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A Case Study of Primary Healthcare Services in Isu, Nigeria

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2013

Abstract

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Public Health: Community Health Education and Promotion

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Abstract

Access to primary medical care and prevention services in Nigeria is limited, especially in rural areas, despite national and international efforts to improve health service delivery. Using a conceptual framework developed by Penchansky and Thomas, this case study explored the perceptions of community residents and healthcare providers regarding residents' access to primary healthcare services in the rural area of Isu. Using a community-based research approach, semistructured interviews and focus groups were conducted with 27 participants, including government healthcare administrators, nurses and midwives, traditional healers, and residents. Data were analyzed using Colaizzi's 7-step method for qualitative data analysis. Key findings included that (a) healthcare is focused on children and pregnant women; (b) healthcare is largely ineffective because of insufficient funding, misguided leadership, poor system infrastructure, and facility neglect; (c) residents lack knowledge of and confidence in available primary healthcare services; (d) residents regularly use traditional healers even though these healers are not recognized by local government administrators; and (e) residents can be valuable participants in community-based research. The potential for positive social change includes improved communication between local government, residents, and traditional healers, and improved access to healthcare for residents.

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Dedication

I dedicate this work to my family for the warm support, prayers, and financial help they gave to me during these long years of adult learning; to my wife Eunice for her great understanding and care; to my sons, Chidozie, for his feedback on my initial efforts of this project, and Chimdike, for his unrelenting prayers to God that I may have the strength to accomplish this task; to my parents, the late Simon Chimezie and Anthonia Chimezie, who began this journey for me earlier in my life; to my uncle, the late Chief Hilary Obiechefu, who always has supported my quests in life and wished that I get a doctoral degree; to my late father-in-law, Chief Bernard Ogbuji Nwadike, whose encouraging words will remain with me as long as I live; and to my late uncle, Elder Alex Asuzuo, who inspired me in the face of great suffering and difficulties. Finally, I dedicate this work to the people of the Isu Local Government Area and particularly to my own community, Nnerim Umundugba, for all they have suffered and endured in the face of neglected healthcare. To those whose lives were cut short by lack of access to healthcare—I wish that they rest in perfect peace that Christ Jesus gives.

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I thank Almighty God for the strength and sustenance both to begin and complete this study. Without His guidance and assistance, I would not have overcome the great challenges I faced.

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Finally, I am grateful to Walden University for the opportunity to realize my dream and for instilling in me the philosophy of social change. I am greatly empowered by it.

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Chapter 1: Introduction to the Study

Many countries have limited access to primary healthcare for residents (Rutherford et al., 2009; World Health Organization [WHO], 2008b). A combination of factors contributes to this condition, including sociodemographic characteristics of the population, lack of resources, challenges posed by the primary-care model, and government healthcare administrators' failure to incorporate input from the community regarding healthcare needs (Higgs, Bayne, & Murphy, 2001; Uneke et al., 2009). As a result, many people suffer illnesses unnecessarily, and communities experience high mortality and morbidity rates from preventable causes (Irwin et al., 2006). This unfortunate situation is the case among many African countries (World Bank, 2011).

Compared to other countries, African countries bear a greater burden of disease and death from preventable and terminal causes. In fact, 72% of all deaths in Africa are the result of communicable diseases such as HIV/AIDS, tuberculosis, and malaria; respiratory infections; and complications of pregnancy and childbirth. Deaths due to these conditions total 27% for all other WHO regions combined (WHO, 2006). In addition, the WHO reported that 19 of the 20 countries with highest maternal mortality ratios worldwide are in Africa. Data from a 2009 report from the World Bank (2011) indicated that the prevalence of HIV among people ages 15–49 in sub-Saharan Africa is nearly seven times of that in other areas of the world (5.4% compared to 0.8%, respectively). Similarly, WHO (2006) reported that Africans account for 60% of global HIV/AIDS cases, 90% of the 300–500 million clinical cases of malaria that occur each year, and 2.4 million new cases of tuberculosis each year. As of 2003, infant mortality rates were

reported to be 29% higher than in the 1960s (43% up from 14%; WHO, 2006). Lack of safe drinking water (58% of the population) and access to sanitation systems (36% of the population) contribute to these poor health outcomes (WHO, 2006). However, these poor health conditions also are due in part to the historical and current states of primary healthcare in Africa, and particularly in Nigeria (Asuzu, 2004; National Primary Health Care Development Agency, 2007; Tulsi Chanrai Foundation, 2007; WHO, 2008b).

Over the years, international attention has been drawn to the global issue of limited access to primary healthcare for many populations. The outcome of this attention has been the initiation of numerous efforts to change this condition and develop modern and effective healthcare systems focused on preventing diseases (McCarthy, 2002; United Nations Children Fund [UNICEF], 2008; United Nations Population Fund, 2010; Wang, 2007); reducing disparity in health care (Andaya, 2009; Cueto, 2004; Gofin & Gofin, 2005; Latridis, 1990; Negin, Roberts, & Lingam, 2010; WHO, 1946); improving access to healthcare (Bourne, Keck, & Reed, 2006; Dresang, Brebrick, Murray, Shallue, & Sullivan-Vedder, 2005; WHO Country Office for India [COI], 2008); promoting active community participation in healthcare planning (International Conference on Primary Health Care [ICPHC], 1978; International Conference on Primary Health Care and Health Systems in Africa [ICPHCHSA], 2008; WHO, 1974); and promoting overall health and well-being (Hall & Taylor, 2003).

Efforts to this end have been effective in many nations (WHO, 2000b, 2008b). However, the early influence of Christian missionaries (Ityavyar, 1987; Kaseje, 2006), years of British imperialism leading to the amalgamation of Southern and Northern

Nigeria (Ityavyar, 1987), Nigeria's continued reliance on the ineffective British system of healthcare (Ityavyar, 1987), governmental inadequacy (African Development Bank, 2002; Asuzu & Ogundeji, 2007), and a 3-year civil war (Uche, 2008; Uchendu, 2007) have left the Federal Republic of Nigeria in a state of political, economic, and social unrest, unable to accommodate a governmental infrastructure to satisfy the diverse cultural needs of its people (Hargreaves, 2002). Particularly strained is the nation's ability to provide access to effective healthcare for its growing population, especially in rural areas (African Development Bank, 2002). The sociodemographic characteristics of the population compound this condition (Labiran, Mafe, Onajole, & Lambo, 2008). Access to healthcare remains inadequate in Nigeria; however, there are very few data on community perceptions regarding this inadequate access to healthcare in rural Nigeria, and none in Isu.

Problem Statement

The residents of rural Nigeria lack access to adequate healthcare. One of the many factors contributing to this lack is the failure of the healthcare system to incorporate input from the community in planning and implementing services. As a result, there are very few reports of community input. There is a need to explore community perceptions regarding access to primary health care in the rural area of Isu. This problem is worthy of study because inability to access healthcare services is directly related to poor health outcomes (Cohen, Chavez, & Chehimi, 2007) such as those described in the introduction to this study.

