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Residents' Perceptions of Healthcare Disparities in Rural Sierra Leone

Joseph Gbanabom Conteh
Walden University

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Walden University

College of Social and Behavioral Sciences

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Joseph Gbanabom Conteh

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Review Committee

Dr. Christopher Jones, Committee Chairperson,
Public Policy and Administration Faculty

Dr. Douglas Mac Kinnon, Committee Member,
Public Policy and Administration Faculty

Dr. Kristie Roberts Lewis, University Reviewer,
Public Policy and Administration Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2021

Abstract

Residents' Perceptions of Healthcare Disparities in Rural Sierra Leone

by

Joseph Gbanabom Conteh

MPA, DeVry University, 2016

MBA, DeVry University, 2015

BS, University of Sierra Leone, 2003

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Limited or lack of access to essential healthcare services affects the social and economic wellbeing of residents in most remote, neglected, and underserved rural communities of Sierra Leone. The ability of residents to embark on productive activities is directly connected to poor health conditions resulting in high mortality rates, increasing levels of poverty, and prevalence of disease and illness. The lived experience was explored of lack of access to essential healthcare services and resources for residents in the Bombali Sebora chiefdom of Sierra Leone. The theoretical framework guiding the research was the Levesque conceptual framework and model for healthcare access. The research questions involved how lack of access to essential healthcare services affects the wellbeing of the study population. A qualitative phenomenological approach was employed with a purposive sample of nine village residents. Nine participants from the two identified remote rural communities, Rotein and Rogboreh, were interviewed individually and face-to-face. Research findings confirmed that disparities in terms of access to essential healthcare services result from demographic and geographic differences between urban and rural communities. Therefore, future studies are recommended to investigate disparities in terms of allocation of healthcare resources between urban and rural communities. Health care decision-makers can create positive social change by adopting and using results of this research to provide appropriate healthcare services and resources that could increase access to essential services for people residing in places that are far away from urban centers, and hence improve the socioeconomic wellbeing and quality of life of rural residents of Sierra Leone.

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Dedication

This dissertation is dedicated to my parents (father, Santigie Conteh, and mother, Dampy Yonkotha Kamara), who never went to school but thought education was a good path for their son. My wife, Josephine Conteh, deprived herself of material benefits and provided inspiration and strength to my success through her caring and compassionate spirit and always believing in me through difficult times. Moreover, my daughter, Keiannah Dampy Conteh, is my mentee.

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Chapter 1: Introduction to the Study

Introduction

There has been a persistent national outcry about the poor health conditions in Sierra Leone. The poverty level continues to rise as a result of increasing illnesses, which renders the bulk of the country's population vulnerable and economically dependent on the limited working population (Treacy et al., 2018). The problem of health care access has been a challenge for past and present governments of Sierra Leone to make essential healthcare services and resources accessible to every part of the country. Despite efforts put forth by governments, nongovernmental organizations, missionary and religious organizations, and traditional medical practitioners, some remote communities in the Bombali Seborra chiefdom still lack access to adequate healthcare services and resources (McGrail et al., 2018), which is necessary to maintain sound social and economic wellbeing.

Individuals living in a remote rural setting of Sierra Leone perceive themselves as victims of circumstances beyond their control due to their inability to acquire the basics of a healthy and quality lifestyle. Levesque et al. (2013) identified healthcare accessibility constraints for residents of rural communities involving the inability to realize individual healthcare needs, difficulty in the ability to seek care, inadequate ability to reach out to sources of care, lack the capability or limited financial resources to make payment for healthcare services and resources, and the absence of the potential to attract healthcare providers. Other conditions that limit or prevent access to primary health care include lack of approachability, acceptability, availability and accommodation, affordability, and

appropriateness. Poor road networks, lack of healthcare centers, absence of healthcare personnel, and lack of medications and medical supplies in remote rural areas have worsened the problem of limited or no healthcare services (Treacy et al., 2018). Although many studies have investigated factors responsible for deplorable health conditions in rural areas, lack of healthcare access is still negatively impacting the social and economic wellbeing of population in those affected areas (Eide et al., 2018). Understanding both healthcare needs and barriers to accessing such needs is essential to this study because they serve as a guide for the formulation of healthcare policies that address such needs and barriers.

The gap in the literature is limited research regarding rural residents of the Bombali Seborra chiefdom in Sierra Leone lived experience and perceptions about health, social and economic services, and policy disparities. My research revealed participants' perceptions of health, social, and economic disparities that exist between their rural communities and their counterpart urban communities. These perceptions are reflected in global concerns regarding the plight of rural areas or poor communities in terms of their lack of access to basic health. Kohen et al. (2018) said policymakers, providers of national healthcare services, and government personnel often prioritize cities and urban towns, and urban centers have the best healthcare, schools, hospitals, clinics, and resources. Governments of most developing countries are dependent upon limited foreign aid, and remote rural communities are left out of national budget planning and the resource allocation process. I investigated the lived experience and perceptions of rural residents and healthcare providers regarding persistent lack of critical healthcare services

and resources, which are necessary to create a better and healthy life in difficult-to-access and underserved communities of the Bombali Seborá chiefdom in Sierra Leone.

Provision of quality healthcare in the most remote and isolated communities in Sierra Leone has never been a national priority. On April 27, 2010, an initiative of free healthcare for infants below 5 years of age, women expecting babies, and breastfeeding mothers was launched in Sierra Leone by the former head of state Ernest Bai Koroma to enhance universal accessibility and affordability of essential healthcare services for the most vulnerable populations in the country. However, despite the establishment of the free healthcare initiative as well as extensive interventions by both local and international nongovernmental organizations and the plethora of research conducted regarding lack of access to essential healthcare services, disparities in terms of the provision of health services between poor and affluent communities remain unresolved (Ministry of Health and Sanitation, 2017). Narayan et al. (2018) said that Sierra Leone healthcare policies fail to address inequality in terms of distribution of national resources between the poor, underserved communities, and affluent urban cities, which continues to negatively impact the social and economic wellbeing of populations that reside in remote areas of Sierra Leone. Therefore, evidence of higher mortality rates, specifically maternal and infant mortality, higher levels of poverty, and increasing cases of chronic diseases and illnesses in rural settings are the result of citizens of poor communities being deprived of their right to access necessary healthcare facilities.

In this research study, I examined the lived experience and perceptions of rural residents of the Bombali Seborá chiefdom in Sierra Leone. Cohen et al. (2018) said

policymakers in Sierra Leone have an existing practice of restricting opportunities for remote communities, which has continued rural-urban inequality in terms of distribution of social and economic resources. The wealthy continue to be prosperous, while the rural communities are subjected to interminable low incomes and poor health conditions because of inequality in the distribution of national resources.

Sierra Leone, like many other countries in Africa and Asia, has obstacles in terms of accessing primary healthcare services. Sekhon et al. (2017) emphasized critical barriers to healthcare access such as lack of healthcare facilities and other resources, lack of transportation and poor road networks, inadequate healthcare supplies, weak healthcare policies, limited knowledge and skills of health personnel, poverty, and marginalization. Nevertheless, the costs related to health care services are more exorbitant in Sierra Leone, unlike other African and Asian countries, because of differences in their healthcare systems. Addressing barriers to universal healthcare will ensure rural accessibility to and affordability of healthcare when considering level of demand and economic difficulties of healthcare consumers in underserved communities.

Background of the Study

The Sierra Leone administrative structure is comprised of two primary governing bodies. The first group are national government ministries and departments headed by cabinet ministers or department heads appointed by the head of state or president. The second level are local governments, which include chiefdoms headed by paramount chiefs and are further divided into sections that are governed by section chiefs, village chiefs, or headmen who lead the villages; the smallest and the most remote rural unit is

the fakai, in most cases occupied by a large and extended family. Most fakais are rarely included or considered during national planning and are often forgotten and underserved by national governments as well as chiefdom headquarters. My research focused on samples of residents of those remote and neglected communities in the Bombali Seborá chiefdom within the Kagbere section. My research was beneficial to show which factors were perceived to contribute to lack of essential healthcare services and quality of life in rural communities.

The Bombali Seborá chiefdom is a small administrative unit within the Bombali district of the Northern region. The inhabitants in the chiefdom practice rice farming as their primary economic activity, and secret society initiations involving both males and females represent their major social activities. Residents live in poverty with poor health conditions, and they have high mortality rates (Togoh et al., 2017). Healthcare systems of the national government have very little or no impact on the villages and fakais of the Bombali Seborá chiefdom. Yakob and Ncama (2016) said traditional healers or herbalists often serve as the primary care point-of-contact for the treatment of critical illnesses within the chiefdom. Consequently, increasing rates of maternal and infant mortality have been observed due to malnutrition, respiratory infections, and anemia because of hardships and dependence on ineffective means of treatment.

The Department of Health and Sanitation in Sierra Leone is the political branch of the Sierra Leone government that has the responsibility to formulate and implement all policies in the national health service system. The Sierra Leone healthcare system is comprised of a complex network of sectors and activities and is undergoing policy and

administrative reforms to adopt the United Nations' Sustainable Development Goals (SDGs) and improve quality of life for Sierra Leone's citizens, like healthcare systems in other countries (Gou et al., 2018; Guttman, 2018). Despite efforts of the central and local governments and international partners to make healthcare a priority to enhance SDGs, the country still has the highest rates of maternal and infant mortality, HIV/AIDS, tuberculosis (TB), and malaria (World Health Organization [WHO], 2018). Poor health conditions in the country continue to worsen because of denial of access to essential healthcare services, since the limited supply of healthcare providers cannot adequately meet the country's collective medical demands.

Isolated communities in Sierra Leone have persistently had limited or no access to healthcare services and resources. This deprivation of access to firsthand healthcare poses constraints on inhabitants of remote and underserved rural settings, preventing them from having a better understanding of their healthcare services, needs, use, consequences, and motivation to seek primary care (Levesque et al., 2013). The only significant economic activity in the remote areas of the Bombali Seborra chiefdom is small-scale farming, which includes the cultivation of upland and swamp rice, cassava, and vegetables. Limited economic activities in rural areas appear to have exacerbated the level of poverty that serves as a deterrent to healthcare accessibility and affordability.

Problem Statement

Limited or lack of access to primary healthcare is a critical contributing factor to poor living conditions of many underserved rural communities in Sierra Leone. Vaishar et al. (2018) noted that the literature has explored urban wellbeing as compared to rural

wellbeing by a 3:1 ratio. There is a widespread perception that life in remote rural communities is linked with poverty, poor health conditions, lack of necessary and essential life services, chronic illnesses and incurable diseases, and maternal and infant mortality. Kagabo et al. (2018) said high infant mortality rates mostly affect poor African countries and Bakundukize et al. (2018) noted that time and distance to access necessities of life are more difficult for rural communities compared to their urban counterparts. Disparities in terms of the distribution of primary life resources in many nations in the world has left most remote and neglected rural communities at a disadvantage, with limited or no means to essential health services, resulting in adverse health conditions as well as poor socioeconomic wellbeing specifically for rural communities in the Bombali Sebora chiefdom of Sierra Leone.

The belief among stakeholders of the Sierra Leone system is that livelihood problems in remote rural communities are natural, caused by conditions where they live. There is a gap in the literature regarding the impact that denial of access to essential healthcare resources and services has on the social and economic lifestyles of rural residents as a result of their poor health conditions. Many studies have only concentrated on factors responsible for limited access to healthcare resources. My research may contribute to the literature regarding perceptions, beliefs, and experiences of remote rural residents concerning their access (or lack thereof) to healthcare services and resources. My research involved exploring the lived experience and perceptions involving the relationship between access to healthcare and poverty and other socioeconomic

conditions, which could promote understanding cultures of inequality in terms of distribution of healthcare resources between urban and rural communities.

It appears that limited information regarding lack of access to essential healthcare available to policymakers, funding agencies, and other stakeholders restricts the establishment and implementation of policies and practices that might overcome life-threatening consequences of inadequate access to healthcare services. Kagabo et al. (2018) said infant mortality in impoverished African communities occurs because of distance and limited access to life-saving healthcare interventions. Patients are unable to acquire health personnel, finances, medical facilities, and equipment. Existing literature appears limited from the standpoint of the lived experience and opinions of average people involving access to healthcare services.

Sierra Leone, like many other countries, has suffered from a series of challenging circumstances such as the 11-year civil war, the Ebola outbreak, and now the COVID-19 pandemic. These life-threatening events negatively impacted the country's healthcare system and quality of life of Sierra Leoneans. According to the Ministry of Health and Sanitation (MoHS, 2017), the life expectancy rate is 51.3 years and the mortality rate of children under 5 years old was 156 per thousand. The pandemic and other factors mean that Sierra Leone and its population are increasingly vulnerable to poverty, illness, and disease. Therefore, the quality of healthcare services and resources in Sierra Leone is essential for a sustainable future for the country and its people.

Purpose of the Study

The purpose of this phenomenological study was to address perceptions and the lived experience of lack of access to essential healthcare services and resources in remote and underserved rural communities in the Bombali Seborá chiefdom of Northern Sierra Leone. There is little existing research regarding perceptions of limited healthcare services faced by people residing in hard-to-reach and remote villages who constitute the research population. Residents in remote areas experience high maternal and infant mortality rates, increased prevalence of chronic diseases and illnesses, and high levels of poverty compared to their urban counterparts.

Research Questions

My research questions were:

RQ1: What are the lived experience of and perceptions of access to essential healthcare services and resources for remote rural community residents of Bombali Seborá, Sierra Leone??

RQ2: What events and situations have had an impact on rural residents of Bombali Seborá, Sierra Leone and their perceptions regarding access to primary healthcare services and resources?

Theoretical Foundation

Addressing the lived experience of indigenous people requires extensive and in-depth investigation and understanding of perceived factors or situations responsible for such experiences. My research employed the conceptual framework for health care access model established by Levesque et al. This model explained healthcare access by

comparing the factors that are limiting or preventing the supply of and demand for healthcare services and accessibility (Davy et al., 2016; Richard et al., 2016).

The five dimensions that describe the lack of healthcare resources because of the variability in: approachability, acceptability, availability and accommodation, affordability, and appropriateness of healthcare resources used to address the healthcare supply system while ability of the patients to perceive, seek, reach, and pay involve consumers' capabilities in terms of effectively demanding healthcare services and resources (Davy et al., 2016; Richard et al., 2016). Providers and consumers offer an understanding of how the supply side of the model influences level of demand for healthcare services and resources. The desire of the patients to access and use needed care can only become real if such passion transforms into effective practices via the willingness and ability of the consumers to acquire needed healthcare services. This indicates patients' readiness to perceive healthcare needs, seek healthcare facilities and services, reach out for care, pay for care, and engage with healthcare providers (Levesque et al., 2013). Therefore, policymakers need to understand demand and supply factors as they determine level of access to and use of healthcare services, which are critical issues in terms of public health planning and policy formulation.

In-depth knowledge of the identified six factors, which are: healthcare needs, perceptions of needs and desire for care, healthcare seeking, healthcare reaching, healthcare use, and healthcare consequences—factors that provided me the ability to adequately explore beliefs about the lack of healthcare resources in the rural communities

of Sierra Leone that serve as an impediment to equitable access to primary healthcare services and resources.

Levesque et al.'s model of access to healthcare was a lens for research which helped me to better understand social and cultural determinants of health that serve as barriers for remote rural residents of Bombali Sebor, Sierra Leone, their families, and communities in terms of access to care. Poverty is a prominent social determinant of health issues, with some residents of Bombali Sebor chiefdom, Sierra Leone finding it difficult to afford either transportation to costs of obtaining services. The Levesque conceptual framework for healthcare access model also helped explain why the lack of necessary communication infrastructure, such as telephone service, within communities hinders access to healthcare guidance and advice.

