.

Caton (2007) also agrees that rapport building is supreme in getting to know who the client is in order to be able to solve the client health problems. According to Caton, if professional Community Health Nurses do not build rapport, the clients will simply give the professional Community Health Nurses what they as professional Community Nurses want to hear, but not tell who they really areas clients. What this implies is that the building of rapport leads to knowing very well who the client is, so as to be able to solve the client’s health problems.

5.4.2 The Use of Community Resources as an Approach to Health Care Delivery

Another way of creating rapport among community members cited by the participants is the use of human resources in the community, including community volunteers and opinion leaders such as the assembly men and women, chiefs, elders and institutions in the communities. This according to the Community Health Nurses (CHNs) makes them accepted in the community
since these leaders more or less authenticate and build trust in the activities of health nurses. Also, getting involved with already established institutions in the communities creates avenues for community members to get to know about Community Health Nurses in the communities. This could later open up community members for further interaction.

The United Nations International, Cultural and Educational Fund (UNICEF) sponsored “Bamako Initiative,” emphasized the potential benefits of mobilizing human resources in the community such as traditional chieftaincy, lineage, and social network systems for convening health committees, recruiting volunteers, and maintaining basic pharmaceutical supply kits. The current study result support the position of the “Bamako Initiative” that the use of certain opinion leaders such as chiefs and assemblymen could help champion the health needs of the community. The findings also corroborate the position of Knippenberg, Levy-Bruhl, Osseni, Drame, Soucat, and Debeugny (1990) that community governance provides low-cost mechanisms for dispensing essential drugs, maintaining, revolving accounts, and providing essential health services.

On the contrary, several evidences indicate the use of voluntary community resources as controversial in the Primary Health Care delivery process. For instance, Amonoo-Lartson (1981), Agyepong and Marfo (1992); Agyepong (1999), found that volunteer programmes have had a long legacy of international support, but the full range of preventive and curative care, such as safe-motherhood interventions, antibiotic therapy, comprehensive family planning, and other essential services require technical expertise that only trained health professionals such as Community Health Nurses can provide, not the community volunteers, who usually do not have any professional expertise.
5.4.3 Home Visiting as a Way of Rapport Creation

It was largely indicated by most participants that rapport is built through home visiting which could be in the form of checking up or following up on some clients who have defaulted or reported at the unit with some health needs. This according to the Community Health Nurses gives them opportunity to know about the community and build connections so that the communities feel loved and understood that the nurses have empathy. Again, the community health nurses opinionated that visiting established groups within the community can be very helpful in the creation of good relationships.

A home visiting programme of Southern Nevada had three (3) broad goals Sands (2007): to improve maternal and fetal health during pregnancy by helping women improve their health-related behaviours, to improve children’s health and development by helping parents provide more competent care and to enhance mothers’ personal development by promoting planning of future pregnancies and helping women continue their education. The visitors helped women accomplish these goals by promoting adaptive behaviours through regular home visiting. The current results agree largely with the Sands (2007) findings on Primary Health Care experiences of the Community Health Nurse. Similarly, the current findings agree with the ensuing three studies that were done by Maybin, Clover & Redman as well as Rippke and others.

The strongest message heard from older people receiving care from visiting Community Health Nurses was one of gratitude. It is difficult to overstate the value that they placed on having health professionals visit them to provide the care that they needed (Maybin, 2016).
Again, Redman & Clover (2007) posited that a home visit, if carried out well, is a powerful tool to help at-risk families experience their strengths. Accordingly, it is a door to empathy and an opportunity to strengthen partnerships with the families visited.

Also, Rippke, Briske, Keller, Strohschein, & Simonetti (2001) recommended that when one is planning outreach strategies, one should include those who consider themselves invested in the outcome of the effort. In line with what were established, it was found, for instance, that Primary Health Care services offered by providers was significantly greater in communities that participation component was included Clover & Redman (1996). The reason was that representation created a rapport for participation to take place.

5.4.4 The Use of Professional Work Ethics to Create Rapport

Ethics talk about what is good or bad, right or wrong, relating to moral duty and obligation. It also includes the need to act in accordance with the principles of right and wrong governing the conduct of a particular group, such as nurses.

The participants’ responses in the current study that reflect core competences required for the successful execution of the work of Community Health Nurses include being competent to the extent of being on top of issues in order to give out the required help that community members approach the CHN with. The competency was also indicated by the participants to be a good requirement for rapport creation with the community members. This is based on the fact that it enabled the nurses to gain respect and trustworthiness from the community members.
The issue of confidentiality also came up. The community members put a lot of value on some issues discussed with the Community Health Nurses and as a result expect those health issues not to be disclosed to third parties. The current finding agrees largely with the findings by other authorities which have been discussed on the immediate ensuing paragraphs.

In a series of surveys, patients pointed to the fact that what was required for opening up relationships is the care and trustworthiness required in relationships between the Community Health Nurses as consultants and the community members as clients. For instance, (Baki & Baki, 2008) stated that success in the Community Health Nurse’s work largely depends not only on the knowledge and technical skills, but also on the nature of the rapport that is established between the CHN and the client.

Again, Nelson (2008) identified a number of factors emanating from professionalism and display of ethical standards of the CHN that create rapport with the client. They include: confidence of the CHN; empathy (which indicates that the nurse understands the feeling and experiences, physically or emotionally of the client); being humane (which implies the nurse is caring, compassionate, and kind); personal (nurse is interested in me more than just as a patient, interacts with me, and remembers me as an individual); frank (tells me what I need to know in plain language and in a forthright manner); respectful (takes my input seriously and works with me); and thorough (is conscientious and persistent). The current results confirm the Nelson (2008) findings on the experiences of Community Health Nurses’ Primary Health Care delivery.