Purpose of the Study

The purpose of this study was to explore the perceptions of rural community residents and healthcare providers regarding residents' access to primary healthcare services in Isu and to engage in community-based research to demonstrate its potential to promote resident access to healthcare services. Specifically, I gathered information regarding availability, accessibility, accommodation, affordability; and acceptability of government healthcare services; characteristics of the healthcare system that hinder and that promote residents' use of healthcare services; and the potential for community-based research to promote residents' use of available healthcare services. By exploring these concepts through study participants' perspectives, I generated data that may be used in constructing and distributing a ground-up model of a healthcare system that satisfies the expressed needs of the people of rural Isu. In addition, I have provided an example of community-based health access research—a relatively new area of research.

Conceptual Framework

Penchansky and Thomas's (1981) model of healthcare access provided the framework that guided this study. According to Penchansky and Thomas, although access to healthcare is relevant to advancing health legislation and services, the concept has yet to be adequately defined; however, it is a condition that promotes inequality in healthcare distribution and widens the gap in health outcomes between the rich and poor, particularly evident between urban and rural populations. According to Penchansky and Thomas, access to healthcare does not refer generally to the use of a healthcare system or the factors that influence that use, nor is it measured by the health of the clients. Rather,

access to healthcare refers to the compatibility between a person and the healthcare system available to them and is measured by factors that assess patient satisfaction or prevent them from using healthcare services.

Penchansky and Thomas's (1981) model of healthcare access provided a framework for developing my study. Specifically, I considered the five dimensions of access—availability, accessibility, accommodation, affordability, and acceptability—while designing Research Questions 1 and 2 so that I could elicit responses related to all dimensions of access to healthcare in the community. I considered the dimension accommodation while designing Research Question 3 so that I could elicit responses related to the community-based research aspect of my study. In addition, I used the five dimensions of healthcare access to understand the barriers to healthcare access and the importance of overcoming those barriers as a means of improving rural health conditions. Also, in my literature review, I organized the presentation of the barriers to healthcare access according to the five dimensions. The model also provided an organizational structure for the presentation of my results. Finally, using Penchansky and Thomas's (1981) model of access allowed me to present recommendations for improving healthcare access based on an accepted and proven conceptual framework. By exploring the conditions of healthcare access for the rural people of Isu through the lens of Penchansky and Thomas's model of access, I gathered data that provide a deeper understanding of the impact of these dimensions of access to the health of Isu residents. Because of this understanding, I was better suited to present suggestions that may bring about changes in

current government healthcare policies and practices and guide efforts to improve access to healthcare services for the residents of rural Isu.

Nature of the Study

In this case study, I used qualitative research methods to explore the issue of healthcare access for the rural people of Isu. To collect data, I used two methods—personal interviews and focus group discussions—and four data collection instruments. To analyze the data, I used Colaizzi's (1973, 1978) seven-step method for coding data into themes and patterns. To guide my study, I developed three research questions. The focus of the questions was on the perspectives of healthcare providers and residents regarding residents' access to and use of primary healthcare services as well as community-based research as a means of promoting the use of healthcare services in Isu. I anticipated that not only would I find differences between the perspectives of community residents and government healthcare administrators, but also that I would find differences among healthcare providers themselves. Also, I anticipated that healthcare administrators would provide insight into administrative or policy issues impacting primary healthcare. Because nurses and midwives must work with the population of Isu within the constraints of the government healthcare system, I anticipated that they would be helpful in providing a broad understanding of the conditions I sought to explore. I discuss my methodology in more detail in Chapter 3.

Research Questions

To guide this study, I developed three primary research questions and eight subquestions:

Research Question 1. What are the perceptions of healthcare providers regarding residents' access to and use of primary healthcare services provided in rural Isu?

1a. What are healthcare providers' perceptions regarding the characteristics of the local government healthcare system that work well?

1b. What are healthcare providers' perceptions regarding the main challenges and barriers faced by the local government healthcare system?

1c. What are healthcare providers' perceptions regarding solutions to the main challenges faced by the local government healthcare system?

1d. What are healthcare providers' perceptions regarding the potential for closer relationships between the local government healthcare system and traditional healers?

Research Question 2. What are the perceptions of local community members regarding their access to and use of healthcare services in rural Isu?

2a. What are residents' perceptions regarding characteristics of the local government healthcare system that fulfill residents' needs?

2b. What are residents' perceptions regarding the main challenges and barriers faced by the local government healthcare system?

2c. What are residents' perceptions regarding solutions to the main challenges faced by the local government healthcare system?

2d. What are residents' perceptions regarding confidence in the local government healthcare system and in traditional healers?

Research Question 3. What are the perceptions of healthcare providers and residents regarding community-based research as a means of promoting the use of healthcare services among the rural residents of Isu?

Definition of Terms

Access. Based on Penchansky and Thomas's (1981) model of healthcare access, refers to a concept that comprises five dimensions: accessibility, availability, acceptability, affordability, and accommodation, which determine the degree of fit between clients and a healthcare system.

Community-based participatory research. Focused on a topic relevant to the community, actively involves community members in the research process, and promotes positive social change (Centre for Community Based Research, 2011).

Healthcare administrator(s). Person(s) who plan, direct, coordinate, and supervise the delivery of health care (U.S. Bureau of Labor and Statistics, 2012).

Health system. An organizational framework for the distribution or servicing of the health care needs of a given community (Asuzu, 2004).

Midwife. An accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth,

the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency (International Confederation of Midwives, 2011).

For the purpose of this study, a midwife is a healthcare provider who may be self-employed in private practice or may be an employee of the Isu Local Government who is responsible for administering prenatal, delivery, and postnatal care in government-run health and community centers or private dedicated locations.

Nurse: A person who cares for the sick or infirm; *specifically* **:** a licensed health-care professional who practices independently or is supervised by a physician, surgeon, or dentist and who is skilled in promoting and maintaining health (Merriam-Webster Dictionary). For the purpose of this study, a nurse is a healthcare provider with the requisite professional nursing license charged with direct care of patients in the in the local government-run health and community centers. .

Primary healthcare: Healthcare systems include three levels: primary, secondary, and tertiary. At the primary level, healthcare can be described as a "prevention-oriented approach to health and well-being" (Cohen et al., 2007, p. 1) and refers to essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and the country can afford to maintain (ICPHC, 1978). Primary healthcare is distinguished from secondary healthcare, which refers to disease intervention and prevention (Cohen et al., 2007);

tertiary health care refers to "reduction of further complications, treatment, and rehabilitation" associated with disease (Cohen et al., 2007, p. 5).

Residents: All people 18 years and older who live or work in and depend on the primary healthcare services provided in the Isu Local Government Area.

Traditional healer: A healthcare provider who is not an employee of the Isu Local Government (private practice), provides healthcare services based on traditional medical practices (in contrast to medical practices based on Western medicine), and has a considerable history living among the residents whom he or she serves.