Nature of the Study

This study was qualitative, and I used a phenomenological approach to explore and understand the real-life stories and the lived experience of underserved remote rural residents who experience high mortality rates, diseases and chronic illnesses, and high levels of poverty resulting from lack of access to essential healthcare services. My goal was to provide an in-depth understanding of situations involving the Bombali Sebor chiefdom in northern Sierra Leone. I collected data of the lived experience and perceptions from underserved rural residents with poor health conditions and healthcare providers to address the lived experience associated with lack of access to healthcare services and resources, which have an impact on the socioeconomic wellbeing of rural residents. Sources of data collection for this study included in-depth face-to-face

interviews with rural residents with poor health conditions and healthcare personnel, which provided insights into the participant's lived experience, actions, and choices. Raw data were transcribed, coded, and analyzed using Levesque et al.'s model of access to healthcare. This theoretical framework served as a lens to better understand residents' perceptions of health conditions in terms of rural living.

Definitions

Chieftdom: A chieftdom is a geographical division within a region or province that is headed by a paramount chief.

Healthcare acceptability: This refers to the likelihood that patients develop trust in healthcare services offered by providers and remain willing to participate in their treatment plans or use services and facilities available to meet their immediate healthcare needs.

Healthcare approachability: Levesque et al. (2013) said healthcare approachability is when patients with healthcare needs become aware that healthcare services or resources that could create an impact on their wellbeing do exist and can be accessed.

Healthcare appropriateness: Davies et al. (2016) said healthcare services or resources accessed by consumers satisfy or meet their needs or expectations, which is determined in terms of quality and timeliness of services as well as quality of healthcare personnel and available technology.

Healthcare availability and accommodation: According to Richard et al. (2016), accessibility and accommodation of healthcare services and facilities involves physical

existence of healthcare facilities that can be easily accessed by users as well as presence of healthcare personnel whose services are made available in a ready and timely manner.

Healthcare consequences: Davy et al. (2016) defined healthcare consequences as effects or outcomes that patients experience after accessing healthcare services or being treated. Results of medical treatment or healthcare access might be negative or positive—it might improve quality of life and wellbeing or result in poor health conditions.

Healthcare reach: According to Richard et al. (2016), this involves patients reaching out for medical treatment and their willingness and capability to break barriers involving communication, costs of care, transportation, and competitive advantages to access essential healthcare services and facilities on time.

Healthcare seeking: Patients' desire to obtain healthcare services starts with awareness of their healthcare needs and treatment from facilities or providers to have a higher quality of life or increased socioeconomic wellbeing (Druetz et al., 2018). Kagabo et al. (2018) defined care-seeking for children as “actions taken by caregivers of young children in response to a predisposing factor” (p. 3).

Health care use: Patients' ability to afford costs of healthcare services, facilities, and products to determine the actual and potential use of such medical services and resources (Richard et al., 2016). Healthcare users can access and use healthcare resources.

Assumptions

I assumed that disparities in healthcare services were a result of demographic and geographical differences. The rural-urban welfare imbalance has created a steady lack of

access to first-contact lifesaving medical treatment in the faraway *fakais* of the Bombali Sebora chiefdom in Sierra Leone.

Scope and Delimitations

This study was a comparative analysis of the perceptions of socioeconomic wellbeing of both rural and urban residents involving disparities in terms of access to primary healthcare services and resources. Shah et al. (2018) said rural residents have restrictions in terms of reaching out to healthcare centers and accessing healthcare facilities physically. Unfair access to healthcare services and resources between urban and rural communities has led to global concerns involving unprecedented high mortality rates in poor rural communities. Providing a logical and reliable study outcome required in-depth interviews on the consumers of health care within the Bombali Sebora chiefdom in the northern region of Sierra Leone. My research was focused on remote, rural, and poor consumers of healthcare services in Bombali Sebora, Sierra Leone. Participants were between 35 and 64 years of age who had experience with primary healthcare in the study environment of Rotein and Rogboreh and lived or worked in the Bombali district for at least 5 years.

Limitations

There were only two villages in the northern region compared to many remote areas throughout the country. The remoteness of the sampled villages also created constraints due to technological challenges (i.e., the constraints of teleconferencing during the pandemic, transportation, and lodging) restricted the scope of the study.

Significance of the Study

Study outcomes could influence healthcare policy reform and help decision-makers accommodate healthcare needs of remote rural communities in the Bombali Sebora chiefdom of Sierra Leone, which could enhance patients' health and economically empower individuals in rural communities. The rationale was to adopt a system of healthcare that would improve the health and socioeconomic wellbeing of fragmented and neglected populations. Such an effort will reduce health inequalities that affect underserved rural communities and strengthen public health and promote people-centered health systems that are universal, equitable, accessible, sustainable, and high-quality.

The life stories and experience of a sample of nine affected participants may serve to influence needed social, economic, and developmental changes by assuring every citizen of Sierra Leone, irrespective of geographical location or place of residence is guaranteed essential, equitable, affordable, and accessible healthcare services. A healthy population leads to a healthy and socially and economically developed nation. Findings obtained from this study added knowledge to limited research regarding rural residents' continued beliefs in supernatural or traditional healing because of the inadequate supply of primary health care services and resources. Determining factors including transportation, poverty, distance, and inadequate and incompetent healthcare personnel serve as push factors that lead to traditional treatment (Guo et al., 2020). Moreover, in Sierra Leone, unlike developed countries in other parts of Africa and Asia, such factors are informed by differences in the healthcare system. Cost-effective health care should reflect the needs of populations and economic difficulties faced by healthcare consumers.

Levesque et al. (2013) said that individuals without the abilities to demand for healthcare services and resources were more likely to avoid seeking healthcare facilities and continue to seek traditional medicines and believe in sorcery, witchcraft, faith-based healing, and herbal treatment. Traditional healing and beliefs persist in rural areas, especially when villagers cannot afford to seek healthcare services and resources. Therefore, policymakers should consider integrating traditional healing into modern healthcare treatments for illnesses and diseases. Study findings revealed that most residents of rural communities often consulted traditional healers because of one or more identified barriers (e.g., lack of income, long distances to hospitals or clinics, lack of trained and qualified healthcare providers) when accessing healthcare services. Some traditional medicines are necessary and safe for integration into Western medicine and treatment, and are arguably essential for rural residents who must walk long distances to seek healthcare services. For example, training local midwives or traditional birth attendants could be made more widely available to provide first aid and nonemergency healthcare that reduces maternal and infant mortality rates.

Motivating direct providers or suppliers of healthcare services and resources to willingly serve in every part of Sierra Leone must be a priority for the healthcare system and healthcare experts who serve as government personnel to carry out policy reforms that will affect citizens of Sierra Leone for their wellbeing and quality of life across the country. Therefore, it is vital to recommend that future inquiries into the study phenomenon target a broader coverage of data to include more rural communities from

more chiefdoms, districts, and regions in the country. This would help the participants to have a detailed and in-depth understanding of the study phenomenon.

Summary

This qualitative phenomenological inquiry involved exploring the lived experience and perceptions of neglected and underserved rural populations included experiences and views about beliefs and other factors responsible for persistent lack of access or limited access to primary healthcare services and resources. This lack of access exists because of geographical or spatial disparities in terms of national and universal healthcare services and resources between urban and rural settlements. Such limitations or failures to access healthcare resources and facilities has negatively impacted the socioeconomic wellbeing of residents in rural communities of the Bombali Seborá chiefdom in northern Sierra Leone compared to their urban counterparts.

The Levesque et al. access model was used as the theoretical framework to guide data analysis and presentation of study findings. Perceptions of healthcare disparities result from demographic and geographical differences in terms of distribution of healthcare resources and services. This study was delimited to two remote rural communities of Rotein and Rogboreh in the Bombali Seborá chiefdom of northern Sierra Leone.

Chapter 2: Literature Review

Introduction

Primary healthcare has been a global challenge for the public health sector in healthcare systems in both developed and developing countries. Diseases, chronic illnesses, and natural and human-made disasters are the most life-threatening events for people (Davies et al., 2018). The aftermath of such events has a more devastating impact on hard-to-reach and underserved rural communities compared to affluent urban districts. The remote villages of the Bombali Seborá chiefdom in Sierra Leone have high rates of mortality, chronic diseases, and illnesses, as well as high levels of poverty because of lack of medical facilities and personnel who can provide members of those communities with required essential healthcare services (Narayan et al., 2018). International organizations such as the UN and WHO, have made efforts to overcome challenges of primary healthcare to achieve universal health coverage as part of SDGs that ensure all people have access to essential high-quality health services.

In many cases, people in remote rural communities of the Bombali Seborá chiefdom seek other means of healthcare such as herbal treatments, sorcery, and supernatural interventions that are offered by pastors in miracle churches (Magezi, 2018; Yakob & Ncama, 2016). At present, if lack of access to essential healthcare services continues, residents of the Bombali Seborá chiefdom will continue to seek alternative means of treatment that are based only on faith. Traditional ways of seeking health care

offer no guarantee of solutions because death rates, levels of illness and disease, and maternal and infant mortality are still prevalent.

The social and economic effects of healthcare disparities in rural communities have negatively impacted livelihood and survival of people residing in those neglected and underserved communities. Tlou (2018) said critical factors associated with high levels of infant and maternal mortality rates in most remote rural communities include poor social and economic status, high birth rates, and high mortality rates. Despite growing concerns of nonprofit organizations and public services and government agencies regarding establishing and sustaining equitable public health systems to enhance accessibility, affordability, and quality of healthcare services for all, lack of access to basic healthcare services remains a problem for many in most remote rural communities in Sierra Leone.

My research was designed to explore people's lived experience and perceptions about lack of access to essential healthcare services and resources among remote and underserved rural communities in the Bombali Seborra chiefdom of northern Sierra Leone. Lack of access to primary healthcare in rural areas is a perennial social problem that has adversely affected the socioeconomic wellbeing and life patterns of rural communities in Bombali Seborra.

Qian et al. (2017) reported that unfair treatment in terms of use of healthcare resources has led to inequalities in terms of standards of living between rural and urban societies. Variations in terms of access to healthcare services and resources determine the level of inequality. Urban centers attract well-trained and more qualified medical and

health care personnel, which leads to disparities in terms of accessing health services. Consequently, health care disparities create problems involving national health care policy planning in terms of national development because vulnerable populations of a nation usually have little to contribute to their economies.

The ability to understand and seek healthcare services, reach out and identify sources of care, meet high costs of care, and engage and participate in treatment processes that enhance maximum satisfaction and quality of life are supportive pillars of the Levesque conceptual framework for healthcare access (Levesque et al., 2013). According to Kyei-Nimakoh et al. (2017), for consumers to meet requirements for accessing basic healthcare services, providers at all levels of a healthcare system should be willing to offer practical, efficient, and good-quality services that are consistent with healthcare needs of clients.

There is a significant gap in the literature regarding belief systems held by residents of remote rural communities and other key stakeholders in most developing countries, where there exist persistent socioeconomic disparities between urban and rural communities. There have been minimal efforts by researchers to explore beliefs and the lived experience that involve remote rural communities in terms of equal distribution of healthcare resources and services.

In this literature review, I address the nature, scope, and structure of primary healthcare (PHC) in Sierra Leone and the role of PHC in the Sierra Leone healthcare system. I also elaborate on factors influencing access to PHC services and resources, which include demand and supply factors. Factors responsible for the provision of

adequate, quality, and affordable healthcare services and resources include approachability, acceptability, availability and accommodation, affordability, and appropriateness (Levesque et al., 2013). Simultaneously, demand factors influencing access to healthcare services and resources require that patients have the ability: to understand their healthcare needs, to find out about healthcare needs and desire for care, to reach out for services, to pay and use services, and to engage with healthcare providers. This chapter also includes a discussion of social and economic impacts that lack of access to primary healthcare services have on participants' lives as well as a review of urban-rural health care disparities and their effects on the socioeconomic wellbeing of healthcare consumers.

Literature Search Strategy

I reviewed relevant literature regarding the studied phenomenon. I conducted my search for related literature using Walden University's scholarly databases and ProQuest Central, Academic Search Complete, Health Science Research, Google Scholar, PubMed, Medline, Science Direct, ABI/INFORM Global, Nursing & Allied Health, Public Health, Health & Medical Collection, EBSCO Host, and SAGE Journals.

For this study, I reviewed peer-reviewed scholarly articles, journals, and books, using the following search terms: *healthcare, lack of access to primary healthcare services, rural communities and healthcare services, rural health and barriers to access, healthcare barriers and healthcare access, poverty and rural health, healthcare access, rural settings and healthcare disparities, healthcare disparities, healthcare beliefs, lived experience and lack of healthcare, healthcare and healthcare services policy, healthcare*

policy and healthcare services, healthcare and healthcare access disparity, healthcare policy and healthcare access, beliefs about access and healthcare services policy, healthcare policy, healthcare policy and public health, healthcare policy and socioeconomic factors, healthcare and socioeconomic factors, and healthcare access and rural settings.

Theoretical Foundation

Healthcare access is a broad and complex concept that continues to attract the interest of scholars, researchers, and policymakers. The perception is that the poor health conditions in the most remote rural communities exist because of the unfair distribution of health care resources between rural and urban residents, which creates a lack of access to essential healthcare services and resources, forms the fundamental theoretical foundation of this study. Here, I used the theoretical base from the work of Levesque et al. (2013), which accommodated a wide range of theories that offer an expansive description of the access to and the accessibility of health care facilities and services. Following Levesque et al.'s framework, I will discuss the positive efforts required by the health care consumers and the attributes of the health care system alongside its five phase-linear theoretical models. The advantage of Levesque et al.'s conceptual framework over other models regarding the access to health care services is the fact that the former goes beyond the situation where a patient reaches out for health care services. Lévesque et al.'s framework continues to a level at which other relevant issues concerning vulnerable populations can attract and captivate the continuing attention and interest of health care providers.

Levesque et al.'s model of conceptualizing access to health care services developed its premises from the broad economic concepts of demand and supply, found in the production and consumption of healthcare services and resources. The supply side, according to Levesque et al.'s (2013) model, comprises the providers of healthcare services and every other force or factor that may enhance the availability and easy access of the healthcare services to consumers based on their needs or desires for healthcare. The speculation behind the application of the Levesque et al.'s model-based its fact on the lived experience of healthcare consumers residing in most remote rural communities with limited or no access to essential health care services is influenced by a lack of one or more of the supply factors. The supply factors determine the patients' demand for or access to primary health care services (McGrail et al., 2017). This assumption acknowledges the existence of health care barriers, as highlighted by many researchers (Amalba et al., 2018; Davy et al., 2016; Johansson et al., 2018; Richard et al., 2016), and is associated with limited resources (finance, equipment, personnel, and time) and poor infrastructural network linking the suppliers and consumers of health care services (such as poor roads, lack of transportation, and lack of healthcare facilities).

Indigenes of remote rural areas face difficulties accessing healthcare, which has been the central focus of many research kinds of literature that have been reviewed about the subject matter. Corcadden et al. (2017), in their extensive research on the existing literature, argued that the underserved and neglected residents in poor communities are deprived of necessary healthcare services because of low income, failing to meet the high cost of care and falling prey to the disparity in the distribution of resources that

negatively impact the rural poor. Concurrently, Yakob and Ncama (2016) considered health care accessibility as a crucial component among the fundamental rights of human beings. Still, they stated that individual differences, as well as the geographical inequalities concerning resources and capabilities, therefore, serve as barriers to accessing health care, tending to persist in certain countries as opposed to others. The literature suggested that barriers to access health care services vary regarding space, culture, norms, shortage of supply from the health care system, and certain constraints that are faced by users in accessing such services.