The most fundamental tool for getting the client to change to health seeking behaviors is the use of a professional relationship, a precondition for effective work with individuals, families, or groups of clients. According to Caton (2007) effective change depends primarily on the
relationship between worker and client, and that a bond of trust must exist before people are willing to risk that difficult human experience called change. The current results agree with the Caton (2007) study results that the exercising of professionalism ethics in the client-consultant collaboration process goes a long way to create a cordial relationship with the client, which is good for healthcare delivery.

Despite the current findings agreeing with many others discussed in the preceding paragraphs, Baki & Baki (2008) demonstrated contrarily that although rapport building and communication skills can be taught to professionals such as Community Health Nurses (CHNs), crucial elements such as confidence, empathy, humanity, and frankness are absent in most nurse-client encounters. This according to them does not open up the client to the Community Health Nurse.

5.4.5 Provision of Health Information Builds Rapport

Also considered as one of the ways through which Community Health Nurses ensure rapport is through the provision of health information to community members. This was described as giving out health advice to aid individual decision making as well as entire community enlightenment. This according to the participants made the client feel the nurse has empathy. That is, the previous encounter with the CHN gives the client some confidence to approach him/her further, since they trust in the Community Health Nurse’s ability to provide some form of solution to their problems.

Some findings that the current results agree with are discussed in the ensuing paragraphs.

For instance, Baki & Baki (2008) identified seven issues that emanate from encounters between Community Health Nurses and their clients which serve as important information for both client
and consultant. They include the buildup of relationship which leads to opening up for discussion
of pertinent health issues; gathering of information which leads to a better understanding of the
perspective; the sharing of information between the client and consultant; reaching agreement on
problems and plans to implement and resolve the problem and finally draw a closure.
These points focus on overcoming barriers that can occur and enhance efficiency in the nurse-
client communication, improve quality of care and time management (Nelson, 2008). Thus, the
purpose of communication becomes not just to deliver a message but to produce a change in both
sender and receiver in view of their knowledge, attitude or behavior.

Consequently, it could be said that the Community Health Nurses who make an effort to
understand the client’s perspective during interaction can help reduce patient anxiety, identify
knowledge gaps and offer information or direction that improves health care outcomes.
When the individual, group or the entire community are involved in creating a health plan,
involved in the implementation of the plan; there is more likely to be better outcomes and
satisfaction with the outcomes.

In summing up the chapter five on discussion of findings, themes and subcategories were
considered. Largely the participants’ results confirmed many similar studies, while in a few
cases, contrasted some other findings. Cases in point were the participants’ opinion on
motivation of Community Health Nurses for job performance, in-service training and career
advancement opportunities while being on the job, the availability of good infrastructure such as
road network and electricity which promote job performance, including a good community and
Community Health Nurse Relationship, just to mention a few. These instances and others not
mentioned in this concluding page largely confirmed other study findings. However, community attitude to health seeking contrasted other findings.

The theoretical framework used for the study is the Neuman System Model, which is an open systems model. It states that the client or patient interacts with and influences the environment just as the environment influences the client or patient and that the feedback, which is the outcome of the interaction, is a wellness-illness continuum, depending on the presence or absence of stressors.

Using the Primary Health Care Prevention principles according to Neuman, if all the prevention measures are put in place and these measures achieve the targets of primary prevention, the client system will be stable, since no stressors will be encountered. However, if primary prevention measures fail and the client (individual, group or community) develop a stressor, a state of illness is initiated, for which secondary or tertiary prevention measures must be put in place in order to help the client relapse to stability and state of wellness, otherwise the stressor could lead to death. The ability to put in place the appropriate prevention measures could see the client system restored to the initial level of health or even beyond the original level of wellness. It is also possible to fall below the original level of health.

Community Health Nurses who serve as the front line Primary Health Care providers have the responsibilities to ensure that the client does not get exposed to stressors, thereby preventing sickness of all kinds, including psychological, mental, physical, spiritual, developmental and socio-cultural.

Also, the Community Health Nurse has a second responsibility to help the client identify early infection for prompt treatment and avoid complications.
The third stage where the Community Health Nurse needs to discharge some other critical functions is when the client enters into complications, needing further advanced treatment. The nurse needs to help the client reach the next level of care delivery safely, without sustaining further complications.
CHAPTER SIX

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

6.1 Summary

Globally, Community Health Nursing has its origin from the Maternal and Child Welfare Movement of 1982 in Britain. The Community Health Nurses had responsibilities to educate mothers on hygiene and the diet of children.

The Alma Ata conference of 1978 in the United Soviet Socialist Republics (USSR) advocated for health for all through the use of Primary Health Care Services and allied health professionals such as Community Health Nurses in all health-related projects in the developing world.

Since the Alma Ata declaration of health for all in 1978, Community Health Nurses have become the front liners in the delivery of Primary Health Care services in many countries with Ghana inclusive, bringing health to the doorstep of the client thereby closing the inequity and access gap between rural and urban dwellers.

In the Ghanaian health sector, several successes have been chalked in the area of Primary Health Care (PHC) through the Community Health Nursing concept, such as immunization, eradication of diseases and in the mobilization of community volunteers. For instance, Palmer and Short (2010) asserted that the Community Health Nurses programme has produced a group of workers with a different, superior conception of the appropriate aims of the health care system in Ghana. Irrespective of the coordinated efforts that have led to the series of successes, the expansion and
adaptation of Primary Health Care (PHC) services to serve vulnerable populations such as the poor and rural dwellers remains a herculean task.

The study was conducted on the experiences of Community Health Nurses on Primary Health Care Services in rural communities in the Nkoranza South municipality of Ghana, using an exploratory qualitative approach. In-depth unstructured interviews were conducted on a face-to-face basis with community Health Nurses in a time span of about 45 minutes to two hours with each interviewee.