Assumptions and Limitations

The underlying assumption in this study was that by identifying and confirming healthcare access problems of the people of Isu, ways could be found to improve access to and use of primary healthcare. I made deliberate choices regarding my chosen topic of study and study participants. I also acknowledged the limitations associated with these assumptions.

Regarding the general topic under investigation, I assumed that with regard to qualitative outcomes, access to healthcare is measurable when it is examined through the characteristics of accessibility, availability, acceptability, accommodation, and affordability. This was a limitation because these characteristics may not sufficiently capture the conditions represented in Isu. However, data from this study may be used to develop a clearer understanding of these conditions. Also, I assumed that this study would identify and confirm problems associated with seeking healthcare in Isu and expose ways to remedy them.

I assumed participants would be honest in their responses, respond willingly, and participate throughout the duration of the study to the best of their abilities. I also assumed that participant responses are dependent on participant memory, and how much they are able to reflect on past conditions or experiences due to the passage of time. However, when participant responses were analyzed for themes, the data provided general patterns of perspectives that may be useful in designing a model of healthcare delivery that meets the needs of the people of rural Isu.

I assumed that the results of this study would accurately reflect conditions in Isu of residents' access to healthcare services and provide data useful for developing a model of health care based on the specific needs described by residents of rural Isu. In addition, I assumed that these data would be relevant to healthcare providers in that area. These assumptions were limitations because I used a small sample of the population from which to gather my data. Thus, the sample may not have represented the overall experiences of the total population, and my ability to generalize findings to the entire population of Isu, and especially to other local communities, was limited. However, this study serves as an initial attempt to understand conditions related to residents' access to healthcare services in Isu and provides a valuable foundation for the development of a model of healthcare delivery that meets the needs of the people of rural Isu and for additional study on this topic.

Scope and Delimitations

The scope of this study comprised residents' and healthcare providers' perceptions of resident access to healthcare services in rural Isu, as well as the potential

of community-based research to improve resident use of healthcare services. This study was delimited to four specific groups: government healthcare administrators, nurses and midwives, traditional healers, and residents of Isu. Government healthcare administrators included in this study held senior administrative or leadership positions in the health department or positions directly involved in healthcare decision making at the local government and had worked in that capacity for at least 3 years. Nurses were actively working in government-supported healthcare facilities, and midwives were actively working either in government-supported healthcare facilities or in private practice. All nurses and midwives were licensed to practice and had no less than 3 years' experience providing direct healthcare services. Traditional healers were residents of Isu and had provided healthcare services to the local population for at least 5 years. Residents had lived in Isu for at least 5 years and could not have been employed as government healthcare administrators, nurses or midwives, or traditional healers. All participants were over the age of 18 and capable of giving informed consent and participating fully in all aspects of the study. No potential participants were excluded based on race or gender.

Significance of the Study

The literature demonstrated that health research in general contributes to improved decision-making procedures for healthcare administrators and performance of national healthcare systems (Briss, Gostin, & Gottfried, 2005). Specifically, community-based research supports positive social change (Centre for Community Based Research, 2011). Results from this study add to the body of knowledge that community-based

research can generate important information to support social change, such as the improvement of people's access to healthcare.

By exploring the conditions affecting access to healthcare in Isu, I generated data that the Isu Local Government Area chair and healthcare administrators can use to construct and distribute a ground-up model of healthcare that satisfies the expressed needs of the people of rural Isu. In addition, private-practice healthcare providers could implement aspects of the model appropriate for improving patient care in private-practice situations. Ultimately, such efforts by healthcare providers may offer a means of improving resident access to healthcare in Isu and contribute to the reduction of healthcare inequity among residents.

Summary and Content of the Remaining Chapters

Limited access to healthcare services can be a major cause of health disparity in any population (Bourke, 2006; Irwin et al., 2006). Thus, increasing access to primary healthcare is critical to decreasing rates of death and sickness from preventable causes. Primary healthcare is designed to promote good health by reducing mortality and morbidity (Irwin et al., 2006), support overall health and well-being, and improve community and individual behavior regarding self-management of healthcare—all of which can result in tremendous savings in financial and human resource investments in secondary and tertiary levels of healthcare (World Bank, 1993; WHO, 2000c). For example, Kaseje (2006) indicated that poor access to healthcare results in a lack of access to modern health facilities for 50% of the African population, and consequently, low levels of immunization and high levels of maternal, child, and infant mortality.

According to Kaseje, for primary health care to meet the needs of contemporary society, it has to adopt a business attitude of tailoring services to needs; it is essential that healthcare administrators seek input from community members and incorporate this input in healthcare plans and programs. Community-based research provides that opportunity for implementing a community-oriented healthcare delivery system.

Penchansky and Thomas's (1981) theory of access provided a guide for understanding the different factors that inhibit or promote healthcare access for consumers and improve healthcare use. Healthcare access largely is determined by availability, accessibility, accommodation, affordability, and acceptability (Penchansky & Thomas, 1981). Because no research has been done in this community, in this regard, gathering primary data through personal interviews and focus-group discussion was an appropriate step for bringing a community together to talk about their problems and suggest solutions. This method produced real-life experiences from people living the phenomenon under study, which were relevant for identifying obstacles to healthcare access and which will be relevant for improving healthcare use and creating a need for continued use of community input to solve community health problems. I analyzed the collected data using Colaizzi's (1973, 1978) seven-step method for content analysis.

In Chapter 2, I review literature on the traditional healthcare system and modern efforts to improve primary healthcare, including health reforms in Nigeria from colonial times to the present. In Chapter 3, I discuss the study's methodology, including the study design and approach, research questions, data-collection methods and instruments, and procedures for data analysis. In Chapter 4, I present my findings. In Chapter 5, I provide

an interpretation of the findings, discussing the findings as they relate to the theoretical framework used in this study; and offer study limitations, recommendations for action, recommendations for future study, and implications for social change.

Chapter 2: Literature Review

Most residents of rural Nigerian communities suffer from lack of access to healthcare, which results in death and sickness from preventable causes. One of the many factors contributing to this situation is the failure of the healthcare system to incorporate input from the community in planning and implementing services. The intent of this study was to explore the perceptions of rural community residents and healthcare administrators and providers regarding residents' access to primary healthcare services in Isu, and to engage in community-based research to demonstrate its potential to promote resident access to healthcare services. This section comprises six major subsections. First, I provide a detailed discussion of the conceptual framework I used in this study. Second, I present a historical and modern overview of the Nigerian healthcare system. Third, I present literature related to healthcare conditions in Nigeria to illustrate the healthcare crisis in Nigeria and illuminate the importance of this study. Fourth, I discuss the importance of primary healthcare to a population's health. Fifth, I present literature related to barriers to healthcare access and the role of community-based research in improving healthcare. Last, I discuss literature relating to the methodology of this study.

As part of my exploration into perceptions of healthcare access in Isu, I conducted a review of applicable literature. I searched scholarly literature databases via Academic Search Complete, Health Science Research, Science Direct including the Education Resources Information Center (ERIC), and gathered information from scholarly journal articles, magazine articles, reports, fact sheets from state and private organizations, and books. I selected literature based primarily on publication dates between 2000 and 2011.