People with health-care needs require knowledge about the availability of resources (Davy et al., 2016; Richard et al., 2016) or services as well as need the opportunity to access the resources to meet their health care needs. Levesque et al. (2013) aligned the six dimensions of healthcare accessibility with the forces of demand and supply based on the perceived understanding of the existence of healthcare needs, the desire for accessing care, the effort to acquire the needed care and receiving maximum satisfaction from the limited resources in exchange for care. This model indicates that providers should maintain a conducive environment that would offer adequate and precise knowledge about the health care services, maintain appropriate standards of behavior, with reasonable direct and indirect costs of care, and ensure excellent customer-service relationships with patients.

In a qualitative descriptive study design, Dassah et al. (2018) applied the conceptualization of the access model advanced by Levesque et al. (2013) to explore the lived experience of persons with disabilities regarding their access to rural primary health

care services. The authors utilized the opportunity of putting the Levesque et al.'s model at work by assessing the quality, equality, and health outcomes. Dassah et al. argued that elements from both the health care consumers and health care delivery system work side-by-side to determine the rate at which people utilize healthcare services in a rural setting. With the aid of the conceptualization model in the data analysis, Dassah et al.'s study results indicated that inadequate knowledge about policies and procedures contributed significantly to the lack of access to basic health care services.

The reason for using Levesque et al.'s model of health care access is centered around three key factors: 1) the extensive effort of the framework to provide a detailed understanding of the concept of access to primary health care, 2) the use of simple economic theories to portray the cultural and social behaviors of both health care consumers and suppliers, which influence their access to health care services, and 3) the ability of the conceptualization model to go beyond the physical transactional contact between the patient and the health care provider/health care system to further clarify how best and to what degree the providers/health care system can offer maximum satisfaction to their patients/consumers. The model addresses the reality of vulnerable populations living in poor socioeconomic and health conditions who have limited or no access to health care services and resources (Jepsen et al., 2018; Tlou, 2018). These factors align with the purpose of this research study because Levesque et al.'s details on how an understanding of people's health care needs, lived experience, and perceptions about accessing basic health care services and resources can provide answers to the policies enhancing equitable distribution of health care services (Cohen et al., 2018; Qian et al.,

2018). As a result, the research questions focus on what the lived experience and perceptions residents of remote rural communities might have, the situations that have had an impact on such perceptions about, and experiences with, the limited or lack of access to primary health care services. Therefore, the need for a broader definition of the concept of access is necessary, which can provide in-depth knowledge of health care consumers' and providers' limitations concerning the health care demand and supply equation.

The broader concept of access, as it relates to the health care policy, connotes a complicated and holistic theoretical framework that embraces five categories of identified vital health care needs. This framework examines these five dimensions of health care needs about the market forces that control the behaviors of both suppliers/providers and consumers/users of health care services (Davy et al., 2016; Richard et al., 2016), finding factors which offer explanations to provide in-depth knowledge about the health care access policy that is aimed at promoting the fair allocation of health care services and resources.

Healthcare Need Components

I examined literature from the Levesque et al. (2013) access framework, which centered their analyzes on participants' lived experience as conceptual foundations in their studies. As Levesque et al. used the needs component as a central focus to present a detailed explanation of the demand and supply factors of health care access, many other researchers on the topic provided substantial evidence on the importance and influence of human health care needs to access health care resources. For example, Andersen (1995),

presented health care needs as perceived and evaluated characteristics of a population at risk. As a critical component in any health care system, access to and utilization of health care resources and services enhance the possibility for individuals to identify health care needs, seek, reach out, and obtain health care services.

Perception of Needs and Desire for Care

Perception of needs and desire for care explains the consumers' ability to see, hear, and feel the existence of health care or the awareness that health care services, facilities, and other resources that exist somewhere familiar, as well as their ability to develop the interest to receive care or contact care providers. Kyei-Nimakoh et al. (2017) expressed the importance of patients' awareness of health care services as such an understanding would enhance their ability to make the appropriate use of health care services and resources. Kyei-Nimakoh et al. maintained the position that knowledge about what kind of health care services is what individuals need to determine when, where, and how to reach out for essential health care services.

Healthcare Seeking

Healthcare seeking refers to clients' response to their understanding of the importance of finding health care needs to enhance their well-being. Tong et al. (2018) endeavored to explain the full range of factors that influence individuals to seek health care. For instance, the need for accessing healthcare arises due to a network of individual factors, interpersonal factors, community-related factors, health care service-related factors, and health policy-related factors. According to Clewley et al. (2018), patients' efforts to search for health care access enhances the capacity to use health care.

Subsequently, patients act upon their knowledge about the desire for wellbeing to find and obtain appropriate medical care.

Healthcare Reaching Out

Healthcare reaching out refers to the efforts of patients to establish a point(s) of contact with health care facilities and care providers for issues relating to their well-being. Reaching out for care includes patients' endeavors to have access to health care and participate in the processes of preventing and treating diseases and illnesses (Canuto et al., 2018). The apparent implication is that consumers' understanding of health care existence and searching for health care services and facilities does not necessarily mean access to care but it creates a holistic process of knowing, exploring, acquiring, and achieving maximum care satisfaction, all of which have a positive effect on patients' complete physical, social, and mental health conditions and the quality of life. Health care seeking refers to clients' response to their understanding of the importance of finding health care needs to enhance their well-being. Tong et al. (2018) endeavored to explain the full range of factors that influence individuals to seek health care. For instance, the need for accessing health care arises due to a network of individual factors, interpersonal factors, community-related factors, health care service-related factors, and health policy-related factors. The patients' efforts in search of health care access enhance the capacity at which an individual uses health care.

Healthcare Use

Canuto et al. (2018) defined healthcare use as the aggregate of care an individual patient acquires from the various health care categories for the prevention and treatment

of diseases and illnesses, respectively. The authors were confident in their presentation that the quantity of care a patient receives for his or her well-being is determined or measured by the total cost incurred and the number of visits to hospitals and other health care facilities. Moreover, a patient's utilization of health care is dependent upon the level of satisfaction derived from the services and treatments acquired from health care providers and facilities.

Consequences of Accessing Care

Research has suggested that the consequence of accessing care is the outcome from the health care access and utilization, as indicated by patients' well-being and quality of life. Gage et al. (2018) found that the rate at which the individuals' access and utilize health care services determines health care outcomes. The authors in their findings outlined that the residents of remote rural communities encounter an array of barriers to essential health care services and facilities and also fail to connect with such medical facilities and services. Additionally, Erchafo et al. (2018) also discovered that the lack of access to health care may affect patients' social, economic, physical, and emotional comfort and security. Therefore, the patient's quality of life has a direct link with the consequences associated with accessing health care.

Ability to Perceive Healthcare Needs

Fan et al. (2018) defined the ability to perceive health care needs as an important dynamic in health care consumers becoming aware of their health conditions. The authors provided examples in support of their definition showing that individuals know the social, physical, and mental conditions that affect their well-being or health status.

Erchafo et al. (2018) and Maseko and Harris (2018), in their studies of preventive medicine, concluded health care provider knowledge about the need for patients' understanding of the symptoms of chronic illnesses promotes the prevention and treatment of those diseases. Irrespective of the fact that the framework places the perception of health care needs as a demand factor supporting health care access, the researchers also considered the role of the providers' attitudes in promoting and accommodating patients' desire to search for and participate in acquiring medical treatment. That is, if patients can identify what is wrong with their health, that will serve as a prompt for them to seek care and hence increase positive health outcomes.

Ability to Seek Healthcare

According to Davy et al. (2016), the ability to seek health care is a driving force inspired by the readiness and capability of individuals to connect themselves with health care facilities and providers. The authors also raised a concern about certain obstacles restricting patients from seeking treatment and care, which included the absence of positive cultural inspirations and oversight of consumers' health care needs by the public policies and practices within the health care system. Consequently, health care users lack confidence and trust in the health care system for their well-being.

Ability to Reach Out for Healthcare

Levesque et al. (2013) in their framework of health care access presented the ability to reach out for health care as the aptness of health care consumers to get in touch with the health care system. That is, they are apt to establish a link with health care facilities, suppliers of health care services, and inclined to take part in or engage in the

treatment scheme. Indeed, Levesque et al.'s point of view refers to the breaking of the transportation and communication barriers to accessing health care services as well as patients' effort to forgo or sacrifice other compelling and competing needs to attend to health care facilities.

Ability to Pay for Healthcare Services and Products

Richard et al. (2016), according to their model of health care access, concluded that the ability to pay for health care services and products is the capacity of the patients to transform their health care desires into effective demand. Davy et al. (2016) also explained that the ability to pay for health care services is attributable to consumers' possession of the economic means to acquire health care services or products. The literature made clear the cost of care as a central factor that influences the demand and supply for health, which also doubles as a barrier to accessing health services for vulnerable and underserved populations.

Literature Review

Literature from several researchers have identified access barriers in past research studies conducted in developing countries like Sierra Leone and some developed countries. Barriers to accessing primary health care services and facilities include: the lack of health care facilities and other resources, the lack of transportation and poor road network, inadequate health care supplies, weak health care policies, limited knowledge and skills by health care personnel, poverty, and marginalization (Ahinkorah et al., 2021). Nevertheless, factors determining the understanding of health care needs and gaining access to primary care to accomplish such needs are critical in health research. Moreover,

in Sierra Leone, unlike developed countries, such factors are informed by the differences in its health care system. According to the views of health care practitioners and organizations (Kalra et al., 2018; Magwood et al., 2018; Renggli et al., 2018), a universal scheme of cost-effective health care should reflect the needs of populations. The mechanism of change in the health care conditions of patients is explained in the following sections. The global objective is to meet the challenges of the equitable distribution of health care services and resources to achieve universal accessibility and affordability of health care, considering the level of demand and economic difficulties faced by health care consumers.

Primary Health Care in Sierra Leone

Primary health care is a critical component of the health care system of any nation. Primary health care serves as the foundation of a country's health care system, offering a broad spectrum of care to cover all populations and communities in society (Budreviciute et al., 2018; Guttman, 2018; Kalra et al., 2018; Weel & Kidd, 2018). Sierra Leone has, in each of its 16 districts, a district primary health care unit that supervises all the primary health care services, including vaccinations, environmental health, water and sanitation, disease surveillance and response, and the coordination of disaster management and prevention within the district.

Factors Affecting Access to Primary Healthcare Services and Resources

An array of factors exist that can determine the level at which a population or community utilizes health care services. Devkota et al. (2018) recommended the appropriate allocation of health care resources by recognizing the difficulties of service

positioning and delivery and understanding the needs and rights of patients. Ntambue et al., (2018) suggested that citizens require the continuing support of governments and other stakeholders who must provide the necessary funding and logistics needed to achieve universal service coverage. Ntambue et al. suggested that policy makers should prioritize the need for explicit financial policies and the establishment of clear procedures that will guide the implementation of such policies to achieve a broad scale of access to and utilization of health care services.

Service availability is a critical factor for enhancing the accessibility and utilization of health care resources. Gao et al. (2018) argued that the establishment of action plans will guide the decision-making process regarding what types of health care services are needed, the quantity of care services, the different population needs, within how much time are the services needed, the sources of the services, who provides the service, and who pays for the service. Figueira et al. (2018) found that the disparity in the distribution and utilization of health care services and its consequences in jurisdictional administrative locations is a result of the complex nature of health care policies and the perceptions of demographic and geographic differences in the populations. Gao et al. (2018) identified the key features of health care services that include service locations, the magnitude, or proportion of care (the availability of workforce and facilities). Gao et al. added other features of a health care system as the nature or variety of services, which are all products of the health care policies that inspire and motivate health care providers to improve on the quality and outcomes of health care services, ensuring more comprehensive coverage and access to essential health care services.

According to Mirghafoori et al. (2018), the broad spectrum and complex nature of the health care system and services, including preventive care, rehabilitative care, curative care, and palliative care, attracts a wider scope of market size. Mirghafoori et al. reported that the broad market offers services to the entire population in each geographical location and a span of suppliers/providers within the different levels of the health care system. Even though individuals desire health care services, Baily (2018) noted the restrictions on the supply-side of health care. He claimed that specific requirements (e.g., certification and licensure) for practice, care provision, and the establishment of health care facilities serve as an impediment to increasing the supply of health care services to meet the demand for care. According to Baily, the forces of demand and supply serve as the primary pathways through which the behaviors of both the users and providers are understood. As a result, from the above findings, the two market forces influence or determine the level of access to and utilization of health care services.

Supply Factors

Consumers' or patients' willingness to seek and secure the services or products depends on certain factors—approachability, acceptability, availability and accommodation, affordability, and appropriateness (Levesque et al., 2013). Health care is an asset that enhances the well-being of individuals to fully engage in productive activities and minimize the incidence of poverty, chronic diseases, and illnesses.

Approachability

This is a supply factor found in phase one of the linear framework of Levesque et al. (2013), which provides details about the efforts of health care systems (suppliers of health care services) to educate, sensitize, and provide accountability of information to their consumers/patients about their health care facilities, services, and products. Haggerty et al. (2014) outlined the critical role of this supply factor in the framework by stating that the health care needs of patients can be met only if the users of health care services can understand the kind of health care services or support they need for their wellbeing. Besides, Price et al. (2016) stated that the patients understand their health care needs through the knowledge they acquire from the providers' educational information on healthy lifestyles and how such services provided meet the health care needs of health care consumers with a reasonable financial burden. Relating this notion of an open and pleasant relationship expected of both suppliers and consumers of health care products and services to the economic view of supply, Johansson et al, (2018) explained the responsibility of the producers or suppliers of goods and services to apply marketing strategies to promote the sales of their products and services by providing adequate information or education about their offer, to persuade consumers to develop an interest in acquiring such commodities or services.

Acceptability

According to Richard et al. (2016) and Day et al. (2016), the supply factor of acceptability, as used in the Levesque et al.'s framework, defines the characteristics of the health care services by meeting the holistic nature of health care needs of patients. Yakob and Ncama (2016) in their study concluded that the features of acceptability fall in

a broader spectrum of cultural appropriateness, community belief systems, individual characteristics of emotion, social, wellbeing, and comfortability of service. Therefore, researchers confirmed that providing an offer of services that are compatible with the health care needs of consumers—for example, providing culturally appropriate services, recruiting health care personnel who understand and appreciate the lifestyles of patients and communities, and providing a broader scope of health care coverage that enhances the social and emotional needs of patients—will increase the supply of health care services.

Availability and Accommodation

According to Levesque et al. (2013), as a supply factors, availability and accommodation influence the quantity of services providers or suppliers are willing to offer to the patients, to provide more opportunities to incorporate the needs of all patients irrespective of their capability to pay for services or their place or region of residence. Halle et al. (2018) explained availability and accommodation determine how the health care system can best address the equitable distribution of health care services and facilities to all geographic locations. Halle et al. held that adequate and equitable health care services requires increased hours of operations, increased numbers of medical appointments, and create an atmosphere conducive to patient-provider interaction for better care. Cohen et al. (2018) reinforced Halle et al. noting that health care consumers can only fully gain access to essential care services when medical products and the services are at their disposal at a time when they need them, appreciate them, and can afford those services or products.

Affordability

Corscadden et al. (2017) defined affordability in the context of health care accessibility as the opportunity for health care consumers to judiciously allocate their meager resources, including income and the time to acquire and utilize health care products, facilities, and services that are relevant for their well-being. O'Sullivan et al. (2017), in their findings, expressed what the patients should expect from the health care system, that is, the health care personnel and facilities will offer goods or services that are cost-effective, offer more available services, and ensure access to health care services for every patient. Galea and Dias (2018) and Bright and Kuper (2018) suggested that countries should establish a funding policy for health care systems that provide subsidies to producers of medical commodities and health care services to ease the cost of production burden and hence lower the health care market price.