The study therefore explored both the negative and positive factors impacting on Primary Health Care delivery as provided by Community Health Nurses including the methods of equitable health care as well as rapport adopted for effective service delivery. The study also used the Neuman Systems Model (three levels of interventions; namely primary, secondary and tertiary levels) as the theoretical framework to assess Primary Health Care interventions.

Out of a total of 38 Community Health Nurses, sixteen (16) with experiences on the job of at least three years were recruited purposively and interviewed on their experiences on Primary Health Care services. The researcher had a face-to-face in-depth interview of about 45 minutes to two hours with each nurse at their place of work and in-depth probing was done to obtain details. The content analysis approach according to (Tesch 1990) in (Cohen, Manion & Morrison 2007) was adopted to analyze the data. This approach requires verbatim transcription of the interviews and several readings over the raw data transcripts to ensure that the exact position of the interviewee is what was captured. The approach also uses a rigorous analysis process of the data as can be seen under the data analysis section. The results realized under the current study are in four thematic areas, namely: factors that hinder Community Health Nurses’ (CHNs) Primary
Health Care service delivery, factors that facilitate CHNs service delivery of Primary Health Care services, CHNs methods of equitable health care delivery and ways Community Health Nurses create rapport with community members.

The results indicate that Community Health Nurses are delivering their job with a high degree of competence, using various approaches to ensure that health care is delivered to the door step of the clients, thereby providing access and equity in Primary Health Care, even though much still needs to be done. On the other hand, Community Health Nurses in the rural communities are encountering enormous impediments in providing health care to the people of Ghana, which range from logistics difficulties, workforce shortages and infrastructure difficulties to community negative attitudes and behaviours toward health seeking.

As regards factors that enhance the smooth running of the activities of Community Health Nurses, the participants narrated that there is the need to empower the Community Health Nurses through in-service training for community engagement. The in-service training also updates the knowledge of these Community Health Nurses and therefore motivates them to perform.

Again, the need for infrastructural development in the area of roads is very critical. Some roads are not motorable even by motor bike on a rainy day in some catchment areas described as ‘hard to reach’. Some facilities too do not have power and as a result have hard times in maintaining the potency of vaccines. The need to have some form of general community education to change the attitude of many community members toward health care seeking behaviours is also critical, owing to the fact that larger proportion of these communities attaches more value to their economic activities than seeking healthy lifestyles. They therefore prefer to self-medicate rather than go to a Community Health Nurse for a health care service. The last issue on the factors
when addressed could make the work of Community Health Nurses in the study area acceptable is the creation of good rapport and community support. This according to the participants will create cordiality between the health personnel and community members.

The third thematic area in the study was to explore the various methods Community Health Nurses offer Primary Health Care services in order to be seen as delivering equitable and optimal job. These methods as documented from the participants are: the use of home visits and community based surveillance volunteers, outreaches to groups, churches and mosques, the use of general health education through various media such as information centers, durbars and opinion leaders in the communities, with referral of complicated cases to the higher hierarchy been the last resort.

The last theme of the results has to do with the various ways Community Health Nurses create rapport with their communities, since rapport creation is very critical for opening up communication and building up relationships which in turn are crucial in the Community Health Nursing professional’s roles and responsibilities performance.

It was therefore concluded that even though Community Health Nurses play a major role in the provision of Primary Health Care in rural communities of Nkoranza, many challenges stall the success stories of these cadre of health professionals. If these impediments are resolved, the health for all the citizenry in Ghana and the globalized world campaign initiated at the Alma Ata conference of 1978 through access and equity will become a thing of the past. Ten points recommendations were made under the present study towards achieving access and equity in Primary Health Care in Ghana as championed by Community Health Nurses.
6.2 Conclusion

In conclusion, the Community Health Nurse delivers care using a blend of approaches. The consultant-client-centred approaches are considered the strength of the community Health Nursing education. Demonstration is an effective method of health care delivery and education among the CHNs. The field trips and visiting programmes increase the efficiency of CHNs in teaching and changing clients’ attitudes about providing services in the community.

A number of factors enhance the service delivery of Community Health Nurses in rural Ghana. First, when Community Health Nurses are empowered through in-service training, provision of logistics and equipment such as fridges, motor bike, vehicles, weighing cards, vaccines as well as infrastructure like good roads and electricity among others, they perform their duties creditably. A good client- Community Health Nurse interpersonal relationship also facilitates job delivery. The display of professionalism through respect of rights and confidentiality of clients also endures the community to the community Health Nurse and creates a cooperative environment between the nurse and community for service delivery.

Second, many factors account for the stalling of Community Health Nurses’ service delivery in the rural areas of Nkoranza. Among them are the impassable roads due to distance and non-motorability, insufficient motivation of workforce due to overload of work and inadequate stuffing and non-existence of electricity required for the storage of vaccines. Others are network challenges in telecommunication, bad attitude of community members towards seeking orthodox health services as against self-medication and herbal medicine, including valuing farm work more than accessing health care, relied upon largely by the communities. The unavailability of potable water in some communities also hampers service delivery of Community Health Nurses.
because many hours are used to access water for domestic purpose, leading to lateness at the work place.

Third, the Neuman Systems Model is an appropriate, effective and innovative theoretical model for assessing Primary Heath Care service delivery of Community Health Nurses. It is a broad and flexible model for assessing stress as well as work motivation and communication related behaviours across health and education fields.

6.3 Recommendations

Based on the findings the following recommendations are being made:

1. Government should reconstruct some of the roads in the communities either by gravelling, re-gravelling and at best asphaltling in order to make them motorable and open up these communities described as ‘hard to reach’ for health care services, even with motorbikes.