When I included literature published before 2000, I did so because it either represented a significant contribution to the field of study or because it contributed to the well-rounded description of the conditions prompting this study. Search terms included *primary healthcare, healthcare, access to healthcare, traditional healing in Nigeria, health disparity,, barriers to primary healthcare, achievements of primary healthcare, community-based research, rural health, Nigerian National Health Insurance Scheme, Nigerian Development Plan, colonial health model, problems of healthcare in Africa,* and *healthcare perceptions.*

Conceptual Framework: A Model of Healthcare Access

According to Penchansky and Thomas (1981), access to healthcare refers to the compatibility between a person and the healthcare system available to him or her and is measured by factors that assess patient satisfaction or prevent them from using the healthcare services. To define access and provide a means by which to measure it, Penchansky and Thomas conducted a quantitative study using survey data collected in Rochester, New York in 1974 from General Motors Corporation electrical-parts assembly-plant personnel and their spouses. Penchansky and Thomas's primary purpose was to explore what factors contributed to participants' choice of a healthcare plan and what roll satisfaction played in those choices. The researchers used one questionnaire for employees and another for spouses, and although 626 employees and spouses originally participated in the study, only 287 people completed all the survey questions pertaining to satisfaction. The researchers scored participant responses using a 5-point Likert scale and found that 16 items related to five dimensions of access. As a result of this work,

Penchansky and Thomas outlined five closely related dimensions of healthcare access: availability, accessibility, accommodation, affordability, and acceptability (p. 127).

Availability refers to the relationship between the supply and demand of available health services (Penchansky & Thomas, 1981). In this dimension, Penchansky and Thomas suggested there is a relationship between the number of healthcare facilities, healthcare personnel (physicians and paraprofessionals), and types of services offered and the extent and types of need expressed by a population. As described by Cham, Sundby, and Vangen (2005), availability measures the extent to which available services meet the health needs of the population being served.

Accessibility refers to the degree of fit between clients and the healthcare system (Penchansky & Thomas, 1981). According to Penchansky and Thomas (1981), the focus of this dimension is "the relationship between the location of supply and the location of clients, taking account of client transportation resources and travel time, distance and cost" (p. 128). McLaughlin and Wyszewianski (2002) described this dimension as geographic accessibility, "determined by how easily the client can physically reach the provider's location" (p. 1441). Clark (1983) and Ige and Nwachukwu (2010) described accessibility as equity in healthcare. Similarly, according to WHO (2000b), a healthcare service, regardless of its proximity to a client, cannot be said to be accessible if a client is unable to pay for the service.

Accommodation refers to the relationship among the manner in which the supply resources are organized to accept clients (including appointment systems, hours of operation, walk-in facilities, and telephone services), the clients' ability to accommodate

to these factors, and the clients' perception of their appropriateness (Penchansky & Thomas, 1981, p. 128). In this dimension, Penchansky and Thomas suggested that even when all other factors are adequately provided, people still will not seek or continue to use a healthcare system in which the design and operation do not consider their sociocultural circumstances.

Affordability refers to the "relationship of price of service and providers' insurance or deposit requirements to the clients' income, ability to pay, and existing health insurance" (Penchansky & Thomas, 1981, p. 128). According to the World Bank (1993), affordability also is related to increases in healthcare costs and associated outcomes for patients.

Acceptability refers to "the relationship of clients' attitudes about personal and practice characteristics of providers to the actual characteristics of existing providers, as well as provider attitudes about acceptable personal characteristics of clients" (p. 129). In this dimension, Penchansky and Thomas suggested clients may determine provider acceptability based on demographic characteristics and location of a facility, whereas providers may develop attitudes toward clients based on sociodemographic characteristics and need for physical accommodations (p. 129).

Because Penchansky and Thomas (1981) developed the five dimensions of access model, researchers have used it as the basis for measuring the impact of access to healthcare on health outcomes. More recently, Bourke (2006) used it to explore consumers' perspectives regarding access to healthcare, and Rutherford, Mulholland, and Hill (2010) used it to explore the impact of healthcare access on child mortality. I discuss

the details of these studies more thoroughly later in this chapter in the barriers to healthcare access section.

Traditional Healthcare System in Nigeria

Health and religious beliefs are tightly interrelated and thus have influenced how Nigerians have perceived health and healing from the earliest time of traditional medicine to the introduction of Western medicine in the late 1800s (Awojoodu & Baran, 2009; Ityavyar, 1987). The health perspectives of many Nigerians continue to be influenced by religious beliefs (Abubakar, Musa, Ahmed, & Hussani, 2007; Okeke, Okafor, & Uzochukwu, 2006). Because of the strong religious connection with health, the people of Nigeria have long believed certain illnesses to be associated with wrongdoings in the past or present world and their offense of gods and evil spirits (Nwoko, 2009; Onyioha, 1987). For example, the Hausas and Fulanis of northern Nigeria believe that cancer is caused by contact with an evil spirit (Abubakar et al., 2007). Among the Igbos, convulsions associated with malaria are believed to be diabolic (Okeke et al., 2006). Similarly, the Igbos believe mental illness to be the work of evil spirits (Nwoko, 2009). For this reason, historically, healthcare systems in Nigeria have been based on traditional medical practices and administered by traditional medical practitioners (healers) and birth attendants (Nwoko, 2009).

These traditional healers often are priests or religious people with a good knowledge of herbs and spiritual appeasements who are called on to diagnose and cure illness (Awojoodu & Baran, 2009). To be successful, healers must understand the physical, mental, spiritual, and social environment of the patients they treat (Onyioha,

1987). This practice regularly includes mending the relationship between patients and their *chi* (creator) or the spirits of the ancestors (Izugbara & Duru, 2006; Offiong, 1999). Often, traditional healers are called on to prepare healing concoctions, typically consisting of plants, herbs, and animal products (Okeke et al., 2006). In some cases, the healers perform healing ceremonies, including the use of healing concoctions and often animal sacrifices (Mafimisebi & Oguntade, 2010). Birth attendants perform deliveries, care for the health needs of pregnant and nursing mothers, and perform circumcisions; they also treat patients for infertility and manage threats of miscarriage (Ofili & Okojie, 2005). Although not adherent to strict spiritual practices associated with traditional healing medicine, birth attendants regularly use herbs when performing deliveries and providing pre- and postnatal care (Peltzer, Phaswana-Mafuya, & Treger, 2009).

Traditional medical practices have been fundamental to healthcare delivery in Nigeria because they help maintain patient–healer relationships and thus support open communication between patients and healers. Traditional healers live among the people, providing services that are accessible, affordable, and culturally acceptable to the people (Abioye-Kuteyi, Elias, Familusi, Fakunle, & Akinfolayan, 2001; Saad, Azaizeh, & Said, 2005). In addition, healers display a pragmatic approach in obtaining personal health information and histories from their patients—they use clues and language common to the people (Onyioha, 1987). When necessary, they also obtain information by observing and analyzing the patients' sociocultural environment, which may suggest the need to repair relationships between the patients and offended spirits (Ityavyar, 1987).