Appropriateness

According to Levesque et al. (2013), appropriateness is the point of compromise or equilibrium between the services offered by providers and the needs of health care users. Appropriateness is what determines which treatment and conditions of services are considered relevant or pertinent to the patients' needs (Levesque et al., 2013). Wang et al. (2013) argued that the appropriateness of the service or treatment could be achieved if the quality of the products/services is enhanced by encouraging the patients to participate in planning and designing the type of services that fit their needs. Wang et al. provided a guide for public policymakers in the health sector to carry out research on the needs of

health care consumers while developing policies on the required health care services and facilities.

Demand Factors

The factors influencing the demand for goods or services are circumstances that determine the quantity of a product or service that consumers would be able and willing to buy or pay for at a given price and a given period. Richard (2016) identified the following demand factors, which include but are not limited to the following: 1) education or knowledge about the services or products (ability to perceive); 2) the personal characteristics of the consumer (the ability to seek); 3) environmental conditions such as distance and road network (the ability to reach); 4) patients' income, health insurance, social capital, and social assets (the ability to pay); 5) community support and consumer empowerment (the ability to engage). These demand factors address the opportunities that can enhance individuals' access to health care services or facilities as well as the situations that might serve as constraints or prevent them from affording health care services. Therefore, these demand factors or determinants can pose devastating health care effects on patients' quality of life in any community.

Ability to Perceive Healthcare Needs

The ability to perceive health care needs is the first step an individual patient takes in his or her journey of accessing care and acquiring better health care services. In this regard, researchers (Levesque et al., 2013; Dowhaniuk, 2021; Guo, et al., 2020; and Nachianppan & Hargreaves, 2020) established the fact that a higher number of informed residents in remote areas would attract a higher rate of access to and utilization of health

care services because their understanding of primary health care would enable them to seek and reach out for treatment.

Ability to Seek Healthcare Needs and Desire for Care

According to Richard et al. (2016), the ability to seek health care services or treatment is the demand factor that influences the patients to demonstrate their interest and willingness to acquire health care services or visit a health care facility for treatment. Price et al. (2016) investigated how personal experiences in accessing hospital services have impacted the behaviors of health care consumers and their attitudes toward seeking health care services in a hospital setting. For example, factors such as the distance from the patient's residence to the care facility, financial constraints, education, opportunity costs, and cultural and social barriers can affect the ability to seek care (Corcadden et al., 2017). Therefore, the barriers to accessing health care services can prevent individuals from seeking health care.

Ability to Reach Out for Healthcare Facilities and Services

According to Perriat et al. (2018), the ability to reach out for health care facilities and services as a determinant of demand explains the capability of an individual to have physical interaction with the health care system; Davy et al. (2016) referred to such interaction as having direct contact with health care personnel or with health care facilities. Many health care researchers have found that in most rural communities, residents face difficulties in accessing health care facilities because of long travel distances, poor road networks, and the lack of transportation (Corcadden et al., 2018; Ford et al., 2018; Kyei-Nimakoh, Carolan, & McCann, 2017; Shah et al., 2018).

Consequently, Tong et al. (2018) found that barriers of access to medical treatment serve as push factors that influence remote rural residents to prefer traditional healing at their doorstep over accessing modern health care, whose facilities and services are a great distance away.

Ability to Pay and Use Healthcare Services

Richard et al. (2016) considered the ability to pay and use health care services as a demand factor that describes the financial power of an individual to acquire treatment or services from health care facilities or personnel. Fischer and Born (2018) discovered, in their research on rural poverty in Austria, that the lack of access to health care is prevalent and persistent in most remote and neglected rural communities because of inadequate resources and inadequate means to meet basic needs. This situation becomes worse with the inequality in the distribution of national resources between urban and rural settings.

Ability to Engage with Healthcare Providers

According to Richard et al. (2016), the ability to engage with health care providers is the demand factor where patient achieves the best treatment and satisfactory service because the consumer is involved or motivated to participate in the planning and implementation of his or her treatment plan throughout the process. McMahon et al. (2017), in their findings on community stakeholders' role in providing basic health care, stated that patients have the opportunity to develop a sense of control over their health and well-being. The consumers have ownership of every treatment plan or procedure

required to achieve quality and timely health services. Hence, they appreciate the opportunity to engage with the health care system to improve their quality of life.

Policy-Based Belief System of Healthcare Disparity

There is some evidence of a policy-based belief system that discriminates against indigenous populations of isolated rural communities in accessing health care services. Cohen et al. (2018) asserted that policy makers persistently face the difficulty of understanding the health care implications of the rural-urban disparity. Subsequently, policymakers often underrate the conditions of rural settings because they tend to be held captives by and confined within the net of urban centers, which establish and present their type of understanding and beliefs to keep the rural outskirts in isolation and disregarded in the national policy planning and development. However, the variation resulting from the strategies, governmental policies, and statuses of different communities, and therefore influencing the access to health care services, would also vary.

The perception of policymakers and other key stakeholders that focuses on the belief that the poor quality of life in the rural areas is a natural phenomenon and nothing can be done to eliminate the biases that create an unequal distribution of health care resources between rural and urban communities. Schwaderer and Itano (2007) identified a policy-based belief system that prevents decision-makers from establishing evidence-based policies and, instead, rely on the previously-held stances—cultural beliefs and social inequality that cause disparity among populations always persist. Kyei-Nimakoh et al. (2017) argued that the authorities responsible for formulating critical public health

policies are required to have a broad understanding of the health needs and services of different communities and populations for better planning and equitable distribution of health care resources. The failure or negligence of the policymakers to acquaint themselves with the reality of life in the remote rural areas limits their perception and understanding of evidence-based information on the residents' lack of access to primary health care services.

Malekinejad et al. (2018) noted that policymakers should assess a population's health condition to develop suitable policies that will address the occurrence and potential spread of life-threatening diseases. The authors further suggested that policy decisions be evidence-based and offer outcome predictions responding to prevailing and prospective health conditions. Well-articulated public health policies have the potential to provide adequate and essential procedures that consider the development of health care action plans by establishing directives that can minimize or eradicate disease risk factors. Druetz et al., (2018), Kenny et al., (2013), and Shah et al., (2018) noted that despite the claims of global health care development partners on health care successes, the inequality in the distribution of health care resources remains a central problem that causes difficulties for vulnerable populations in accessing and utilizing health care services, which require policy reform. Health care policymakers, therefore, should offer in their policies equal opportunity for every citizen to have access to health care resources irrespective of their residential statuses.

The literature broadly reported that existing health care policies are inadequate to address the rural-urban health care disparity problem. While Guttman (2018) reported

the unequal priorities on policy implementation that disadvantage the rural poor, Gian et al. (2017) suggested that the allocation of health care resources should be based on the needs of a population and not on factors of social and economic interest that consider financial and ethnic statuses. Guttman, as well as Gian et al. believed that communities that have the same health care opportunity should be able to access and utilize the same health care services, irrespective of their economic, social, regional, and physical needs.

Social and Economic Impact of Lack of Access

Fatima and Khan (2018) described social and economic evidence that shows a causal relationship between the socioeconomic status of individuals and their wellbeing. Fatima and Khan further noted that socio-economic status included the provision of essential social services such as education, healthcare, housing, and income-generating opportunities. Ideally, Ford et al. (2018) noted that an improved socio-economic status enhances better health outcomes as healthcare services are more available and affordable. When the population is healthy, people can engage in economically productive activities that will improve their socio-economic status and standard of living. On the other hand, deprivation of these basic social services will result in poor health outcomes as healthcare services are not readily available and affordable, not because of the absence of such facilities but also the lack of knowledge and money to seek health care. The causal relationship between socio-economic status and physical wellbeing is clear.

Rural communities are popularly described in the literature as a “test case for development” given the nature of their socio-economic and cultural diversities coupled

with resource-constrained compared to urban communities. According to Fischer and Born (2018), rural communities are located far away from the center where development resources are distributed. As a result, most of these resources hardly reach the rural poor. Dassah et al. (2018) and Qian et al. (2017) reported that although efforts are being made through rural development projects to ensure that essential social services are available to the rural communities, the majority of the rural population are deprived of critical social services like education and healthcare. Socio-economic status affects health and that the more people are socio-economically deprived, the weaker the health. This situation is valid for the converse as well, the more vulnerable the health of a population, the lower their socio-economic status.

The health care outcome of an individual or a community is a result of the level of access to and utilization of extensive and excellent health care services and resources. Figueira et al. (2018) stressed the significance of access to health care services, particularly the disparity in the utilization and provision of health care services. While Figueira et al. outlined the differences in accessing health care services among groups, McGrail et al. (2017) are convinced that the only way to address such disparities in health care access is to enhance the access to essential health care services. The two schools of thought portray an understanding that while the differences in accessing health care services persist, there is a way forward to minimize the consequences to the most vulnerable populations. Such an opportunity should continue as a concern that ultimately empowers remote rural communities and influences health care policymakers. The significance of access to health care services is divided into three key elements, which

include having access through insurance coverage, gaining access to health care services, and timeliness of care.

Some of the literature (Dassah et al., 2018; Sekhon et al., 2017; Yakob & Ncama, 2016) acknowledges that access to health care as a complicated matter. They see access an essential tool to determine the quality of services, the fairness of the distribution of services among every segment of the population, as well as the level of its outcomes in terms of patients' quality of life after accessing the services. Yakob and Ncama (2016) considered the access to health care services as an essential factor that seeks to secure and promote the fundamental rights of human beings (that is, the right to access necessary primary health care treatment).

Timeliness plays a critical role in accessing health services, especially when a patient desperately needs it. As noted by Davy et al. (2016), Levesque et al. (2013), Richard et al. (2016), and Yakob and Ncama (2016), access to care is a process of understanding, seeking, entering, passing through, and obtaining satisfaction from available and timely care that offers patients the needed or desired outcomes. At this point, the timeliness of access comes into play about the health care system's ability to provide good quality and appropriate health care service or treatment immediately after the patients identify their health care needs. The length of time an individual patient spends waiting for a service provider (such as a doctor, physician, nurse, and any other primary contact) and the availability of consultations and care for sickness or pain when it is needed is a key element in the decision to seek services.

Some researchers have reported that the lack of access to health care services or a time delay in the delivery of needed services has sometimes devastating and life-threatening health consequences on patient lives and socio-economic well-being (Sangaramoorthy & Guevara, 2017; Shah et al., 2018). Musunuru and Reddi (2018) and Owen and Celik (2018) argued that the access to health care could immensely impact an individual's entire physical, social, and mental status and the quality of life. Despite the array of research studies and interventions on the problem of access to health care services, there are still persistent barriers that prevent populations from accessing and utilizing health care (Owen & Celik, 2018), both of which negatively impact the healthy lifestyle and wellness of individuals.

The barriers to accessing and utilizing health services serve as obstacles to populations' efforts to achieve a healthy and quality of life, which adversely affects or limits individuals' social and economic activities in their communities. Rutherford et al. (2010) claimed that the lack of access to essential health services is a critical factor that contributes to the increased mortality among children under five years of age. Not only did Rutherford et al. consider the lack of access as a problem, but they also suggested the way forward, by providing a solution to contain the rising infant mortality rates. They recommended that the provision of abundant and extensive care with modern health care facilities and the timely presence of health care personnel would help prevent the high death rates of children under five years of age.

Cohen et al. (2018) addressed the potential negative outcomes that have resulted from the lack of or inadequate access to essential health services and resources. Similarly,

Kim and Chung (2019) and Springgate et al. (2018) identified the adverse effects of the lack of access to medical treatment including: high rates of unmet health care needs, increased hospitalizations, financial burdens, increasing incidence of infant and maternal mortality, increasing levels of chronic diseases and illnesses, and rising levels of poverty, decreasing productivity (which affects the economy of the society). Davy et al. (2016), Levesque et al. (2013), and Richard et al. (2016) found that poor health outcomes are more prevalent in vulnerable populations in most remote rural communities, where the supply of health care resources and services are not made available, accommodative, affordable, approachable, acceptable, or appropriate to the culture of the community. Residents in rural communities often face social and economic hindrances while trying to meet the underlying social and economic needs that promote a better quality of life.

According to Fatima and Khan (2018), the access to health care services and resources is a mystery to rural residents who have little or no knowledge of or faith in modern-day health care services and technology. In addition to Fatima and Khan's observation, Gray et al. (2018) revealed in their study that cultural practices, norms, and the belief systems of indigenes play a crucial role in the spread of diseases in Sierra Leone communities. The perceptions of many residents of poor and remote rural communities may often be based on their beliefs about supernatural or metaphysical powers. Magezi (2018) supported the claim that these perceptions limit the effort of many people in rural communities to understand their health care needs, seek improved health care services, and to appreciate modern health care services and resources. As a result of such traditional or uninformed beliefs, the mortality rate, the level of chronic illnesses,

and diseases are on the increase. The report from the National Health Sector Strategic Plan (2017) found that the remote rural residents in Sierra Leone mostly rely on resources and services they can easily have access to and therefore utilize the services of traditional healers, priests, sorcerers, and prophets whose services are available at all times, unlike modern health care services.

Fils-Amie et al. (2018) evaluated the need for establishing a mobile clinic to ease the problem of inaccessibility regarding essential health care services and resources in remote rural communities. Fils-Amie et al. carried out an evaluative experiment of a mental health mobile clinic to communities with difficulties accessing health care and to those who cannot reach out to experienced health care personnel. The mobile clinic promotes the abilities of health care consumers to seek, reach, and afford care and engage with care service providers situated within or close to their communities. This model may be of value in other countries and situations.

Urban-Rural Disparities and Patient Impacts

A population's quality of life is an outcome of a society's investment in its health care system. Folland et al. (2010) submitted that health economists consider health to be a capital good that individuals or societies utilize to acquire and sustain social and economic well-being. Richard et al. (2016) discovered that health care inequalities are the consequences of poor public policies and the inadequate allocation and distribution of common national resources. Kenny et al. (2013) and Qian et al. (2017) argued that substantial inequalities in the health care system between the rural and urban communities negatively affect the social and economic growth of the most vulnerable

populations residing in extremely remote villages. Given the biases against the rural population, the need for improved rural health care should be a prime concern for policy reform in developing countries.

According to Roemer and Dias (2016), policymakers and national planners often face the challenge of understanding the real distinguishing features of rural and urban communities. Gage et al. (2018) reported how nations often institute policies to support the training and retention of health care personnel or providers to increase the number of health care interventions and ensure universal coverage. Gage et al. further explained how policymakers have not fully translated the policies into a possible reduction in the rates of rural-urban inequalities in health care access and utilization. The literature indicates that the quality of life of residents living in remote rural areas is hugely affected by the disparity in health care services and resources compared to urban centers. Therefore, the affected rural populations tend to have the highest risk of morbidity and mortality because of the health care disparities.

Summary

Chapter 2 included a detailed review of related literature on the phenomenon of primary health care access or lack thereof and its impact on the socio-economic well-being of underserved residents of the remote rural communities within the Bombali Seborra chiefdom in northern Sierra Leone. The chapter addressed the theories and concepts underlying the policies to address the lack of access to health care services and the existing disparities in health care distribution among a population based on their remote rural geographical location. The review and analysis of the various theories were

guided by the Levesque conceptual framework for healthcare access. The literature search centered around the concepts and factors explaining the dimensions of health care needs and how the two forces of health care providers or suppliers (supply-side dimension) and consumers or patients (demand-side dimension) influence the access to and utilization of health care services.