2. Government and the Ghana Health Service need to intervene for some Community Health Planning Services (CHPS) compounds and health posts to be re-wired for power, while others which do not have power need to be connected to the national electricity grid in order to provide electricity for the Community Health Nurses who stay and work in these communities. The existence of power will help in the maintenance of vaccine potency and also reduce the time spent in going to preserve vaccines in nearby communities.

3. There is the need for more Community Health Nurses in some communities. The Ghana Ministry of Health, in collaboration with the Ghana Health Service, need to reshuffle some staff in some facilities or new staff should be sent to those catchment areas that have only
one or two Community Health Nurses. This will reduce work drudgery due to overload and also serve as workforce motivation for better work performance.

4. Closely related to shortage of workforce in a few facilities and the associated problems are the issues of some staff needing either in-service training in community engagement, adult learning approaches or full time knowledge upgrading. Many of the CHNs feel they have worked too long without any form of knowledge upgrade and this is hampering job performance. The Nurses and Midwives Council, in collaboration with the policy makers and implementers are recommended to address these issues through the training of Community Health Nurses.

5. The logistical challenges of the CHN must also be resolved by government, Non-governmental Organisations and the Ghana Health Service. These have to do with frequent maintenance of broken down motor bikes, replenishing depleted supplies such as vaccines, and Child Welfare Clinic cards, vaccine fridges maintenance or replacement.

6. The Ghana Health Service should also permit Community Health Nurses to use the office motor bikes after work to run their personal errands. This serves as a motivation for performance. By extension, each Community Health Nurse could be provided a means of transport such as a motor bike or even a vehicle, since their counterparts in other countries are supplied with these conditions of service.

7. The superiors or authorities of the Community Health Nurse should allow these nurses to enjoy some incentives such as fuel funds offered by some Non-Governmental Organizations (NGOs) for motor bikes and outreaches. In addition to that, other non-cash motivations such as being praised for a job well done, award of certificate of recognition for hard work,
including appreciation of the efforts of the Community Health Nurses for what they do in terms of Primary Health Care delivery will all serve as motivation to advance Community Health Nursing practice in the rural areas.

8. A general sensitization by the GHS and MOH should be done to change the mental orientation or attitude of many of the rural communities towards health seeking behaviours. This will help bring acceptability of the services delivered by the Community Health Nurses. This is due to the fact that many clients love their work more than seeking to keep themselves healthy, and as a result there are lots of people who self-medicate including the use of herbal medicine instead of orthodox medicine.

9. The use of the Community Based Surveillance Volunteers (CBSV) should be fortified and expanded by the Ghana Health Service, since they live with the communities, know the health exigencies, as well as easily get accepted by the community. Other community personalities such as the chiefs, assemblymen and assemblywomen should be encouraged by the Ghana Health Service and Community Health Nurses to join the train in order to bring quality health care to the people. Their opinions on Primary Health Care delivery carry the community along.

10. It is finally recommended that future studies investigate both the experiences of the Community Health Nurse and the client, since this will reveal reasons why communities have negative attitude towards CHNs intervention programmes.
6.4 Implication for Policy Makers, Researchers, Practitioners and Community Health Nursing Education.

The results of this study on experiences of Community Health Nurses in the rural communities have far reaching implications for health care delivery in Ghana that bother on the training of Community Health Nurses.

The Ministry of Health and the Ghana Health Service in collaboration with the Nurses and Midwives Council need to develop and enforce a strategic plan for Community Health Nursing education, which incorporates all the elements for the provision of fortified training and in-service training. The need to incorporate in the training of Community Health Nurses some adult learning and education theories has become rife, as this will enhance the acceptability of health information by the communities.

Government as the policy making body should see to it that the policy on the training of Community Health Nurses, especially in-service training, should be expanded to include community engagement and enforced to the letter. An adult education component embedded in the training programmes of Community Health Nurses will also be beneficial for the policy implementers to follow. Government again should prioritize the construction of roads that lead to rural communities, particularly where concerns about negative attitude to health seeking exist. Government also should be the lead provider of health education and promotion in these villages where there are health concerns.

The Community Health Nurses, as a cadre of health professionals need to be motivated to perform through various ways such as the issuance of awards, appreciation for a job well done,
including modification of some aspects of conditions of service which make further training and education unattractive.
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APPENDICES

APPENDIX I

IN-DEPT INTERVIEW GUIDE QUESTIONS FOR COMMUNITY HEALTH NURSES

1. Please tell me about yourself

   Age
   - Marital status
   - No of children
   - Education eg SSS/WASSCE, diploma (CHN), Certificate (CHN)
   - Rank eg Senior CHN, Principal CHN, CHN Officer
   - Number of years of practice
   - Place of work

2. Please tell me all about the work of a Community Health Nurse

   a. Home visits
      - Number of times a week/month/year
      - What means do you use to go visiting home?
      - What do you do during home visiting?
      - What problems are associated with home visiting?
   b. Immunization against diseases
      - Please, what are the names of the vaccines used to immunize people/children?
      - What diseases are these vaccines supposed to prevent?
      - Please, tell me whether people/children have ever reacted to any of the vaccines
      - How do you ensure that the vaccines given to people/children remain potent and viable (maintaining the cold chain)?
      - Please, how do you ensure maintenance of the cold chain of vaccines when in the field?
   c. Health education
      - How do you go about the education of people about their health? Eg face to face (lecture), use of adult volunteers, media, print etc.
      - What things do you educate people about? Eg healthy living, environmental sanitation, nutrition, family planning etc.
      - Please tell me what you do for the sick of homes eg serve medication, refer to hospital etc
• Please tell me, what conditions are referred?