This pragmatic approach to particular aspects of patient information and service typically is missing from consultations between patients and Western medical practitioners (Abubakar et al., 2007). In fact, the persistent use of traditional healers and birth assistants today rests on the healers' and birth assistants' ability to understand their patients and their patients' belief systems (Saad et al., 2005), adapt their services to the needs of their patients (Offiong, 1999), and provide services based on sincere interest in patient health rather than interest in making profit (Titaley, Hunter, Dibley, & Heywood, 2010). These conditions fit well with the typical health-seeking behaviors of the people of Nigeria.

Modern Healthcare Systems

International Origins and Scope of Primary Health Care

Over the years, international attention has been drawn to the global issue of poor access to primary health care (ICPHC, 1978). The outcome of this attention has been the initiation of numerous efforts to change this condition and develop modern and effective healthcare systems focused on preventing diseases, reducing disparity in health care, improving access to healthcare, promoting active community participation in healthcare planning, and promoting overall health and well-being.

Beginning in the 1940s, individual health professionals and health organizations in Africa and around the world began engaging in projects and programs that defined primary health care and worked to improve access for those without it. For example, in the 1940s in rural South Africa, Sidney and Emily Kark began to promote the concept of primary health care, or community-based primary care, a comprehensive approach to care

that took into account the "socioeconomic and cultural determinants of health, identifying health needs, and providing health care to the total community" (Gofin & Gofin, 2005, p. 1). The focus of this type of care was community participation, preventive care, and provision of services that are affordable and accessible to the people in need (Gofin & Gofin, 2005).

Less than a decade later, in 1946, the Indian government set up the Bhore Committee to study and recommend ways of improving public access to healthcare (WHO COI, 2008). Among their recommendations were "(a) integration of preventive and curative services at all administrative levels, (b) short term-primary health centers for 40,000, (c) formation of village health committee, [and] (d) three months' training in preventive and social medicine to prepare social physicians" (WHO COI, 2008, p. 1). This innovative approach to public health access led the way for the formation of WHO in 1946.

WHO (1947) was established by the United Nations to deal with global issues of health among member nations. WHO promoted the idea that good health is a fundamental human right and that populations and states alike would benefit from state involvement in the promotion of good health (WHO, 1946). In its constitution, WHO identified health not as the absence of disease but more holistically "as a state of complete physical, mental, and social wellbeing" (p. 1). Since its inception, the organization has provided guidelines, formulated health policies, encouraged intra-agency collaborations, and presented declarations as a means of urging member nations and healthcare providers to adopt healthcare policies and programs that are relevant to established needs, and to

improve global access to healthcare as a means of improving healthcare and healthcare outcomes (WHO, 2008b). During the same year, the United Nations created what is now the United Nations Children's Fund (UNICEF, 2011) "to provide food, clothing and health care" (para. 1) to European children facing famine after World War II.

During the 1960s and 1970s, the People's Republic of China experienced a growing demand for the expansion of rural medical services (Cueto, 2004). This demand led to the development of the barefoot-doctor program: a program that trained local farmers in basic and paramedical procedures as a means of servicing members of rural communities not otherwise able to gain access to trained physicians (Cueto, 2004). The barefoot-doctor program was primarily concerned with preventive rather than curative measures and focused on serious disease planning, mutual aid, and fraternity between rural residents in the healthcare system (Wang, 2007).

Like the barefoot-doctor program in China, Cuba implemented a community-based program to improve primary healthcare delivery to the most remote and vulnerable populations of its society (Bourne et al., 2006). In 1964, Cuba began to develop a community-based healthcare system that "focused on wellness rather illness; incorporated social, political, and psychological aspects of wellness into medical practice with the help of community support-groups; and developed a unified service-delivery system" (Latridis, 1990, p. 30). The underlying framework for this system was a network of doctors who lived among the people they cared for, which allowed for uninterrupted access to healthcare, but also the opportunity for doctors to develop intimate relationships with their patients (Andaya, 2009). Similarly, in Fuji during the 1970s, doctors and

nurses "had been delivering health services on horsebacks to villages, built dispensaries, and trained local residents on the treatment of minor ailments" (Negin et al., 2010, p. 14).

The attainment of independence during the 1960s and 1970s by otherwise colonized countries also stimulated the desire to provide health services to improve the life and welfare of the people through the provision of high-standard healthcare, education, and other services (Hall & Taylor, 2003). In Tanzania, for example, the government began a primary healthcare program through a network of multisectoral primary healthcare committees at national, regional, district, ward, and village levels (Primary Health Care Institute, 2010).

The appointment of a new director general for WHO in 1973 resulted in a new understanding of the roles of WHO and UNICEF in the provision of basic health care (Cueto, 2004). That understanding led WHO and UNICEF to produce a collaborative report, *Alternative Approaches to Meeting Basic Health Needs in Developing Countries,* identifying key factors in health care for a variety of countries, including Bangladesh, China, Cuba, India, Niger, Nigeria, Tanzania, Venezuela, and Yugoslavia (Cueto, 2004). The report suggested that, for such developing countries, "the principal causes of morbidity … are malnutrition, vector- borne diseases, gastrointestinal diseases, and respiratory diseases—themselves the result of poverty, squalor and ignorance" (Djukanovic & Mach, 1975, p. 14).

In 1974, the World Health Organization established the Expanded Program on Immunization (EPI) to address root causes of death and disease among children and vulnerable populations in the world (Centers for Disease Control and Prevention, 2011).

Specifically, EPI focused on the prevention of death from the five known prominent diseases at that time: diphtheria, whooping cough, tetanus, measles, poliomyelitis, and tuberculosis (United Nations Population Fund, 2010). Although EPI targeted residents in poor environments and those with restricted access to healthcare, EPI struggled to reach residents with logistic problems, low capacity of health workers, and lack of availability of vaccines (Salaudeen, Musa, & Bello, 2011).

Health education as an essential tool for improving community health through self-empowerment became evident with the introduction of the Twenty-Seventh World Health Assembly Resolution. The resolution emphasized *health education* as a means to "improve health care utilization, increase community participation, and involve people in new responsibilities for their own health, that of others, and for the global community" (WHO, 1974, p. 3). The Twenty-Seventh World Health Assembly Resolution added that the most critical element for improving the health of the population was an informed public that could cooperate actively in their own healthcare (WHO, 1974, p. 5). This concept highlighted the importance of community partnership and participation in effective planning and implementation of healthcare.

One of the most notable efforts to advance improved public access to healthcare was the Declaration of Alma-Ata, an outcome of the 1978 International Conference on Primary Health Care joint conference sponsored by WHO and UNICEF (Cueto, 2004). The purpose of the conference was to focus attention on primary healthcare as a way of promoting global health and removing injustice in the distribution of health outcomes (Cueto, 2004). In the Declaration of Alma-Ata, members of the conference defined

primary healthcare as essential health care based on practical, scientifically sound, and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and the country can afford to maintain at every stage of development in the spirit of self-reliance and self-determination (ICPHC, 1978, p. 1).