According to the literature search, there is limited research on the remote rural quality of life. Underserved and neglected rural life characterized by poor health most often relied on supernatural and traditional beliefs and treatment for their healing and prevention of diseases and sicknesses because of their perceptions of rural-urban healthcare access disparity. Research revealed that most residents of poor and remote rural communities and the perceptions of their lived experience and quality of life are related to their belief about supernatural healing powers. This belief system limits the ability to understand their health care needs, seek improved health care services, and appreciate modern health care services and resources. As a result of such beliefs, the mortality rate and level of chronic illnesses and diseases is on the increase.

Chapter 3: Research Method

Introduction

This qualitative phenomenological study involved exploring the lived experience and perceptions of individuals in rural communities of the Bombali Seborá chiefdom of northern Sierra Leone regarding lack of access to essential healthcare services and resources. Lack of access to healthcare services is a recurring situation faced by people residing in hard-to-reach remote villages who experience high maternal and infant mortality rates, chronic diseases and illnesses, high levels of poverty, low life expectancy, premature mortality, cost-specific death rates, and age-specific death rates as compared to their urban counterparts. I assumed poor health conditions were a result of lack of access to primary healthcare services. I used one-on-one interviews to investigate perceptions and the lived experience of rural residents in the Bombali Seborá chiefdom to explore the impact of poor health indicators on quality of life in remote rural communities.

This chapter addresses tools and procedures for data collection as well as the research design and rationale, methodology (sampling, sample size, inclusion and exclusion criteria, setting, instrumentation, participant recruitment, data collection, and participant contact), research questions, role of the researcher, data analysis plan, informed consent procedure, validity and reliability of the study, and a summary.

Research Design and Rationale

My research was informed by the Levesque conceptual framework for healthcare access and involved using a qualitative phenomenological study design. Through this study, residents of remote rural areas with limited access to primary healthcare had the

opportunity to share their experiences regarding this phenomenon as lived as well as perceptions of the phenomenon. The study's primary objective was to provide a detailed description of residents' lack of access to essential healthcare services in remote and neglected rural communities of Rotein and Rogboreh to provide an understanding of how the study population experienced the phenomenon.

This rationale guided the research to provide knowledge regarding views and the lived experience of the study sample via in-depth interviews. I addressed coding themes, as well as the population sample, participants' the lived experience and perceptions' data collection, characteristics of the data, and issues involving universality and representativeness. Understanding participants' concerns about health conditions and access to services increases the necessity to enhance community contributions to policies and decisions affecting their wellbeing and implementation of healthcare projects that promote healthy lifestyles and improve health outcomes.

Research Questions

My research questions were:

RQ1: What are the lived experience of and perceptions of access to essential healthcare services and resources for remote rural community residents of Bombali Sebora, Sierra Leone??

RQ2: What events and situations have had an impact on rural residents of Bombali Sebora, Sierra Leone and their perceptions regarding access to primary healthcare services and resources?

Role of the Researcher

My role as a qualitative researcher was critical to establishing the validity, reliability, and success of the study. According to Van den Heuvel et al. (2019) the researcher contributes to the entire research process that can impact truthfulness and believability of study outcomes or results. In addition to ensuring the trustworthiness of the findings, my position in the data collection and analysis processes required me to have necessary knowledge and understanding of the phenomenon. My role was to ensure a conducive environment that promoted a fair and reliable research process and made sure that research questions, problem, purpose, and objectives align with analysis and outcomes.

My role as a researcher involved my personal background beliefs, values, norms, and experiences, which were not in conflict with the study's purpose and alignment with the phenomenon. My understanding of the research process and its participants did influence the analysis. My background as a former community teacher, community development worker, and administrative assistant in healthcare played a critical role in terms of data collection and analysis. Also, as an informed qualitative researcher and indigene of the research setting, I believe that I contributed positively to the success of the research.

What I considered as a limitation to the study was my perception of the phenomenon, especially on previous knowledge about the research topic from a literature review standpoint, my hopes for the study outcome, and some influences of human biases that were expected during the data collection and analysis processes. These human

factors might interfere with the participants' expression of views and the sharing of their lived experience. To avoid such biases, I employed the services of a colleague to review the interview transcripts as a way of triangulating the data collection to maintain the reliability and accuracy of the data. However, to sustain phenomenological reduction, I remained aware of my previous knowledge and dispositions to control the intrusion of bias into the entire research process. I applied mindfulness meditation to become aware of my thoughts (Junior & Brreira, 2018) as they began to shift to previous knowledge rather than being open and receptive to the information coming from the participants. I also endeavored to be neutral in all my interactions with participants and data analysis to avoid confirmation bias (Schweiger & Cress, 2019) that might occur in the process of collecting, analyzing data, and presentation of findings. Therefore, my role in monitoring and minimizing my disposition to interpret too quickly was essential to the validity and reliability of the research findings.

Methodology

Research Setting

The interviews were conducted in rural Bombali Seborá Chiefdom, situated in Northern Sierra Leone, West Africa. The most recent national census revealed that the indicators of poor health conditions, extreme poverty, high mortality rates, and growing incidences of chronic diseases and illness were present in the proposed study communities (Statistics Sierra Leone, 2015). The remote villages known as *fakais* are situated over thirty miles away from the chiefdom headquarter and over fifty miles from the district/provincial headquarter town of Makeni city. The participants were drawn

from two fakais, Rogboreh and Rochain, in Bombali Seborá chiefdom. The two villages are only accessible by foot and motorcycle. The primary economic activity is subsistence farming in which the residents cultivate upland rice, swamp rice, cassava, groundnut, and low-level hunting. The residents mainly depend on traditional herbs and remedies for treating diseases and illnesses of all kinds since the only health clinic is in the chiefdom headquarter town.

Each of the potential participants and I decided on a date, time, and place convenient for them to participate in the interview. The proposed designated locations to conduct the face-to-face meetings include an office in a community school, a community hall, and under a tree or farm hut.

Sampling and Sample Size

The research study applied a sampling strategy using a purposive recruitment procedure to select a small sample of nine participants. The study used purposive snowball sampling, as necessary, to recruit participants. Willing participants were expected to freely share their experiences or stories openly and honestly about the phenomenon.

Participant Recruitment Criteria

Participants were recruited for the study based on the following requirements: first, they must be 18 years and older; second, they must have lived in their communities for five years or more; and third, they must be interested in the study, willing and able to give consent for participation. The study excluded any resident who did not meet the criteria listed above and those who met the requirements but did not provide consent. The

recruitment process commenced after approval from the Walden IRB and after I visited the study site for fact-finding: pre-study observation and exploration to familiarize myself with the setting and with potential participants. During the fact-finding visit, I had a conversation with potential interviewees, acquainted them with the proposed study, and asked for their consent and agreement to participate in the study. After the respondents registered their consent to participate, I requested an interview date and hour of the day that was convenient for the intended interviewee. I informed participants that their consent for participation was voluntary and informed participants that they might not have any direct benefit for participating in the study. However, participants who volunteered and gave consent to participate were compensated with the equivalent of 5 US dollars.

Instrumentation

I employed face-to-face standardized open-ended interviews with semi-structured, open-ended questions. The research questions aimed at eliciting responses relating to participants' experiences about the phenomenon in their communities or the cultural and environmental factors in using health care services. I asked all participants identical questions that allowed open-ended responses. I asked follow-up questions as a means of eliciting more information. Appendix A contains the main interview questions and the proposed follow-up prompts.

Data Collection

I aligned the data collection procedures with other research components such as the study problem, purpose of the study, the research questions, and the research design.

To achieve such an alignment, I paid attention to three factors or attributes: 1) steadiness, that is, following a pattern of facts presentation that is consistent with the qualitative dissertation rubrics aligning the factors listed above; 2) maintain a logical pathway of evidence that support all the processes and ideas guiding the study from start to end; and, 3) accountability or openness in the collection of data, analysis, and reporting of the findings. The three characteristics of logic, persistence, and transparency in reporting enhanced the quality of the study from its conceptualization, organization, and convincing the intended audience of its findings. I kept track of these characteristics by following the highlighted patterns above.

Data Analysis Plan

Researchers have employed varying strategies in the process of analyzing data in qualitative research. Gale et al. (2013) claimed that the framework method of analyzing qualitative data had gained popularity among qualitative researchers conducting health research. Srivastava and Thomson (2009) also recommended the framework of analysis for studies that are aiming at investigating applied policies in the health care system. Srivastava and Thomson further stated five steps research must follow to accomplish a framework of analysis in any qualitative studies such as “familiarizing, identifying a thematic framework, indexing, charting, and mapping and interpretation” (p. 72). Martinez-Garcia et al. (2019) identified three forms of qualitative analysis that they referred to as “novel methods of qualitative analysis for health policy research.” (p. 73). The three methods discussed by Martinez-Garcia et al. include: “documental corpus identification, semantic network analysis, and content analysis” (p. 74). My study

adopted the five steps of Srivastava and Thomson to utilize the health care access model of Levesque et al. (2013) to provide a comprehensive analysis of the data.

My research design employed a framework of analysis to transform the data from its raw state into pieces of reduced and manageable information representing the views of the participants. The research questions and theoretical framework served as a guide for management and data analysis. I began by familiarizing myself with the raw data. I did this by listening to the tape recordings, transcribing interviews verbatim from the tape to paper, and then I read and re-read the transcripts. The purpose of this initial interaction with the data was to develop an overall sense of participants views and experiences.

Following my familiarization with the data, the next stage in the analysis process was to take a close look at the theoretical framework, the lens through which I reviewed the data. I related the data to the existing theory, positioned the results in the conceptual framework that assist in facilitating the comprehension of the data within that conjectural standpoint of the theory (Matenga et al., 2019). My interaction with the data enabled the identification of categories and themes derived from the grouping of codes that addressed the purpose of the research study. Thus, the familiarization process and identification of a thematic framework provided a clue or pointer on indexing, charting, and mapping and interpretation of the data.

I applied in vivo coding and open coding and used each coding method on the basis of the thematic nature and scope of the data. I carried out the coding process by cycle in which the pre-coding or cycle one included circling, highlighting, bolding, underlining, and coloring of keywords or phrases in the raw data that portray significant

participants' expressions, views, and experiences, and considered them in relation to the theoretical framework.

The second cycle of coding, which reduced the data into manageable and meaningful information, helped provide insight into the study phenomenon. Open coding assisted in identifying similarities and differences between incidents, events, or other phenomena reported by participants. Codes that had the same or similar features were grouped to form categories (Srivastava & Thomson, 2009). Using the axial coding approach, I compared the data considering the different research questions to locate meaningful connections between categories. This coding procedure was applied to establish the paradigm of context, action/interactional activities, and outcomes as in the case of responses from the question of the socio-economic well-being and poor health conditions because of the lack of access to essential health care services and resources. I integrated the data by bringing together the sub-categories to a broad category. I carried out the selective coding by retrieving a central category (the central phenomenon) to integrate it with all other sub-categories that shared common features.

In considering the limitation of time and cost to complete the study, I used the NVivo software tool to assist in organizing and analyzing transcripts developed from interviews, field notes, observations, and other sources from secondary data. The use of the software complemented the manual coding and categorizing of the data, which helped ensure the consistency and accuracy of the findings.

Issues of Trustworthiness

Validity and Reliability of the Study

Quantitative, unlike qualitative research, is evaluated by the judgments made from objectivity, reliability, and validity. Many educational researchers who have carried out extensive qualitative research recommended alternative criteria that focus on the trustworthiness of the entire qualitative research process and stability of the research findings by emphasizing factors that ensure the applicability of the research outcome to similar settings (Northcote, 2012). For this research, I provided an explanation of only two criteria for evaluating the quality of my qualitative research design: dependability and confirmability.

Dependability was one of the standards employed for judging qualitative research, which accounts for the stability or consistency of data over time and prevailing conditions of the inquiry process used over time. Dependability can be compared to reliability in quantitative research (Sibbald et al., 2018). To ensure that my qualitative research study is dependable, I considered factors such as errors in conceptualizing the study, collecting the data, interpreting the findings, and reporting results. Consequently, I applied triangulation to enable the validity or accuracy of the data transcription.

Confirmability is a criterion used to evaluate qualitative research, and makes the assumption that any research on a particular topic will have a unique perspective. Confirmability is concerned about the quality of the outcome produced by the researcher and identifying variables that are independent of the researcher (Hayashi et al. 2019). Because every individual has a different way to assess and evaluate situations or research,

carefully documenting the procedures and actions help to confirm the trustworthiness of the study's outcome, for example, to repeat the study in a different location or country. I am confident that the findings accurately reflect the participants' views, experiences, and perceptions, by taking care to the best of my ability to put aside my preconceptions and assumptions about the phenomenon and setting.

Ethical Procedures

The significant ethical challenges of protecting privacy, minimizing harm, and respecting the shared experiences of every person that is affected by the research are the standards I observed to preserve the right, the safety, and the wellbeing of participants. Every qualitative researcher has the ethical responsibility to build trust to engage the participants in complete and in depth data, while at the same time maintaining sufficient distance to respect the participants' privacy and safety (Lee et al., 2019). I was involved in every stage of the research process. Some of the ethical challenges I managed had to do with maintaining confidentiality and anonymity, soliciting participants' informed consent, establishing rapport, preventing deception, and upholding the ethics of care.

Because the researcher is considered an instrument in the research process (Ravitch & Carl, 2016), I adhered to ethical standards of upholding the trustworthiness in the entire process of data collection, management, preservation, presentation, and analysis.

Informed Consent

Among the three main ethical principles of respect for persons, beneficence, and justice, I upheld the full worth of participants as human beings and the respect to which

they are entitled (Orjasaeter et al., 2018). I was also aware that such universal rights impose similar responsibilities on the researcher to respect and uphold. Based on the principles of beneficence and respect for persons, I ensured that: the participants understood their role in the study, agreed to participate of their own free will, and could withdraw from participating in the study at any time without prejudice. I carefully followed the ethical codes of conduct established for research, demonstrated by certification, and as required for Walden University IRB approval. Informed consent was a relational and sequential process rather than a contractual agreement between the researcher and the participant. Ravitch and Carl (2016) noted that ethics in qualitative research is a broad-based concept that requires strict protocols during the research process to maintain a professional relationship in social interactions and transactions between the researcher and the participants.

The primary purpose of any qualitative research was to explore, using moral and ethical standars, an identified problem to gain an insight into the underlying reasons, opinions, and motivations people hold about the problem or issue. Burkholder et al. (2016) defined the ethical principle as a researcher's commitment to guarantee participant safety, well-being, and merits and communicating such principles in the consent process.

Summary

This chapter carefully explained the procedures involved or requirements to achieve before, during, and after data collection processes. My research required detailed and in-depth information from a small portion of the remote rural population of the Bombali Seborá chiefdom, and it employed a qualitative research design to collect data

from the participants. The selection of the participants by the method of purposive criterion sampling considered interviewing only information-rich respondents to answer the standardized structured and open-ended questions.

The purpose of the study guides the entire data collection and analysis process. The purpose of the study was to explore the experiences of neglected and underserved remote rural residents about their lack of access to essential health care services and resources as they lived in their remote settings. I employed a qualitative phenomenological design to carry out a detailed and in-depth investigation on the concept of access or lack of access to essential health care services to understand the subjective meanings of access.

I carried out the study by maintaining validity, reliability, and value of findings. I conducted face-to-face interviews with nine participants from two rural communities in the Bombali Seborra chiefdom of Sierra Leone. The interview instrument of the study contained 14 identical and open-ended semi-structured interview questions. The data collection process involved a logical pattern of accountability and steadiness. With this proposed study, I followed prescribed procedures closely involving trustworthiness, ethical values, and participants' informed consent.

Chapter 4: Results

Introduction

In this chapter, I present outcomes from the qualitative data analysis involving participant perceptions and the lived experience of access to primary healthcare services and resources in the remote rural communities of Rotein and Rogboreh in the Bombali Sebora chiefdom, Sierra Leone. This chapter also includes coding and analysis of data according to research questions, as well as the conceptual framework which guided the research. I restate the study's purpose, reiterate the research questions, address the study sample, discuss findings from data analysis, and recapitulate the chapter's key points.