3. What is your relationship with community members regarding solving of health problems?
   • Tell me what problems the community members usually approach you with

4. Tell me how the communities in which you work ensure environmental sanitation
   • Their refuse disposal methods
   • Water supply systems
   • Tell me something about their dietary system

5. Please, tell me the common problems you encounter in getting your work done
   • availability of resources eg transport, fridges, access to electricity etc

6. Tell me how it feels like to be a Community Health Nurse
   • Tell me what facilitates health care delivery as a Community Health Nurse
   • What factors hinder service provision for a Community Health Nurse?
   • Describe the methods employed to deliver equitable Primary Health Care services in rural communities
   • What are the various ways Community Health Nurses use to create rapport among community members

7. Please, tell me any other thing you will like to share concerning your work as a Community Health Nurse.
### APPENDIX II: PROFILE OF PARTICIPANTS

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CHN= Community Health Nurse  
CHNM= Community Health Nurse Midwife  
M=Male  
F= Female
APPENDIX III

Verbatim transcript of sample interviewee (JA)

1. **Tell me about yourself.**

   My name is JA 37 years old, divorced with no child. I hold a certificate in disease control, 7 years of working experience and a senior field technician at Ashiayem health centre.

2 **Please tell me all about the work of a Community Health Nurse (CHN)**

   They work under reproductive child health (RCH) and when you hear nursing attached to it means they take care of children and mothers. When chn is attached it means preventive aspect.

   **Home visits means chns** move from place to place immunizing children less than five years against childhood killer diseases and taking care of pregnant women and some minor ailments, tracing defaulters as well.

   When we organize outreach clinics in cases where we are not able to visit them at their homes, we group them and find out those who were unable to turn up at the clinic and trace such defaulters from time to time and immunize them during our visits, as well as advise them against things they are doing that are not in line with health. I make five houses visit in a week, 20 houses visit in a month and 240 visits in a year.

   **The means for home visits** is two motor bikes, when we get to the community, we then walk around. For him the means are sufficient for the work, except the bikes are not robust enough and frequent breakdowns make maintenance a challenge.
The things I do during home visits include reproduce the services we provide at the Child Welfare Clinic (CWC). Before we even move out, we would want to cross-check and see whether there are children that were supposed to get immunized and yet they did not turn up. We normally carry along our antigens (vaccines) and syringes and immunize such children against particular diseases. We don’t do treatment.

We examine them through sanitation and hygiene, whether their water is good or potable, where it is kept, where children are fed and whether the clothing of the child is neat and advise the client accordingly.

Also, based on what we observe at the OPD (facility level), we develop topics that we would want to discuss with them. For instance, a disease becoming predominant and the things that motivate the disease, the things they have to do to avoid contracting such a disease. We observe and deduce in our mind the consequences of some of the things they are doing. We advise them on current developments of diseases, the rampant nature of some diseases such as diarrhea being brought to the facility and as far as sanitation and the season are concerned.

The sick of homes are normally referred to the clinic.

Problems associated with home visits.

Timing has been the biggest problem. Before one starts a home visit, one must know what time the people are available or always at home since we don’t normally inform them the time we make visits. Normally, by the time we get to our catchment area, the people are not always available. It is only when we have clinics or durbars that we inform them of our visits, if not we will keep them waiting and they may not be happy with that.

Fear is another problem, very close to timing. This is because the time to meet the client at home is the evening (between 6 o’clock and 7 o’clock), and fear of robbery attack and snake bites is a
problem, since one has to cross in-between where there are no houses before one gets to another community.

**Names of vaccines and what they immunize against**

The first is the BCG, given through the shoulder at birth to prevent tuberculosis; polio is given about four times to prevent polio-myelitis. The first is polio zero, given two weeks after birth to prepare the child’s system for the next polio vaccines. The other polio vaccines will then continue after six weeks. PENTA prevents five main diseases namely tetanus, diphtheria, whooping cough, hepatitis B and pertusis. Rota seeks to prevent ordinary diarrhea, yellow fever vaccine to prevent yellow fever disease, the pneumococcal vaccine seeks to prevent pneumonia, the measles-rubella to prevent measles and rubella diseases.

**Reactions by children or people**

There are minor reactions usually reported such as fever after immunization. However, we have advised them to use paracetamol and because of that the clients don’t report with any severe adverse reactions, that is the adverse eventful following immunization (AEI) advice.

**How to ensure the potency and viability of vaccines**

We have a system call the cold-chain system which is checked every morning and evening. We have a vaccine fridge (not like other fridges), whose temperature is calibrated in such a way to suit the vaccine condition, from plus two degrees to plus eight degrees. Anything below or more than plus eight is wayward, that is either too cold or too hot for the life of the vaccine. When less than plus two, it means the vaccine is being exposed to too much cold. Though there are vaccines that can withstand up to minus two eg polio, most of them cannot withstand the minus two. All the vaccines can withstand the plus two up to plus eight. The antigens are life attenuated, (weak
forms) of the organism we want to prevent. We keep them in a form that they will not die so that when introduced into the body, the antibodies will recognize them as foreign system and fight against that, thereby developing resistance against the disease.

Another system that determines the potency of our vaccines is what is called the vaccine vial monitor, (the VVM tag). When the tag indicates white that implies the vaccine is not exposed to heat hence it is potent. However, when it shows black or dark coloration it means the vaccine has been exposed to heat and therefore lost its potency. Any time the vaccines start changing to pink or brown, it implies they are being exposed to heat, and so the ones that have started changing color should be used first.

There are four stages. Stage one is where it is zero (it is still white), stage two it is no more white but it is not also dark,(it is becoming a bit dark or brownish but not as the surroundings) implying the vial is getting exposed to heat and hence should be used first among the lot. Stage three is when it is as dark as the surroundings. Stage four is when it becomes darker than the surroundings. In stages three and four the antigens might have all died as a result of getting exposed to too much heat and hence the vaccines have lose their potency. The vaccines are potent in stages one and two.