Synthesizing primary healthcare concepts from various countries, members of the conference indicated that healthcare should (a) consider the economic, sociocultural, and political conditions of the population it is intended to serve; (b) focus on promotion and prevention in addition to curing and rehabilitating; (c) promote education; (d) appeal to all sectors of the population; (e) use local and national resources to promote a population's involvement in healthcare planning and implementation; (f) be sustainable and progressive; and (g) rely on appropriately trained healthcare workers as well as traditional practitioners (ICPHC, 1978; Negin et al., 2010).

Taking note of the continued limited access to healthcare resulting in low investment in healthcare-sector infrastructure and human development and inequality in income in sub-Saharan Africa, WHO and UNICEF again joined forces in 1987 to sponsor the Bamako Initiative (Ridde, 2011). This initiative was designed to be a pragmatic strategy to source funding for healthcare and focused on (a) reversing dwindling national expenditures for healthcare, (b) increasing access to primary healthcare, (c) promoting equity in health services, (d) improving communication between healthcare providers and communities, and (e) ensuring a regular supply of essential drugs at affordable costs (Ridde, 2011; UNICEF, 1999; World Bank, 2004a). Worldwide outcomes from the

Bamako Initiative were significant, including the revitalizing of a number of health centers and community health centers, which improved and sustained immunization coverage and increased the capacity to provide essential drugs and services to otherwise unreachable local communities (Ridde, 2011).

In 2008, the international and regional agency members of ICPHCHSA (2008) united to reaffirm and update the objectives of the 1978 Declaration of Alma-Ata. After reviewing past experiences in primary healthcare, the members drafted the Ouagadougou Declaration, in which they defined strategies for attaining what they called millennial development goals. In addition, members called on African countries to expedite the restructuring of their healthcare systems to better meet the primary healthcare needs of their people (Nyonator, Awoonor-Williams, Phillips, Jones, & Miller, 2002). The conference emphasized that a primary healthcare program must aim to prevent and cure diseases and to promote health and health education in the communities in which they intend to serve by focusing on nine priority areas: leadership and governance, health service delivery, human-resource development, health financing, health information, community participation and ownership, health research, health technologies, and partnership for development (ICPHCHSA, 2008).

According to WHO (2003), global action initiated in the last 7 decades demonstrated progress. For example, WHO (2003) indicated (a) a global increase in life expectancy, total adult literacy, and reduction in infant and under-5 mortality; (b) increased initiatives and efforts to promote primary healthcare delivery to vulnerable populations; (c) democratization of health programs through community-building

initiatives; (d) improved human-resource development in healthcare delivery, especially in the training of health workers such as traditional birth attendants and community health workers; and (e) stimulated national interest in grassroots healthcare delivery and the recognition of healthcare as a basic human right (pp. 2–6).

Postcolonial Development in Nigeria

Since gaining its independence from the British in 1960, Nigeria, like other nations, has engaged in notable attempts to reform healthcare for its people (Ityavyar, 1987). For example, the First National Development Plan—a series of small projects—was initiated between 1962 and 1968 as an initial attempt to restructure the nation's government and healthcare system under the new Federal Republic of Nigeria (Scott-Emuakpor, 2010). With minimal change initiated as the result of these projects, between 1970 and 1974, Nigeria developed and implemented the Second National Development Plan—also called the Post-Independence Health Plan (Asuzu, 2004).

The Second National Development Plan focused on the use of national planning to implement social change in the face of the destruction brought on by civil war (Erundare, 1971). The plan focused on developing "a united, strong and self-reliant nation; a great and dynamic economy; a just and egalitarian society; a land of bright and full opportunities for all citizens; and a free and democratic society" (Federal Republic of Nigeria, as cited in Erundare, 1971, p. 151). Shortly after, when efforts based on the Second National Development Plan failed to effect the expected changes, Nigeria developed the Third National Development Plan for the years 1975–1980 (Attah, 1976; Scott-Emuakpor, 2010). The purpose of this plan, among other things, was to emphasize

primary healthcare through the development of the Basic Health Service Scheme (BHSS; WHO, 2008a). Recognizing the value of traditional birth attendants as a means of reducing reproduction-related deaths, in 1979, the Third National Development Plan incorporated traditional birth attendants into the healthcare system (Ofili & Okojie, 2005). According to Scott-Emuakpor (2010), the Third National Development Plan "focused [more] attention on trying to improve the numerical strength of existing facilities rather than evolving a clear health care policy" (p. 55).

After the Third National Development Plan failed to effect significant change, Nigeria developed the Fourth National Development Plan for the years 1981–1985 (Scott-Emuakpor, 2010). The purpose of this plan was to address the inherent problems posed by the previous national development plans and focused on the BHSS as a means of implementing preventive care (Scott-Emuakpor, 2010). The implemented structure allocated federal and state funds for local-government operation of facilities at three levels depending on population size: comprehensive health centers for populations of more than 20,000, primary health centers for populations of 5000–20,000, and health centers for populations of 2000–5000 (Scott-Emuakpor, 2010, p. 55).

When the Fourth National Development Plan failed to foster meaningful improvement, Nigeria developed the Fifth National Development Plan for the years 1987–1991 (Scott-Emuakpor, 2010). During the time of this plan, in 1988, Nigeria adopted the philosophy of the Bamako Initiative "to strengthen primary care and promote healthcare at the community and local government levels" (Ogunbekun, Adeyi, Wouters,

& Morrow, 1996, p. 369), which helped ensure access to affordable and sustainable primary healthcare services through the revitalization of health centers (Bellamy, 1999).

Prompted by the Fifth National Development Plan and Nigeria's new philosophy of healthcare, Nigeria developed the first National Health Plan, which led to explicit formulation and adoption of a national primary healthcare policy in 1988 (Federal Ministry of Health, 2004). One of the significant outcomes of the newly implemented healthcare policy was a national 3-year rolling plan focused on promoting immunization, family-planning care (Osibogun, 2004), and child healthcare (Federal Ministry of Health, 2004). The Revised National Health Plan of 2004 called for a "comprehensive healthcare system, based on primary healthcare that is promotive, preventive, restorative and rehabilitative to every citizen of the country, within the available resources, so that individuals and communities are assured of productivity, social well-being and enjoyment of living" (Federal Ministry of Health, 2004, p. 7).

In 1999, the Nigerian federal government implemented the National Health Insurance Scheme (NHIS) to provide easy access to health care for all Nigerians at an affordable cost through various prepayment systems (NHIS, 2005). The NHIS "is designed to facilitate fair financing of healthcare costs through pooling and judicious utilization of financial risk protection and cost-burden sharing for people, against the high cost of healthcare through institution of prepaid mechanism, prior to their falling ill" (NHIS, 2005, para. 3). Since its inception, the NHIS has accredited and registered almost 6,000 providers and numerous other financial institutions (NHIS, 2005).