Purpose

This qualitative phenomenological study involved investigating the lived experience and perceptions of remote rural residents of the Bombali Sebora chiefdom in Sierra Leone of their lack of access to essential healthcare services and resources due to living in neglected and underserved communities. Residents in most rural communities experience high maternal and infant mortality rates, chronic diseases and illnesses, high levels of poverty compared to their urban counterparts. Stated indicators of poor health due to lack of access to primary healthcare services negatively impacts the socioeconomic status of rural residents of Sierra Leone.

Research Questions

My research questions were:

RQ1: What are the lived experience of and perceptions of access to essential healthcare services and resources for remote rural community residents of Bombali Sebor, Sierra Leone??

RQ2: What events and situations have had an impact on rural residents of Bombali Sebor, Sierra Leone and their perceptions regarding access to primary healthcare services and resources?

Interview Setting

Within the Bombali Sebor chiefdom in the Bombali district, I conducted interviews with participants identified as individuals who had experiences with consequences of inadequate or lack of access to essential healthcare services and facilities. Interactive processes involving eliciting in-depth responses from study participants occurred in a conducive environment. Village headmen for both communities offered enclosed rooms in community centers for interviews, which provided needed privacy and prevented interruptions and distractions. Data were gathered over a period of one month. The Institutional Review Board (IRB) guide guaranteed protection of study participants' rights of consent, respect, and privacy. The IRB approval number for this study is 01-11-21-0562464.

Participant Demographics

In this study, I conducted interviews with nine residents of two remote and underserved rural communities (Rochain & Rogboreh villages) in the Bombali Sebor chiefdom district in northern Sierra Leone. All interviewees were between 35 and 64. Three participants belonged to the Temne tribe, two were Mendes, one Fula, two Limbas,

and one Madingo. All participants were able to speak the English-based Krio/creole language, lingua franca, and de facto national language spoken throughout the country. One male participant was married to two wives, and one was married to four wives; two female participants were married, one female was single and never married, two males were single and never married, one male was separated, and one female was divorced. Three male and two female participants had completed high school educations, two males and one female interviewee never went to school, and one female participant only completed primary school. In terms of employment, all participants were self-employed and engaged in subsistence farming or gold mining. Participants' demographic information was included in field notes and not as part of the data analysis process.

Data Collection

The quality of research depends on alignment of data collection procedures with key research components such as the study problem, study purpose, research questions, and research design.

The data collection process was guided by two central research questions and a 15-question interview instrument. The research questions and their subsequent interview questions involved investigating the lived experience involving lack of access to primary healthcare services and resources, perceptions involving access or lack of access to essential healthcare services and resources, events that had an impact on the perceptions of rural residents of Rotein and Rogboreh about their lack of access to primary healthcare services and resources, All participants involved in the study were asked the same

interview questions with varied probing questions. Participants provided similar responses with minimal disparities in terms of their views and lived experiences.

Rotain and Rogboreh were chosen for the study because they are among the most remote and impoverished in terms of access to basic healthcare facilities and services (Statistics Sierra Leone, 2017). I spent one week in each village to recruit participants and collect data via face-to-face interactive interviews; I took 1 month to complete the recruitment and interview process. Interviews for each participant were intended to be 60 minutes or less. None of the participants exhausted the allocated 60 minutes; the average completion time for interviews was 42 minutes. Interviews were tape-recorded, and I also took notes regarding participants' perceptions that were necessary to address the study phenomenon and.

The data collection process followed the pattern as previously planned in *Chapter 3* with no significant change in approach or methodology. The recruitment process adhered to the anticipated range of participants, and nine participants were interviewed. Participants were fully informed about the purpose of the study and its impact and implications to the individual participant and the community. The interviewed participants willingly and gracefully consented to participate in the study. Some residents turned down the request to participate due to the busy schedules of farming activities and family commitments. The interviews were conducted based on individual time schedules.

Data Analysis

I centered my data analysis on the framework method of analyzing qualitative data as proposed in *Chapter 3*. I applied the recommendation of Srivastava and Thomson

(2009), who suggested the framework analysis for students aiming to investigate applied policies in the health care system. Srivastava and Thomson identified five steps that any qualitative research study must adhere to, to achieve a framework of analysis, such as “familiarizing, identifying a thematic framework, indexing, charting, and mapping and interpretation.” (p. 72). I spent over a month familiarizing myself with the transcribed data by repeated readings of individual participants’ transcripts. I focused my analysis on identifying relationships and codes, grouping identical codes to establish categories, and bringing categories together into concepts/themes related to the health care access model (Levesque et al., 2013). The categories and themes were indexed and presented by charts/diagrams. I highlighted codes with different colors based on their relationship to the research and interview questions. I recorded the selected data in abbreviated and logical format.

The next step I took was to analyze the transcripts of the interviews using NVivo. The results from NVivo helped improve accuracy; I was able to identify vague statements from the personal notes. Additional codes were discovered from the results of the NVivo analysis and ensured that the identified codes are connected to the participants’ views as presented during the interviews. I also maintained relationships between the identified codes, the research purpose, and the study phenomenon. The Levesque conceptual model analysis applied in this study provided me with a better understanding of the lived experience and perceptions of residents residing in remote rural areas about their ability to access or lack of access to essential health care services and resources. The concepts or themes derived from the framework were adjusted to capture participants' lived

experience and perceptions related to actual events or situations that impact their health care status and quality of life.

Thematic Coding

The qualitative data analysis immediately followed the transcription of the participants' interviews. I arranged the transcripts into text-based qualitative data, carried out preliminary manual coding, and made a print-out copy of the transcripts as recommended by Saldana (2016). This initial coding process enhanced my familiarity with the content, which helped identify data nodes and blocks. During the first coding cycle, I organized the data for each participant using tables identifying codes connected to elements of the framework. I then critically assessed the data based on the research questions, the phenomenon under study, and the participants' concept of access or lack of access during the interviews.

The recorded data and transcripts have no information that can reveal the identity of the participants nor violate confidentiality. The coding process strictly adhered to demand and supply factors identified by the Levesque conceptual framework of health care access. Therefore, the transcribed data were grouped into tabular structures from which themes were derived based on the perceptions and lived experience relevant to the phenomenon of access or lack of access to essential health care services and resources. I created a coding manual as a guide to enhance the consistency of the conceptual meanings as the participants present them as empirical evidence of their lived experience and perceptions about their access or lack of access to essential health care services and resources.

I also highlighted relevant data elements that comprised words, phrases, sentences, and groups of sentences or paragraphs using different colors representing different themes. Excessive repetitions of irrelevant to the phenomenon under study were minimized during the process of transcription. The codes were grouped into categories, and the categories are further integrated into concepts or themes. The themes are the elements of the framework. The table below illustrates themes and categories/subthemes.

Table 1
Emergent Categories and Themes

Themes	Categories/Subthemes
Group 1 Themes: Determinants of health care services and resources supply	
Availability of health care services and resources	Inadequate health care centers Lack of medical personnel Inappropriate medications and treatment The geographic location of health centers Hours of service
Approachability	Transparency Outreach Health education/information
Acceptability	Professional values Cultural values
Affordability	Direct costs of health care services and resources Indirect costs Opportunity costs
Appropriateness of services and resources	Technical and interpersonal quality Adequacy of services and resources Coordination and continuity

Group 2 Themes:

Determinants of health care services and resources demand.

Ability to perceived health care services and resources (needs)	Health care literacy/awareness Health care beliefs Trust and expectations
Ability to seek health care services and resources	Personal and social values Culture Autonomy
Ability to reach out for health care services and resources	Living environment Transportation Social support
Ability to pay for health care services and resources	Income/poverty Social capital
Ability to engage with the health care system	Empowerment Information Adherence Support from health care personnel

Evidence of Trustworthiness

While working to uphold the credibility and integrity of the analysis of the data and the outcome of the study, I engaged in different ways to describe the patterns, connections, and rational descriptions with inclusive analysis. I closely examined the rival and competing themes and clarifications within the data. This way of analyzing the data required inductive and logical application (Wood et al., 2020). I inductively examined other ways (triangulation) of organizing the data that might differ from the first

analysis or patterns. On the other hand, I logically thought of other possibilities, which I examined to determine if such possibilities have connections or supported the data. I tried not to disprove the emerging theme changes or alternatives hastily; instead, I looked for data supporting such changes or alternative explanations. In some cases, I discovered no strong supporting evidence for alternative ways of presenting the data or different ways of explaining the data. According to Noble and Smith (2015), this attempt to find variations in analyzing the data gave me much confidence in the truth value of the primary explanation I generated during the initial analysis of the data. This process of comparing alternating patterns of analysis did not provide detailed supportive or non-supportive results as a conclusion (Shufutinsky, 2020); instead, I considered the weight of the evidence and how they closely fit between the data and the analysis. Therefore, I concluded that it was essential to present the organized codes, categories, themes, and explanations I examined during data analysis. This process manifested scholarly truthfulness, that is, the truth value, consistency, and applicability of the entire research process,

Transcript checking of the recorded responses and the transcripts developed from those recordings was done by enlisting an experienced colleague who verified the transcripts, audio recordings, and data categorization. Noble and Smith (2015) acknowledge that the prejudices of the investigator could be minimized with the help of experienced research assistants. In this way, I ensured the validity of the data categorization method and guard myself against any research biases during data analysis as proposed in *Chapter 3*.

Transferability was a vital aspect of my research. Shufutinsky (2020) explained the importance of transferability as a factor of trustworthiness in qualitative research. He further pointed out that the audience or readers of a research outcome might consider applying its result in similar settings or situations or groups if the setting of the study is sufficiently alike for its results to be transmittable to their (readers) own situations or settings. To achieve the truth value of transferability, the research findings provided relevant knowledge and understanding of the study phenomenon, which can be applied to similar situations in rural communities. I examined various alternating or competing explanations (see Wood et al., 2020) from the data to discover different opportunities that might elicit meaning from the participants' perceptions and lived experience about the access or lack of access to essential health care services and resources. Therefore, careful thought was given to the potential transferability of the study results to other sociocultural settings. The detailed analysis of the data offered a contextual meaning to parties/readers/policymakers who are not involved in the study but can replicate the study results with their own experience and understanding.

I considered the consistency of the analytical procedures, including accounting for personal and research method biases as indicated in *Chapter 3* that may have influenced the findings. According to Wood et al. (2020), dependability relates to the trustworthiness by which the methods have been undertaken and is dependent on the researcher's clear and transparent decisions. I engaged in detailed discussions and explanations of alternative themes that provided extensive meanings that can be applied to similar groups of participants. The dependability criterion was maintained through the consistency or

reliability of the findings about the participants' views, perceptions, and lived experience and in the analysis.

I used bracketing to set aside any acknowledged or unacknowledged preconceptions emanating from the close relationship between myself and the research topic that came before and developed during the research process. Gearing (2004) noted three broad phases of bracketing, which include “abstract formulation, research praxis, and reintegration” (p. 1432). Gearing revealed the broad nature and complexity of the bracketing terminology in qualitative research. He further subdivided each of the three faces into critical vital elements that guide the researcher to uncover the meanings of human experiences. To achieve confirmability or neutrality to the truth value, reliability, transferability, consistency, trustworthiness during the entire research process, I used a reflective diary to list potential bias, internal and external suppositions, and preconceptions. The reflective diary served as a guide that helped me kept the concept bracketing in my mind throughout the research undertaking.

Reflexivity is a guiding principle that enables researchers to think of activities that might help them identify potential influences during the research process. Reflexivity offers an opportunity for the researcher to be aware of the sincerity in examining the values and interests of himself that may infringe upon the research endeavor (Shufutinsky, 2020). Gearing (2004) also advised that the researcher must be honest in identifying and bracketing personal knowledge, history, culture, experiences, and values to maximize rigor in the research process. I constructed and conducted the interviews using a bracketing technique that removed much of my preconceptions and personal

suppositions. The neutrality or confirmability of the trustworthiness of an inquiry depends upon the ability of the researcher to recall every preconception, experience, knowledge about the phenomenon under study.

Analysis of Results

I conducted a detailed and in-depth face-to-face interview with nine residents from two remote rural villages called *fakais* at the Bombali Seborá Chiefdom, Bombali district in the northern region of Sierra Leone. The purpose of this inquiry was to investigate the lived experience and perceptions of remote rural residents about their access to or lack of access to primary health care services and resources. There were two main research questions, which focused on the lived experience of health care access, the perceptions of health care access, the events that have had an impact on residents' perceptions about access to health care, and the situations that have had an impact on rural residents' perceptions about their access to health care.

The emergent themes correlated with supply-side and demand-side factors of health care access that influenced or determined participants' access or lack of access to primary health care services and resources. As presented by the Levesque et al. (2013) conceptualization of access, the determinants of health care access have links with patients' health care needs.

Theme 1: Availability of Healthcare Services and Resources

Access to health care services and resources start with the awareness of needs and the presence of health care facilities (e.g., hospitals, clinics, health posts, health centers, clinical laboratories, pharmacies), resources (e.g., health care personnel, medical

equipment, drugs), and services (e.g., medical treatment, hospital admissions, diagnoses, personal care, and engagement). Coughlin et al. (2021) expressed that the lack of access to health care is associated mainly with the lack or inadequate supply of health care facilities, services, and resources needed to meet the high demand for care. My research participants clearly stated during the interviews that their problems with the lack of access to health care services were because of the lack of health care facilities in their communities or villages. The following were the views of a sample of participants.

P1 said:

We do not have any hospitals, clinics, pharmacies, or laboratories in our community. When we need health care services or medical treatment, we go to other sections because we do not have these facilities in our community.

P1 continued:

The health care system is not correct because our community and many other communities do not have health care facilities, and the health care services are lacking. There are not enough doctors and nurses in the country. Doctors and nurses do not want to come to the villages to treat people. All the trained and qualified doctors and nurses are found in the cities or big towns.

P2 said:

In our village, we do not have any health center, no clinic, or hospital. The clinics and hospitals we go to are in other sections that are far from our community. People are dying, including children, pregnant women, older people, young men,

and women. There are no hospitals, no clinics, no medicines, no nurses, and doctors in our communities.

P3 added, “Around this community, we do not have any hospital, clinic, or health center. However, there is a clinic in another village where we go for health care treatment, which is about 25 miles from our village.” According to the participants, absence or non-availability of health care facilities, resources, and services is caused by the high level of inaccessibility to essential health care services and resources.

Theme 2: Approachability

There were significant concerns about the openness of the health care providers as an added problem to the lack of health care facilities. The participants who shared their lived experience and perceptions categorically pointed out their difficulties while seeking health care services. The participants responded that it is challenging to access a doctor and some nurses that we meet more often in the rural communities than the doctors. The health care personnel that work in most rural health care facilities are inexperienced nurses or nursing aides. Levesque et al. (2013) emphasized how certain factors such as transparency, knowledge regarding available medical care and services, and outreach activities could make health care services approachable. I gathered information about how participants perceived the element of approachability as a determinant of health care supply.

P1 said that “Some nurses are friendly, but others can be outraged and talk to patients harshly.”

P2 said “While in the clinic or hospital, you join the line or sit on a bench according to arrivals, register, and explain the reason for your visit. The nurse I interacted with does not provide a good customer relationship. The doctor I interacted with was adorable [and] provided me the treatment I needed.”