On rare cases the “shakes system” is also used to determine whether the vaccines have been exposed to too much cold (getting frozen) and have lost their potency for usage. That is one has to shake the tag and see whether it will settle again (clots or some kind of spots would have been formed on the tag), indicating the vaccines have been exposed to too much cold and cannot be used.
Please, how do you ensure maintenance of the cold chain of vaccines when in the field?

We normally go with two vaccine carriers loaded with iced packs. One of the carriers contains the antigens which we normally don’t open and close it often. The vaccines used are put into the other carrier and closed with foam on top, which prevents excessive heat lost to prevent the vvm from changing to indicate whether the vaccines are still potent for use when white coloration occurs and not potent when there is dark coloration.

**Methods of education**

We normally do a general education or the group level first and proceed with one-on-one. Each child may have his or her own problem. The mothers therefore also have different challenges as far as the problems of their children are concerned.

We educate the mothers at the point of the weighing. We usually would want to know what the nutrition of the child is and why the child’s weight is too low or too high. The mother then explains what the challenge has been and we advise accordingly.

We also educate them at the point we want to discharge them, using the weighing card. Looking at the current weight against the previous month’s we are able to advise the mother on whether the child is growing too high or too low in terms of weight with relation to feeding.

In the group method, either at the weighing point or at the facility, we use what we have observed to be frequent at the facility, or during the weighing point, either about the appearance of the child, or the weight (malnourishment based on hair color etc) and base on that to educate the mother to understand that the child may not be lying sick physically and yet on the way to getting sick, depending on some signs. It is not an open forum, hence not a durbar.
(i) The use of durbar

Durbar is another method we use to put our education message across. During such occasions, all the community members gather for the education to take place. Mostly, issues surfacing at the facility or CWC also become prominent during durbars. Such topics could be on personal hygiene, malaria, family planning, sanitation etc.

(ii) The use of adult volunteers

We have adult volunteers called the disease community based surveillance volunteers (CBS). They form a liaison between the CHN and the community. Most of the CHNS information reach the community through the CBS. For instance, if we want to go for child welfare clinic, we could inform the CBS and they too will tell the mothers about our intentions and the mothers will wait for us. When we want to do mass drug distribution, (where somebody is supposed to enter every house and get some people take the drug), we also use the adult volunteers. While the volunteers do the house to house distribution, the CHN does the monitoring or surveillance and supply of the drug. The CBS also do home visits during which they do disease surveillance to monitor which diseases are becoming frequent. There are diseases that we call the epidemic prone diseases which are always under surveillance, namely cholera, meningitis, yellow fever etc. The volunteers survey and prompt us to ensure that the disease does not take the CHN of guard. These diseases are always under surveillance and we use the volunteers to support us to do that. The volunteers are trained to do their work. They are also supposed to record and report every death in the community to the CHN and the nurse will intend forward same information to the appropriate quarters for further surveillance to be made. They need to go to the family members and find out the cause of the death; probably it might be one of the epidemic prone diseases and we may need to monitor it so that it does not go out of hand.
(iii) The use of media tool for education is only at the district level when radio programs are held by our health leaders and people are allowed to phone in and ask questions or contribute, especially when there is a serious epidemic condition. At our level, we normally use the gong-gong announcement or information centre to put our message across.

We don’t normally use print media because majority of the people cannot read. It is only at the national level they are used. Print is not appropriate at our level.

Health education as done by community health nurses

We do health education on several platforms. We have school health that we organize schools and visit them. We try to investigate some of the conditions that are predominant at the OPD or clinic, depending on season. That is, some of the conditions people report at the clinic so frequently with. We then develop education on that and visit the schools, introduce our topic and discuss with the pupils. In effect, we go there with topics and discuss with them and open way for questioning.

At the child welfare clinic (cwc) too, before we start weighing, where we group mothers or start the program with two or three women, up to the point when the clinic is at its peak with almost all the mothers in, we then give the education we want them to have. Room is given for questions and we then proceed to end the education.

Some of the topics we usually educate mothers on are personal hygiene and nutrition (weaning off babies) with solid food. Children most of the time grow very lean and anemic because of bad nutrition and weaning. Malaria is one of the key problems we have over here. We also educate
mothers on the use of nets to avoid malaria. For instance, what mothers should do before going to bed for the children to avoid contracting malaria.

We also educate the mothers on personal hygiene for the children to avoid skin diseases.

We educate them on things we believe or perceive to be an impending health condition. We have epidemiology of disease which helps us to associate diseases out of particular context, pending on time and place, when the disease usually occurs, so that we use the season to educate the people. For instance meningitis sets in during the dry season.

(i) Education on healthy living

We normally start with education of what goes into the mouth. The root of most diseases into the system is in the mouth. What food you eat and its condition all count a lot in talking about healthy living. The surroundings in terms of sanitation also count a lot in talking about healthy living, particularly concerning what food one eats, (nutrition). Do the surroundings encourage vectors like houseflies into the home which could infect our food before it ultimately enters the body through the mouth to cause disease?

(ii) Education on diet or nutrition is also very critical. The ingredients put together to make a balanced food is very necessary. We normally educate them to combine bits of the available food items but not to buy plenty of meat and add to the food. We normally educate them to combine food items found in their settings such as the leafy vegetables, groundnut, pawpaw, banana, oranges and small fish to make a very good meal.

(iii) Family planning education

The main reason for family planning is” to give birth at a time you actually want to, and not to get pregnant when you don’t need the pregnancy. It is no to stop giving birth, as many
misconstrue it to be. It simply seeks to prevent unwanted births. Mothers having children less than six months old, we usually like them to undertake a kind of family planning method.” Mostly the men have fear that going through family planning is to stop their wives from giving birth.