As the United Nations Population Fund (2010) noted, Nigeria's recognition of its "weak health systems and its consequence on access and utilization of services and ultimately serving as one of the precursors to high mortality morbidity rates led to the commencement of national efforts" (para. 3) to address the system's weaknesses. For instance, in 2006, the Federal Ministry of Health (FMOH) introduced the Midwives Service Scheme (MSS) to reduce the high rates of child and maternal mortality in the country. The strategy of the MSS was founded on the principal of making skilled birth attendants accessible to the people by deploying newly qualified, unemployed, or retired midwives to local communities (FMOH, 2006). The implementation of the MSS was an indication that the FMOH recognized the "state of maternal, newborn and child health is an important indicator of [a nation's] healthcare delivery system and the level of the society's development" (FMOH, 2009, p. 3).

Also, Nigeria sponsored the Nigerian Health Conference to review specific issues affecting Nigeria (Uzodinma, 2012). Uzodinma (2012) summarized the identified objectives of the conference: to provide a means for Nigerian stakeholders in the health sector to interact with a focus on primary health care, to develop strategies to ensure that Nigerian primary health care resembles that depicted by the Declaration of Alma-Ata, and to examine the Ouagadougou Declaration's Millennium Development Goals 4, 5, and 6 in light of Nigeria's healthcare-system performance.

As the result of isolated programs developed and promoted by the various National Development Plans and the most recent National Health Plan, certain clinical indices in Nigeria have shown improvement. For example, Nigeria has reached

elimination levels of leprosy, with less than one identified case per 10,000 people since 1998, and between 1988 and 2007, guinea worm disease has declined from 653,000 cases to 73, (WHO Country Office for Africa [COA], 2007). In addition, the implementation of polio vaccines in 2006 led to an 80% drop in occurrence the following year (WHO COA, 2007). However, the prevalence of HIV/AIDS in Nigeria continues to be high, with 2.86 million people infected in 2005 (WHO COA, 2007), and despite global efforts to improve access to primary healthcare and the success of these efforts throughout the world, primary healthcare systems in Nigeria remain ineffective.

Healthcare Conditions in Nigeria

Access to healthcare in Nigeria is extremely limited. This condition is the result of a variety factors, including the early influence of Christian missionaries, Nigeria's continued reliance on the ineffective British system of healthcare, and insufficient resources and skills in the area of health administration (Asuzu & Ogundeji, 2007; Ityavyar, 1987; Kaseje, 2006).

The Catholic Church built its first hospital in Africa in 1504, and the Church Missionary Society sent the first Western physicians to Nigeria in 1850 (Ityavyar, 1987). Although the missionaries established hospitals, dispensaries, and leprosy clinics; were responsible for educating nurses, midwives, and other paramedical personnel; and staffed facilities with physicians, the ultimate purpose of their presence was evangelical in nature (Ityavyar, 1987). In addition, health facilities were located in major urban areas where the missionaries were stationed. Further, the facilities did not follow any known national healthcare plan but rather were designed on an individual basis to suit the particular

interests of the missionaries who built them (Osibogun, 2004). The British refined this system with efforts to eliminate traditional medical practices, placing emphasis on curative rather than preventive medicine and on the establishment of health facilities in urban areas (Ityavyar, 1987).

Although the influence of Christian missionaries, Western medicine (Kaseje, 2006), and the British system of healthcare have contributed to the lack of access to primary healthcare in Nigeria, the inadequacy of the organizational and structural nature of the nation's government also has contributed to this condition. For example, both the Second and Third National Development Plans failed to clearly identify government responsibilities in healthcare planning and implementation related to specific areas such as resource generation, staffing development, health-professional deployment, and service delivery (WHO, 2008a). In addition, the African Development Bank (2002) reported the government was poorly developed, had little interest in investing in healthcare, was able to support few universities to train health professionals, and suffered from poor human-development capacity. Further, the government generally suffered from limited finances and lack of personnel to implement the programs and support its objectives, including those outlined in the BHSS (Asuzu & Ogundeji, 2007).

Uzodinma (2012) summarized the concerns identified at the Nigerian National Health Conference. These concerns included not only the poor outcomes associated with lack of access to healthcare but the underlying causes of the poor healthcare system as well, such as lack of adequate progress toward improved conditions; "lack of coordination; fragmentation of services; dearth of resources, including drug and supplies;

inadequate and decaying infrastructure; inequity in resource distribution and access to care, and very deplorable quality of care" (Uzodinma, 2012, para. 4, item 3).

Uzodinma (2012) also noted a general lack of funding as well as Nigeria's use of Millennium Development Goal funding to replace rather than supplement government funding. In addition, Nigeria faces human-resource challenges such as a poor work ethic among healthcare providers and lack of adequate supervision for healthcare providers, as well as an overburdened government with little interest in responsibility for primary healthcare (Uzodinma, 2012). Also, although some healthcare policy has been implemented at the national level, leadership and governance to implement them at the local levels remains poor; attempts to manage policy in isolation from social determinants of individual health and without credible data and evidence-based planning remains a barrier to progress (Uzodinma, 2012).

Finally, poor program acceptance and support has reduced access and use of primary healthcare in Nigeria. That few Nigerian states have enrolled in the NHIS (2005) exemplifies this poor program acceptance. That the MSS has been met with various challenges (including shortage of midwives, poor retention of midwives, high withdrawal rates, and state and local governments' inability to contribute their expected share to the scheme) exemplifies poor levels of support (Abdullahi, 2010).

Fairchild, Rosner, Colgrove, Bayer, and Fried (2010) suggested that to improve health outcomes, the current healthcare system needs to shift its focus from its previous concern with environmental sources of infection to a concern with the individual (p. 54). This shift requires that governments implement, as part of their national health system or

policy, a program that eliminates deficiencies in living conditions that are precursors to diseases and poor health (Fairchild et al., 2010). Although continued revisions to the National Health Development Plan indicate Nigeria's recognition of the importance of primary healthcare and intent to commit to addressing such deficiencies and improving primary healthcare access for its populations, inequity in healthcare remains a problem in Nigeria (Uzodinma, 2012). Rural communities continue to be affected most by the government's failure to envision that effective healthcare delivery begins with making it available and accessible to the most vulnerable populations (Ajayi, 2009). Incorporating community-based research on health-seeking behaviors into healthcare policymaking and healthcare programs may offer an avenue for improving community access to healthcare (Uneke et al., 2009).

The Importance of Primary Healthcare

According to WHO (2008b), current health services are inadequate: "People are increasingly impatient with the inability of health services to deliver levels of national coverage that meet stated demands and changing needs, and with their failure to provide services in ways that correspond to their expectations" (p. xi). WHO (2008b) suggested that primary healthcare is a means of meeting the healthcare needs of populations worldwide, but that nations have failed to develop it quickly enough and well enough to keep up with conditions in a highly dynamic global setting. Studies have indicated the potential for primary healthcare to positively impact health outcomes.