P4 said:

In my opinion, the Ministry of Health and Sanitation is doing well. Sometimes health workers are sent on outreach visits to provide medical treatment to sick people and vaccination of under-five children. The PHC [Primary Health Care] are doing their best, but sometimes, they become difficult to provide any treatment without money, even if they are very sick. It is not good. They should have sympathy for sick people. The district health team also visits our community to provide treatment and vaccines for under-five children, but they become difficult without money to pay for the treatment. Sometimes we pay in kind by giving them our agricultural produce like rice, palm oil, groundnuts, and chicken. If I do not have money and need medical treatment, I can offer agricultural products in exchange if they accept. Some health care personnel are pleasant; they are friendly and treated us well whenever we visit a health facility. Some are not nice, especially when there is no money to pay for treatment.

Theme 3: Acceptability

The acceptability and achievement of the Primary Health Care (PHC) services are pivotal elements to the health care providers. White et al. (2020) emphasized the cultural background of healthcare providers of suppliers that their attitudes and behaviors tend to

expand, improve, or hinder primary health the access and utilization of primary health care for rural residents. Participants expressed their perceptions and lived experience about health care providers not providing equity health care services to their patients. This culture of inclusiveness and exclusiveness of participants because of their socioeconomic status and geographic location. Therefore, the rural population suffers a disproportionate level of poor health because of providers' inadequate culturally appropriate health care services, limiting rural residents' ability to access and utilize health care services. For example, P1 said the attitude and behavior of a health care provider can limit access to essential health care services and resources. According to Anakwe et al. (2021), the relationship between the patient and the health care services supplier or provider most often influenced the perceived provider cultural competence. The patients' perceptions differ according to their socioeconomic status, gender, ethnicity, and religion. One would conclude that those patients who might be fortunate to have a shared culture with their healthcare services providers may enjoy a more excellent positive perception of provider-patient interactions, improving their quality of life or health care outcomes.

Theme 4: Affordability

Participant perceptions about the affordability of access to primary health care services and resources are among the most common experiences shared during the one-on-one interviews. Every respondent mentioned the cost of health care treatment as a restriction for their access to care. According to some participants, their inability to pay

for costly medical treatment (direct cost) and the high cost of transportation (indirect cost of care) left them with no other option but to seek traditional healing practices.

P3 said:

My family and I do not have any savings; we are imperfect, limiting our access to health care services. We often use traditional medicine to cure ourselves because we do not have money to pay for motorbikes and expensive hospital bills. I do not have enough money to pay for transportation and the same time, pay for hospital bills. The cost of medical treatment is very high.

Theme 5: Appropriateness

The appropriateness of healthcare services and resources addresses the equilibrium point of the health care services and resources available or provided by health care personnel and the needs of patients. This theme addresses how proper and sustainable health care services and resources are to meet patients' requirements for better health and quality of life (Levesque et al., 2013). In their conceptualization of health care access, they believed that the health care supply determinants emphasize the acceptability, availability, and affordability of the service provided and have to do with the service's quality, adequacy, effectiveness, and continuous nature. The participants, during the interview sessions, shared the following:

P6 said, "Health care services in the urban cities are better than what we have in this community. It is worse, especially for pregnant women."

P1 said,

Even though we do not have health care services and hospitals in our *village*, the ones we go to when we fall sick cannot be compared to the health care facilities and services of capital cities or big towns like Makeni and Freetown. The ones we go to have no sufficient medications, no trained and qualified doctors, sometimes only one or two nurses in the clinic, no testing machines, no beds to admit patients, and no ambulances. In the big towns, they have all these things. That is the reason why in most cases, patients are referred to city clinics or hospitals.

Theme 6: Ability to Perceive Healthcare Services and Resources

Participants' perceptions about their wellbeing and quality of life have not been fully integrated into the increasing awareness of modern medication or varying scientific methods of preventing and curing diseases and illnesses. Ameh et al. (2021) expressed their assessment of how disjointed the health care needs are of people living in remote communities from critical health care resources that are required to meet those needs. The participant perceptions about health care fall short in adequate knowledge, attitudes, skills, and self-care about the burden of diseases and illnesses. The lack of awareness about predisposing factors to access and utilize health care serves as an impediment to perceive and seek health care services. Therefore, the ability to perceive is a predisposing factor that enhances an individual's perception of an illness and understanding the location, availability, cost, and appropriateness of services.

P1 said, "Accessing health care services for many people in our village is like a dream that will never come to reality in life. People do not even understand what kind of services they need for their sicknesses."

P1 further said:

Some people believe that some sicknesses are caused by witchcraft or sorcery, and therefore only traditional medicines can cure such sicknesses. Some people believe that some sicknesses are inflicted on victims through witchcraft, such as witch guns, witch poison, and witch breeze and that illnesses resulted from these magical powers cannot be treated with modern medication. Attempting to cure witchcraft sicknesses will worsen the situation and will eventually lead to death. A person fired with [a] witch gun must not be injected will make the witch substance in the victim's body react aggressively and cause death very quickly. Some Christians in our community believe that prayer can heal their sicknesses without going to a clinic or hospital. They believe that Jesus can heal them if they pray and fast with faith.

Theme 7: Ability to Seek Healthcare Services and Resources

The ability to seek medical treatment has to do with the personal characteristics of the health care consumer. It was confirmed by the participants during interviews that their hindrance to accessing health care services and resources was because of distance from participants' communities to the neighboring health care facility, financial constraints, education, opportunity cost, and cultural and social barriers.

P9 said, "It is challenging to seek health care because the distance is too far, and transportation is challenging. When there is no money to pay for transportation, it becomes more complex, especially for pregnant women."

P8 said:

Traditional medicine can sometimes help cure particular illnesses, and people still believe in traditional treatment as an alternative to modern treatment. Also, difficulty in accessing health facilities for modern treatment led many people to resort to traditional medicine. Difficulty in accessing health facilities is why people go to traditional healers that are readily accessible.

P7 said:

We just hope and pray that the Ministry of Health and Sanitation will consider the suffering of our people and extend health care services to this community one day. There are no such facilities, and more so, there is no trained and qualified personnel providing primary health care services within this community and its immediate surroundings. There are good services offered at the district health care level, although the distance from our community to the district headquarters in Makeni is very far.

P1 said:

It is difficult for my family and me to go for health care services and facilities because there are no vehicles. The only means of transportation are motorbikes. The clinic where we go for treatment is far away from our community. If you are lucky, for one to have transportation, that will cost you money. In some cases, people die because of a lack of transportation during overnight emergencies.”

P1 said:

The cost of transportation is another big problem preventing me from going to the clinic or hospital. Come to think about it, if I only have little money with me and

it happens that I am seriously sick. First, I will think of the high cost of paying for a motorbike. Moreover, if I can only afford to pay for the motorbike, what about paying the hospital or clinic bill and buying the medicines.

Theme 8: Ability to Reach Out for Healthcare Services and Resources

The research data revealed that environmental, geographical, or physical barriers such as poor road network, long distances to health care facilities, and high cost of transportation services impede rural residents from seeking and reaching out for health care services and resources.

P3 said:

Because the clinic is located far from us, we have to pay for transportation. That makes it very difficult for us to access health care. If the clinic were built in our village or close to our community, it would have been easy to access essential health care services and resources. For minor illnesses, I might not want to leave my farm work for a whole day. Instead, I prefer to buy drugs from a pepper doctor or seek a herbalist or traditional healer to visit a modern health center.

P4 said:

It is difficult because the distance between our communities and the health facility at Kamalo is too far, and transportation is a challenge. When there is no money to pay for transportation, then it becomes more difficult. Pregnant women in labor sometimes deliver along the road to the health facility.

P5 said, “Without a health facility in our community, our people will continue to suffer from accessing health care services. The distance to Kamalo is far, and the road condition is deplorable.”

Theme 9: Ability to Pay for Healthcare Services and Resources

The impact of health care access can only be felt when a patient could perceive, seek, reach out, engage with the health care system, and afford to acquire health care services and resources (Cu et al., 2021). The demand for healthcare services and resources is effective when it is backed by purchasing power (the ability to pay for services or treatments). The patient's income, poverty, and social capital influence the ability to pay for care.

P1 said, “We could not afford to pay for complex medical treatment.”

P2 said:

The number one barrier is poverty or the lack of money to pay for health care services and resources. Paying for transportation and treatment is impossible for many people in our community and, therefore, push people to seek herbal treatment or native medicines instead of modern medication.

P2 said:

Poverty is one thing, and the distance to health care clinics makes people consider traditional healing as the best option for preventing sicknesses and curing diseases. Some of the difficulties we faced while seeking medical treatment include lack of money to pay for treatment, bad roads, lack of transportation, and distance. Another problem is having someone who will stay with you in the

hospital if you are admitted. For instance, if you, as head of the family, have only two hundred thousand leones (Le200,000) at home, and someone falls sick, the money will not be enough to hire a motorbike. In that case, if you spend all the money to transport the patient, then what can be paid for the treatment. Such a situation can often stop people from seeking health care services. This situation I have just explained to you is one of the reasons why many people in our community consult traditional healers.

P1 said:

Not everyone in our community can access health care services and resources, and even the few people with the opportunity to access health care from other communities cannot fully afford to pay for all the treatment they need. Accessing health care services for many people in our village is like a dream that will never reality in life.

P3 said:

My family and I do not have any savings; we are imperfect, limiting our access to health care services. We often use traditional medicine to cure ourselves because we do not have money to pay for motorbikes and expensive hospital bills. I do not have enough money to pay for transportation and the same time, pay for hospital bills. The cost of medical treatment is very high.

Theme 10: Ability to Engage with the Healthcare System

The opportunity of engaging with the supply structure of the health care system and its suppliers or providers was a significant concern for participants during the

interview process. A patient-centered approach to medical treatment or the process of providing health care services is a qualifying factor for better health care outcomes and increased quality of life (McMahon et al., 2017). Engaging with health care consumers and allowing them to perceive ownership and fully participate in their treatment plan enhances speedy healing and sustainable wellbeing. McMahon et al. were convinced that patients would derive absolute satisfaction from their medical treatment if they engaged with the health care providers and empowered them to follow preventive measures to manage their wellbeing. Therefore, the research data revealed that most residents of rural communities often prefer traditional healing to the modern medical treatment they get from hospitals or clinics because of a lack of proper information, awareness, and not fully engaged or supported by the health care system about hospitals and their treatment procedures. P1 said:

Some people believe that some sicknesses are caused by witchcraft or sorcery, and therefore only traditional medicines can cure such sicknesses. Some people believe that some sicknesses are inflicted on victims through witchcraft, such as witch guns, witch poison, and witch breeze and that illnesses resulted from these magical powers cannot be treated with modern medication. Attempting to cure witchcraft sicknesses will worsen the situation and will eventually lead to death.

Theme 11: Healthcare Disparities

In this study, the data provided evidence about inequity in distributing limited health care services and resources/facilities. According to Gage et al. (2018), nations are still struggling to put health care policies that address the inequality of health care access

and utilization between the rural and urban communities. Quality of life of residents living in the most remote rural areas is immensely affected by disparities in healthcare services and resources that account for lack of access and poor health conditions, which is not the case with their urban counterparts.

P1 said:

Even though we do not have health care services and hospitals in our village, the ones we go to when we fall sick cannot be compared to the health care facilities and services of capital cities or big towns like Makeni and Freetown. The ones we go to have no sufficient medications, no trained and qualified doctors, sometimes only one or two nurses in the clinic, no testing machines, no beds to admit patients, and no ambulances. In the big towns, they have all these things. That is the reason why in most cases, patients are referred to city clinics or hospitals.

P2 said:

City health centers have machines for testing and diagnoses but not in the village clinic. Comparing the health care services and resources in the village and those in the big cities is like comparing life and death. The city health care services are far better than the ones we access in the village.

P3 said, “the differences are apparent. The clinic we go to has only two nurses, no doctors, no testing machines; they have few medications. However, in big cities like Makeni, they have everything.”

P4 said, “There are differences because better services often come to big cities, where everybody would like to go and get health services. Ours is worse than the services provided in bigger towns or cities.” P6 said:

Health care services in the urban cities are better than what we have in this community. It is worse, especially for pregnant women. In the urban areas, there are many healthcare facilities where pregnant women can go for antenatal care and delivery; our community needs to travel the distance to Makama, where the facilities are not the same as those in urban cities. No surgery equipment and blood bank at Makama should an operation is required for a patient, but they are available in urban health facilities.

Theme 12: Cultural Beliefs and Practices and Healthcare Access

Among the participants' most cited lived experience and perceptions during the interviews was the issue of traditional or cultural beliefs that influence access to and utilization of health care services and resources. Traditional cure and prevention of diseases and illnesses are considered cultural values inherited from their ancestral forefathers. The study participants shared fascinating perceptions and experiences on certain traditional or cultural and faith-based beliefs most rural residents hold that limit their access to modern health care services and resources.

P1 said:

Cultural beliefs and traditional healing practices could be good and bad for what I have seen in our community and what I think affects many people in our village. In the first place, many people believe that both English and traditional medicines

work for them, and therefore they continue to apply both for their health. Some people will first try the herbs to cure their sicknesses and only seek medical attention from a clinic or hospital when the illness worsens and is close to the point of death. Other people trusted modern medication more than traditional healing because they believe it cures sicknesses faster than herbs. Some people believe that some sicknesses are caused by witchcraft or sorcery, and therefore only traditional medicines can cure such sicknesses. Some people believe that some sicknesses are inflicted on victims through witchcraft, such as witch guns, witch poison, witch breeze, and that illnesses resulted from these magical powers cannot be treated with modern medication. Attempting to cure witchcraft sicknesses will worsen the situation and will eventually lead to death. A person fired with a witch gun must not be injected with modern medications because that will make the witch substance in the victim's body react aggressively and quickly cause death. Some Christians in our community believe that prayer can heal their sicknesses without going to a clinic or hospital. They believe that Jesus can heal them if they pray and fast with faith.

P2 said:

Many people in our community still hold on to such beliefs to prevent and cure illnesses. For example, people believe that most sicknesses are not ordinary illnesses. They are inflicted on the victim's body by witchcraft or sorcery, and such sicknesses resulting from such inflictions can only be cured by traditional means.

P3 said:

In my view, I think that the people's cultural beliefs and traditional healing practices help modern health care services because all the difficulties we face in trying to access health care is a reason for people to hold on to such beliefs and decided to ignore modern health care. People believe that certain sicknesses do not require hospital treatment. People also believe that traditional medicines are sacred and connect with ancestral spirits, witchcraft, and sorcery. Many people prefer traditional healing to modern medicines because herbal treatment is cheap; sometimes, it is even free of cost and easily accessed.

P4 said:

Traditional healers provide medical alternatives to health care, especially when there is no money to go to a health facility and get modern medical treatment, so traditional healers are helpful to some extent. The traditional healers provide remedial care, some of which can heal, and others can result in other complications. This is not good; the best thing is to go to a health facility and get medical help.

Results Based on Research Questions

RQ1 involved the lived experience involving access to healthcare services and resources, and perceptions of access to medical treatment and resources. In my research findings, participants revealed that access or the lack of access to a hospital or clinical treatment is influenced by both the health care system and their ability or inability to perceive or understand the need for medical treatment, seek medical attention or advice,

reach out to medical facilities, pay for treatment, and engaged with the health care system for appropriate health care needs, consistent with the literature (Levesque et al. 2013; Cu et al., 2021). Participants explained the health care system's influence on their ability to access or not to access health care services and resources. Their responses aligned with the literature regarding the availability of health care facilities, resources, and services, approachability, acceptability, affordability, and appropriateness.

Therefore, participants concluded that they lived in communities without hospitals and clinics and seek treatment from neighboring communities whose health care services and resources are inadequate and inappropriate (as in Dubbink, 2020) to meet their health care needs compared to their urban counterparts. Participants also reported that they live in abject poverty because of their inability to access better health care and subsequently limit their production ability.