To bring the men onboard, we usually organize durbars consisting of the entire community and educate them to understand that family planning helps us to give birth as and when we want. There are long and short time methods, however, when you stop a particular method, within a short time, one could get pregnant again.

**What is done for the sick of homes?**

We refer them to the facility, because of the lots of activities we normally carry out during home visits. We then educate the person when she or he comes to the clinic so that they will be encouraged to come to the facility subsequent times for the healthcare service or seek medical care in the next appropriate quarters. It could have been that the person came once and the condition is not going. We take that opportunity to give one on one discussion and education to the client, after listening well to them and they will be happy to come to us subsequent times.. If we cannot manage the condition, we refer to the next higher level. We don’t normally carry along with us drugs and hence we don’t give medications during home visits. ” I don’t know what others do, but I don’t normally give medications”.

We have the Integrated Community Case Management volunteers (ICCM) who work in similar manner like the CBS. They are empowered to give treatments to minor ailments. They give for instance zinc tablets to children. If it is a minor ailment like ordinary diarrhea I normally ask
whether they have seen their ICCM volunteer, if they haven’t, I ask them to come to the facility. We do meet most of them by the time we get back to the facility.

**Please tell me, what conditions are referred?**

In complications, we take the history of the patient and give first aid before referring to a more qualified doctor. The doctor may even give further consultation advice before the patient gets to the next level, during which they would have made arrangements to handle the condition of the client. Such complicated conditions mostly are severe malaria of children under five. With temperature above 39 or 40, most of such children have convulsion setting in. we normally try to hold the temperature a bit before we refer. Mostly at our level the complications are severe malaria and occasionally accident cases. In accident cases, the police normally come in and ultimately are the ones who convey the patients to the next level of care.

3. What is your relationship with community members regarding solving health problems?

We are supposed to be their immediate doctors. The relationship is cordial because they rely on us for information relating to their health. At times they meet us outside and inform us of their personal health problems; for instance I have attended hospital several times but have not seen any improvement. Because we go there to educate them it always creates a good relationship between us.

Tell me what problems community members approach you with

The first problem is shyness. Many of them feel shy to come to the OPD and tell us about certain health conditions such as gonorrhea. Practically, one client came to me with a condition I suspected was gonorrhea and another Candida. I say suspect because of the explanation by the
person regarding signs and symptoms, but I cannot substantiate this because there was no test done to prove.

The second problem has to do with some family planning methods and their side effects. We have different kinds of methods. Most at times the method doesn’t suit everybody every time. Some use it and don’t have problems as experienced by other users of the same method. Because people feel shy to let others know that they are on one family planning method or the other, they prefer to see the CHN one-on-one and discuss it with you. When they have confidentiality in you, either as a male or female nurse they will approach you privately and seek education or assistance.

4. Tell me how the communities in which you work ensure environmental sanitation.

The communities don’t care how they dump refuse. The disposal methods are not the best. Most of them dump them behind the house and children go there to defecate as well. Where they dump refuse is always important to us. We educate mothers and the communities as a whole on where to keep refuse. Some of the refuse are solid and others watery, all put together; creating nuisance such as inviting flies and sanitation problems for the entire neighborhood.

The people also leave their utensils unwashed and exposed to flies which is not the best.

Water supply system

There are challenges with the water supply system. The water supply is a bit o.k. but not all that. Prusu community is one of my catchment areas and there is no pipe or bore-hole water but they depend on the Pru river for their water supply. In rivers like that all kinds of unhygienic things enter there.

There are other areas where the source of water might not be the problem but where they keep the water for use in their houses. The people normally keep their water in barrels and leave them
ajar. During home visits you see children hold a child with the hand soiled with soup, use the same hand to hold the cup and fetch water from the barrel, with the cup smeared with soup and after drinking drop the cup into the barrel. The other part of the floating cup smeared with soup attracts flies and when someone uses it again to fetch water, contamination sets in.

We always educate them to separate the water we drink from ones used for washing clothing and utensils, as well as cover their potable water to avoid contamination.

The dietary system of the catchment areas

The dietary system is problematic; they don’t know how to combine food to get the correct balanced diet. It is not because they don’t have the food items. For instance in weaning off children; that is introducing children to the family meal, it is always a problem to mothers. Because of the nature of the work they do, largely farmers who want to finish a particular work on a particular day, they usually don’t have time for the food they eat. Imagine somebody on the farm who wants to ensure that a particular work is completed on time or a particular day? The person may not even have time to prepare good meals for him or herself. They roast anything and eat, just to fill the stomach and continue with the work. As one eats only food that will provide energy and not food that will introduce blood into the system, this will not make one healthy. You see the person not physically sick and yet the person might not be healthy. Mothers also don’t have time to prepare food for the growing children, especially when leaving home. All these create dietary challenges for the growing children and the entire family.

5 Please tell me the common problems encountered in getting your done

Truly some of the common problems, especially on administrative issues are about convincing our leaders to provide our needs. Normally it is difficult to appeal to our leaders to provide us
motor bikes and also to maintain those that breakdown, especially if the breakdowns become frequent.

The challenge at the community level is how to get to people (hard to reach) in order to get the information one ones and also how to convince them, on some of the health issues.

Another challenge is that we don’t have a midwife and many pregnant women give birth at home or in other facilities. The women come to us for the ANC services but when it comes to delivery they go to other facilities because they know we don’t have a midwife. We share boundary with the Asante region and because our facility is not equipped with facilities for delivery, many women go to the neighboring towns to give birth. About 60% to 70% go for delivery in other facilities and it is these communities who give them some of the antigens given at the early stages of birth. The remaining few also give birth at home. Home deliveries are almost at par with those who come to the facility to give birth. When this happens and we send reports, our coverage is normally low and our superiors criticize us for non-performance. This is something I am not happy with. It is a challenge mainly because we are given targets based on a given population to achieve. We normally do all we think can help (put in all interventions) in consultation with community members to solve a problem and yet we don’t meet our target. The reality is that we don’t get the people. It is not always easy to convince your boss that you didn’t get them. This normally creates a doubt in the minds of our superiors who are not always interested in whether one has captured (covered) all the children in the catchment area; the criticism always is that the coverage is low. The problem is always not that one got some child unimmunized. The problem is always that one did not get one’s target. It is always hurtful when they tell you in your face that you are not performing.
Another problem already discussed is that concerning motor bikes as the only means for transport, which are insufficient and unhealthy for their purpose.

There is also fridges problem. Ideally we are supposed to have two fridges, one for vaccines and the other for iced pack. For the iced packs, any deep fridge can be used. The vaccine side is not normally a frozen one. Our fridge got spoiled some months ago and a different one brought to us. The vaccine side of the current fridge is not working.

Electricity is not a problem in our facility.

6. Tell me how it feels like to be a CHN

It is interesting to be a chn because per the work one is touching lives. When one sees people who don’t know anything concerning their health and one happens to be in a position to help or educate them to avoid needless death, one sees that one is touching lives.

What facilitates healthcare delivery?

When the chn is provided with the needed equipment to work, healthcare delivery is facilitated. Where also periodically there is on the job training in the form of workshops or refresher courses to help one re-echo what one has been doing as well as briefings in new developments. During such trainings, one learns from the experiences of other colleagues. What one experienced at the work place could help somebody and vice versa. In short, sharing of ideas and getting briefed on new developments are some of the factors that facilitate healthcare delivery. So the availability of tools and getting refresher training are very critical to getting new ideas for work facilitation.

Another factor is when CHNS learn and try to be creative in whatever they do and wherever they find themselves, it facilitates work. Most of the times, at the CWC, if a community health nurse
does not learn to device ways of handling challenges, work cannot go on well. For instance if there is a midwife at a particular facility and the midwife is not committed, still people will not like to go there for healthcare services. In other words, one must devise ways of getting one’s locality problems solved and work will go on smoothly. For instance there are days that people don’t go to work and therefore are available at home and times they are absent. Being dynamic in exploring all these will facilitate work.

**Tell me the factors that hinder health care delivery**

One major hindrance to healthcare delivery is lack or inadequate information reaching the communities. This means that the community members will not know that their problems can be solved at the health facilities. This results in the communities advising themselves rather than relying on their health providers. For example, per the community health nurses guidelines, a child from zero to fifty-nine months (5 years) is supposed to come for CWC. The antigens that we give are all within one year. So by nine months you give measles and YF. The child gets 18 months before you give measles two. But you find out that the moment the child gets the measles and YF, the parents stop the child from coming for CWC. You begin to realize that because they are lacking information, notwithstanding the advice given, within two years the child stops coming for CWC because the mothers or parents stop them they usually think that after receiving measles and YF, the child has finished with the CWC. So within two years the child stops coming for CWC. So one needs to continue talking and giving information. This is more so when the weighing point is distant from the parents and the mother thinks carrying the child to the weighing point is hectic. By two years, most mothers who want to give birth again, many already may be pregnant. They begin to distant themselves from the children. It is a major hindrance, because the mothers don’t have information and therefore rely on advice from others
and discontinue with the CWC. Upon all advice, one can still meet a mother whose child was supposed to take a particular vaccination within a certain month and yet the mother failed to bring the child just because this particular mother was not coming for CWC and therefore did not get information to come for the other vaccination. So these are some of the hindrances. However most of them complete their vaccinations including measles two and that give us the opportunity to continue with the provision of Vitamin A supplements after six months.

Another problem is that others report to the facility late when they are sick. Most of our health education is based on early reporting which is very important because no magic can be performed at the facility when the situation goes bad before reaching the facility. All these boil down to lack of information or inadequate information.

Again another problem is bed preparedness plan. So at the pregnancy level, most of them get to their delivery period without being prepared.

**Describe the methods employed to deliver equitable Primary Health Care services in rural communities.**

We draw a plan for each community and go according to the plan. We have home visit schedule, outreach (immunization schedule), where there are schools we also have school schedule, as well as going by the prevailing health related conditions of the community.

It becomes part of our agenda when we are embarking on these schedules apart from if it is school health and home visit. As for the immunization it cuts across.
There are instances we try to embark on a durbar for the entire community, such as teenage pregnancy being on the increase in a particular area. We do these monitoring for instance on the teenage pregnancy during our antenatal attendance and also during home visits.

In terms of disease prevailing conditions such as malnutrition, diarrhea under five, we also go by that, since it is the same conditions people will bring to the facility level. When we suspect the cases are becoming predominant, any instance one gets one speaks to the community and harms on that, for instance sicknesses which we suspect to result from negligence.

A case in point is the Kantankani community, during my antenatal outreach; I realized that hepatitis B was becoming predominant among the youth and pregnant women. We had to organize a durbar and explain to them what hepatitis B is and how it is transmitted from one person to the other.

These are some of the things we do to bring about equitable healthcare delivery, especially on the prevailing circumstances.

**What are the various ways Community Health Nurses use to create rapport among community members?**

We use an acronym call “GATHER”. “G” talks about greeting from you not necessarily from the client only. There is this popular adage that nurses are rude, hence the greetings and smiling alone bring some calmness in the client. “A” means you then ask about the client eg family health situation back home. “T” also means tell the client the status of your facility ie what pertains at the facility level. For instance as you have come to meet us here, we are all find, that is why we are all smiling. The “H” talks about helping the client in taking decisions that brought them. You then allow the client to express her or himself freely about the reason that brought