The participants' perceptions about access were that their geographical location in the remote rural communities disadvantaged them and, therefore, often suffered from limited or no access to health care services and resources compared to people living in big towns or capital cities (Dowhaniuk, 2021). Participants perceived themselves as having inadequate resources and that their primary source of healing and wellbeing was their beliefs in traditional healing and practices. According to the participants, high rates of maternal and infant mortality, increasing levels of poverty, chronic illnesses, and diseases decreased social interactions and associations. Such situations are not what they want, but they have little or no power or knowledge to stop them from happening because

of limited resources and understanding to perceive, seek, reach, and use their healthcare needs, resulting in unsafe and unhealthy events.

Summary

This chapter included a discussion about the research setting, participants' demographics, and data collection and analysis exercises, which included a detailed and in-depth understanding of the study phenomenon. I also provided a thorough account of ethical trustworthiness of research findings and presented study outcomes critically and cautiously that represented study participants' views, perceptions, and lived experiences. I addressed results if research questions and perceptions of the lived experience regarding lack of access to primary healthcare services and resources. The data collection process involved a rigorous exercise of transcribing interviews, coding, and analyzing codes, categories, concepts, and themes to understand participants' the lived experience and perceptions regarding access lack of access to essential healthcare services. The research findings revealed that the inability of residents to embark on productive activities such as farming, hunting, and animal rearing was because of the prevalence of diseases and illnesses.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

This chapter includes interpretations and discussions of results, limitations of my study, recommendations for further research, implications for positive social change, and a conclusion. This chapter involves how participants' perceptions and the lived experience data complemented existing knowledge regarding lack of access to essential healthcare services and resources. This chapter includes information regarding how the selected research theories and conceptual framework supported the research results.

The purpose of this qualitative phenomenological study was to investigate perceptions and the lived experience of access or the lack thereof to essential healthcare services and resources in remote and underserved rural communities of Rotein and Rogboreh in the Bombali Seborá chiefdom of northern Sierra Leone. There is little existing research regarding perceptions of limited healthcare services available to people residing in hard-to-reach and remote villages who constituted this research population. Residents in remote areas experience high maternal and infant mortality rates, increased prevalence of chronic diseases and illnesses, and high levels of poverty compared to their urban counterparts. Stated indicators of poor health due to lack of access to primary healthcare services negatively impacts rural residents' socioeconomic status.

Interpretations of the Findings

Findings confirmed that disparities in terms of access to essential healthcare services result from demographical and geographical differences between urban and rural communities. The rural-urban welfare imbalance has led to a steady lack of access to

first-contact lifesaving medical treatment in the faraway *fakais* of Rotein and Rogboreh in the Bombali Seborá chiefdom in Sierra Leone.

Results not only confirmed the existence of the problem but also added knowledge regarding rural perceptions that may contribute to healthcare policy implementation or reform. Most related literature mainly focused on physical barriers of access to healthcare and resources. Factors determining participants' understanding of healthcare needs and gaining access to primary care to accomplish such needs are critical in health research.

Results also added to limited research regarding rural residents of Rotein and Rogboreh in the Bombali Seborá chiefdom continued beliefs in supernatural or traditional healing because of limited access to primary healthcare services. Moreover, in Sierra Leone, such factors are informed by differences in the healthcare system. A universal scheme of cost-effective healthcare should reflect needs of populations and economic difficulties faced by healthcare consumers.

My research involved employing a phenomenological approach to describe participants' lived experience and perceptions of access to healthcare services and resources. During the data collection process, I closely examined how healthcare situations and events presented themselves to participants through rich descriptions of the lived experience as they related to health and medical events. To concentrate on the phenomenon, I had to bracket prior knowledge of the subject matter under investigation to ensure trustworthiness.

RQ1 involved the lived experience and perceptions involving access to essential healthcare services and resources for residents of Rotein and Rogboreh in the Bombali Sebor, Sierra Leone. Participants provided additional knowledge regarding lack of availability, affordability, and appropriateness of healthcare, acceptability, and approachability. Research findings highlighted factors influencing access as determined by healthcare providers or suppliers (supply-side dimension of access) and patients or healthcare consumers (demand-side dimension of access).

Levesque et al. (2013) said residents without the five abilities to offer effective demands for healthcare services and resources were more likely to avoid seeking healthcare facilities and continue to seek traditional medicines and hold on to beliefs in sorcery, witchcraft, faith-based healing, and herbal treatments. Traditional healing and beliefs persist in rural areas because villagers cannot afford to seek healthcare services and resources and experience limited (or complete lack of) provider availability, inconsistency in terms of providers, and office wait times as barriers to healthcare access.

All participants acknowledged that poor quality of life in rural communities is an outcome of poor healthcare due to lack of access. Coughlin et al. (2021) said residents of remote rural communities of Rotein and Rogboreh in the Bombali Sebor chiefdom, Sierra Leone experienced difficulties in terms of their efforts to confront and overcome barriers to accessing primary healthcare services and resources and often failed to reach out and connect with such medical facilities and services. Zegeye et al. (2021) said healthcare outcomes based on lack of access to healthcare services and resources affect

residents' socioeconomic wellbeing and quality of life. Consequently, patients' quality of life is clearly associated with access to healthcare services and resources.

Limitations of the Study

The size of the sample limited the scope of understanding the phenomenon under study. Resources such as finances, time, personnel, and equipment required for the conduct of the research restricted the duration of data collection, which affected the quantity and quality of information necessary for analysis and limited the applicability of this research's findings to other studies. The familiarization of the researcher with the participants, to some extent, influenced the outcome of the results. The research findings may offer limited opportunity for transferability and zero opportunity for generalization.

The study sample was small, and findings may of may not be applicable to other communities with different population characteristics. The behaviors of residents from other rural communities might be different based on their socio-economic and health activities. Marshall et al. (2013) said researchers must try to examine qualitative studies as an evidence-based guide to appreciate sample size and argued for quantitative research to increase the knowledge base, and therefore offer policymakers broad evidence to design their policies. Comprehensive policies that seek to address national events require all stakeholders' experiences, perceptions, and experiences impacted by such national issues. Therefore, the sampling method employed in this study, also posed certain limitations. The purposive sampling method employed to recruit participants narrowed down the chances of selecting the right or most appropriate participants who might be more knowledgeable about the phenomenon under investigation. Bhandari (2021)

claimed that the generalizability of the findings becomes limited when a study employed a small size, which might be because of sampling biases. Bhandari noted that smaller research samples jeopardize external validity or population validity. Therefore, findings obtained from a smaller sample (or biased samples) can limit the generalizability of its study outcomes to only populations that share similar characteristics with the study sample. The data collection instrument coupled with the interview duration posed the limitation of insufficient information to address rural residents' vast experiences and perceptions about the lack of access to primary health care.

Recommendations

The first recommendation is to encourage future researchers to carry out additional research on disparities within the health care system that disadvantages the rural poor who have difficulties perceiving, seeking, reaching out, paying, and engaging health care services, facilities, and resources. It is, therefore, essential to encourage future researchers to carry out an extensive study on the topic of disparity (Zakaria et al., 2021) within the health care system that disadvantages residents of remote rural communities over urban communities.

The scope of the phenomenon under study is broad. Cu et al. (2021) recommended more research on health care disparity that kept widening the access gap of the socio-economic wellbeing and quality of life between rural and urban communities. Cu et al. were aware that extensive research on health care access inequality will provide policymakers and other key players in the health care system with expansive knowledge and understanding about the effects of their discriminatory policies on growth and

development. Thus, further studies on this topic of discussion will minimize the limitation on the scope of health care access and build up the sustainable resolution on providing a health care system that will cater to the health care needs of every citizen irrespective of demographic and geographical differences.

Therefore, more researchers should engage in future studies to investigate the disparity in the allocation of health care resources between urban and rural communities. More research on this topic needs to be mounted to get the policymakers and other stakeholders engaged in the planning and implementing fair and equitable distribution of national resources to every citizen of a nation irrespective of their geographical location, socio-economic statuses, and distance away from the cities.

Any further research on the topic of discussion must utilize existing findings to complement the effort of the past researchers, which will guide them to follow ideas. Future researchers will discover fresh ideas as existing gaps in the literature related to the phenomenon of health care disparity and limited access to health care by residents of underserved remote rural areas because of persisting biases in the distribution of health care services, resources, and facilities.

The need for motivating direct providers or suppliers of health care services and resources must be a priority to the health care system and the health care experts who equally serve as government personnel to carry out policy reform that will affect citizens' wellbeing and quality of life across the country. Therefore, it is recommended that future inquiries into the study phenomenon target a broader scope of data collection coverage to include more rural communities, from more chiefdoms, districts, and subsequently to

other regions in the country (Zwilling et al., 2021). This recommended expansion will elicit a much detailed and in-depth understanding of the study phenomenon.

The participants referenced the lack of health care facilities in the study communities and other surrounding communities as one of the keys lived experience and perceived barriers to accessing essential health care services and resources by residents of most remote rural communities. All participants reported that there were no hospitals and clinics in their villages, and they had to walk for over 6 hours to the nearest clinic or hire a motorbike, which is very expensive. In trying to alleviate the lack of access to health care services in rural areas, the health care system should provide health care facilities near every community, including remote rural areas. Another option is that the health care system should organize and implement regular mobile clinics in remote areas far away from health care facilities.

I recommend that the health care system provide subsidies to the manufacturers of medical supplies and drugs and offer motivating incentives to health care providers. Such incentives to suppliers of health care services and commodities will increase affordability, appropriateness of services and treatment, availability and accommodation, acceptability of patient diversity, and approachability in the satisfaction of patients' health care needs.

It is also crucial for future researchers to consider the need to investigate how the health care system can influence the universal accessibility of health care services and resources. Such supply-side issues might include the empowerment of the health care personnel such as doctors, nurses, and allied health care workers. The health care

providers or suppliers require regular in-service training that helps to refresh their skills for quality health care services that are appropriate, acceptable by patients, and available. Such skills must accommodate the health care needs of rural residents and services are affordable to every patient irrespective of economic status or geographical location and, above all, ensure better health care outcomes. Other concerns included: increasing and equitable budgetary allocations to communities based on their population and health care needs, limiting the rural-urban disparity gap that limits residents of underserved communities from accessing primary health care services and resources.

Policymakers should consider integrating traditional healing into the modern health care treatments of illnesses and diseases. The study findings revealed that most residents of rural communities often consulted traditional healers because of one or more of the identified barriers (e.g., lack of income, long distances to hospitals or clinics, lack of trained and qualified health care providers) in accessing health care services. Further studies on which aspect of traditional medicines can be integrated into western medication and treatment are essential for rural communities that must walk long distances to seek health care services. For example, training local midwives or traditional birth attendants to provide first-aid on non-emergency health care situations would reduce maternal and infant mortality rates.

Implications

The findings of this research provided a platform for health care policy reform that can accommodate the health care needs of remote and underserved populations of rural communities in Sierra Leone. Participants' lived experience and perceptions

provided detailed knowledge and understanding of healthcare disparities for rural residents of Sierra Leone and other barriers to access healthcare services and resources, which can help policymakers better understand the challenges facing the rural health care providers and consumers. The research outcomes may stimulate a health care reform that guarantees essential, equitable, affordable, and accessible health care services and resources.

The knowledge and understanding of the study results revealed a clear picture of the barriers that are responsible for the access or lack of access to health care services and resources. Health care decision-makers can adopt changes recommended by this research and use the results of this research findings to provide the appropriate health care services and resources that could increase access to essential health care services for people residing in places far away from urban centers or capital cities. The primary health care needs of Sierra Leoneans living in the *fakais* are addressed, and the quality of life and wellbeing of dwellers in such remote habitations is positively transformed, which can be manifested through the fall in maternal and infant mortality, decrease in poverty and a decrease in the spread of chronic illnesses and diseases. This turn-around of the health care policy because of adopting the participant's lived experience and perceptions about access also increase rural residents' productivity and participation in social and economic activities.

The cost barrier to accessing health care services and resources is a central issue in this research findings. Costs of transportation, medicines/drugs, medical treatment, hospital admissions, and opportunity costs for rural residents to access health care

services and resources disproportionately affect their socio-economic wellbeing (Matin et al., 2020). The recommendations of this research findings and the abundant of related literature on the cost barriers can serve as a pointer for health care decision-makers to increase budgetary spending to provide adequate health care services and resources for the rural communities. The provision of sufficient, suitable, competent, and acceptable healthcare services and resources by building health care facilities in every community or closer to patients, training more health care personnel to serve in the rural areas, and increasing medical supplies can lower the cost for accessing health care resources and services. Subsequently, the rural population is assured of having access to equitable, affordable, and sustainable health care services.

The awareness of health care needs in any society plays a critical role in shaping the quality of leadership and decision-making in the health care system. According to Wallace et al. (2020), lack of quality leadership and decision-making within the healthcare system could affect the creation and implementation of sound health care policies, which will affect the wellbeing and quality of life of vulnerable populations. The research findings revealed that barriers such as the lack of health care facilities in most rural communities and lack of trained and qualified health care personnel serving in rural community clinics widen the rural-urban disparity gap limiting access to primary health care services and resources. Therefore, failing to adopt recommendations of this research in terms of policy reform and improving health care leadership and decision-making could negatively impact the wellbeing and quality of life of the rural populations.

Conclusion

My research purpose was to investigate how the perceptions of health care disparities on rural residents of Sierra Leone affect their access to essential health care services as they lived in their remote and underserved communities. This research explored individuals' lived experience and perceptions in rural communities of the Bombali Seboru Chiefdom of Northern Sierra Leone of access/lack of access to essential healthcare services and resources. Two research questions guided the data collection process.

The study findings confirmed that accessing care is the outcome of the health care access and utilization, as indicated by the patient's wellbeing and quality of life. The residents of remote rural communities encounter an array of challenges in overcoming the barriers to essential health care services and facilities and fail to connect with such medical facilities and services. Therefore, patients' quality of life is clearly associated with access to healthcare.

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Appendix: Interview Questions

1. Can you please identify or name the hospitals, clinics, pharmacies, and clinical laboratories in your community?
2. Why do you think they exist, and do you think that they are important to your community?
3. Do you believe that access to health care services or resources are important for you and your family? If so, why?
4. How difficult or easy is it for you and your family to access health care services or resources in your community?
5. What do you believe are the barriers or challenges to access to health care services to you, individually?
6. What do you believe are the barriers or challenges to access to health care services for people in the community or region?
7. In your opinion, what would you say about the health care system {including, the Ministry of Health and Sanitation (MoHS), Primary Health Care (PHC), District Health Care (DHC), and health care personnel (doctors, nurses, laboratory technicians, pharmacy technicians, community health worker/officers)}?
8. Based on your personal experience, how do you believe health care services and resources benefit or impact the lives of people in your community?
9. In your opinion, how do cultural beliefs and traditional healing practices help or hinder modern health care services and resources?

10. Based on your health experience, do you think that people in your community take full advantage of the health care services and resources that provided or available to your community? If so, why or why not?
11. How do you think that the health care services or resources in your community differ from the ones in the urban centers or big cities? Are they better, worse, or about the same? Please explain.
12. What do you believe about the actions of authorities responsible for making sure that the people have health care services?
13. Can you name any health care personnel or authority you have met with and where? For example, doctors, nurses, pharmacists, laboratory technicians, District Health Officer (DHS), District Medical Officer (DMO), District Health Sister (DHS), and Midwives.
14. What experience do you have about your interaction(s) with the health care personnel or authorities you named in question 13 above?

Probes

1. How do you feel about that?
2. Can you give me an example of what you just explain to me?
3. Can you tell me more about that?
4. Why was that important to you?
5. Why does that stand out in your memory?
6. Why does that matter?
7. What motivated your response?