For example, Starfield, Shi, and Macinko (2005) conducted a review of literature focusing on the importance of primary healthcare in health outcomes. The authors identified six benefits that derived from effective primary healthcare systems:

> greater access to needed services, better quality of care, a greater focus on prevention, early management of health problems, the cumulative effect of the main primary care delivery characteristics, and the role of primary care in reducing unnecessary and potentially harmful specialist care. (p. 474)

The researchers found that despite high per capita income on healthcare in the United States, the nation still is not successful with major health indicators—they suggested that primary healthcare is the best option to achieve better healthcare at a cost that is accessible to the nation's people (Starfield et al., 2005).

Atun (2004) conducted a similar review of studies. In Atun's study, the researcher sought to determine, among other things, "the relationship between access to primary care and health outcomes, patient satisfaction and cost" (p. 6). The author reviewed various key journals for literature on studies that used systematic reviews, randomized control trials, quasiexperiments, evaluative studies, and case-control studies. Atun found that efficient healthcare systems produce better population health outcomes contrary to increased mortality and morbidity from a poorly managed or organized healthcare system.

Magnussen, Ehiri, and Jolly (2004) sought to compare comprehensive primary healthcare to selective healthcare as they impact global health. The authors agreed that only a primary-care system would "respond more equitably, appropriately, and

effectively to basic health needs and also address the underlying social, economic, and political causes of poor health" (p. 168). Primary healthcare has been identified as a significant tool for reducing risks associated with chronic and lifestyle factors and for improving performance in preventive care (Harris, 2008). Harris (2008) explained that primary healthcare will be useful in early detection, assessing and managing chronic disease conditions, and enabling people to take personal control.

Bourke (2006) framed questions around access to health care to understand the perspectives of consumers about their access to healthcare. Bourke found that access to healthcare is a major factor in health outcomes and that poor health status is associated with less or limited access to health services. In addition, Bourke found that understanding consumer perspectives is critical to improving health services, especially for rural populations. Rutherford et al. (2010) used Penchansky and Thomas' (1981) model as a framework to conduct a systematic review of the impact of access on mortality for children under 5 years of age in sub-Saharan Africa. The authors proposed that access is multidimensional and involves factors apart from cost and distance, which can be evaluated by a comprehensive study of the environment.

Barriers to Healthcare Access

Compared to other countries, African countries bear a greater burden of disease and death from preventable and terminal causes (World Bank, 2011). WHO identified lack of safe drinking water (58% of the population) and access to sanitation systems (36% of the population) as contributors to these poor health outcomes (Information Technology Associates, 2011). However, these poor health conditions also are due in part

to the historical and current states of primary healthcare in Nigeria (National Primary Health Care Development Agency, 2007). The following studies, organized in this section according to Penchansky and Thomas's (1981) five dimensions of access to healthcare, support these dimensions as specific barriers to healthcare access.

Availability

Availability of healthcare services influences patients' demand or use of those services. Studies have shown that many factors influence patients' demand for health services in the community. Socioeconomic factors such as education and income (Higgs, et al., 2001), availability of doctors, drugs, facilities, laboratories, and other healthcare equipment (Onwujekwe, Chukwuogo, Ezeoke, Uzochukwu, & Eze, 2011), and inadequacy of healthcare to community needs (Ladipo, 2009) all impact patients' use of a healthcare facility. These factors result in delays in seeking healthcare or obtaining required services at the most appropriate time, and thus affect the healthcare use and health-seeking behavior of rural residents (Cham et al., 2005). In a study in Tajistan, Fan and Habibov (2009) found that the availability of physicians or qualified healthcare providers was a determinant for healthcare use.

Accessibility

Distance to a healthcare facility may pose a problem to use and access of a healthcare. Distance traveled to obtain healthcare may make the difference between life and death and result in low health outcomes. Grzybowski, Stoll, and Kornelsen (2011), who investigated the impact of distance on healthcare use among rural residents in Canada, concluded that rural parturient women who have to travel to access maternity

services have increased rates of adverse perinatal outcomes. In another study in South Africa, Nteta, Mokgatle-Nthabu, and Oguntibeju (2010) sought to investigate the relations between accessibility and healthcare use. The authors found that in the Tshwane Region of Gauteng Province, South Africa the percentage "of use of a rural health facility decreased with increasing distance: 45.3% (within 5km), 39.2% (less than 10 km), and 15% (more than 10 km)" (p. e13909). Other studies have found that close proximity to a healthcare facility is an influential factor in the choice and use of a health provider (Onwujekwe et al., 2010). Okeke and Okeibunor (2010) found, "In rural areas, the effect of distance on service use becomes stronger when combined with the lack of transportation and with poor roads, which contribute towards indirect costs of visits" (p. 67).

Accommodation

The manner in which a healthcare service system responds to people's cultural, social, and personal preferences ultimately determines whether people consider it convenient to use or stay in the service. People seek healthcare in a place that recognizes and accommodates their cultural values, sex, age, social circumstances such as time of operation, and education (Liu & Dubinsky, 2000). Accommodation of peoples' sociocultural preferences was determined to influence preference for traditional healers in a study. Offiong (1999) concluded:

> In a society where healing involves not just the curing of disease but also the protection and promotion of human physical, spiritual, and material well-being, traditional healers remain the very embodiment of conscience and hope in their

> respective communities. The holistic and cathartic nature of their treatment and the fact that in certain places in the country they are the major or only source of health care, make them very important. (p. 118)

Evidence shows that providers or healthcare facilities that offer alternative methods of payment such as "compensation in kind or work" (Hausmann-Muela, Mushi, & Ribera, 2000, p. 276) increase access to such care. People will normally patronize a healthcare facility that clearly understands them and accommodates their current circumstance in healthcare delivery.

Affordability

The inability of people to pay for healthcare reduces their chances of using or seeking services when sick. Poverty and the ability to pay have been shown by scholars to influence healthcare use and access. The ability to pay, or level of poverty, significantly determines when and where a person seeks healthcare (Abdulraheem, 2007). In a cross-sectional study of 756 households, Abdulraheem (2007) sought to find the determinants of health-seeking behavior among elderly people. The researcher found, "Poverty reduced the odds of seeking health care from qualified medical practitioner but increased the odds of using home remedies from the family and consulting patent drug seller" (p. 61).

Onwujekwe et al. (2011) sought to determine the health-seeking behavior of people with malaria in urban and rural areas of southeastern Nigeria. The authors collected data using a multistage sampling method with a sample size of 400 households from each study area. They found that "choice (of healthcare) is influenced by prices

(including travel and time costs of seeking treatment), income, lack of information about appropriate treatment and the difficulties patients have in assessing quality treatment" (Onwujekwe et al., 2011, p. 94).

In a study of rural–urban differences in health seeking for treatment of childhood malaria in southeast Nigeria, Okeke and Okeibunor (2010) sought to identify differences in health-seeking behavior for childhood malaria treatment between urban and rural residents. Using qualitative and quantitative methods, the authors sampled 1,200 caretakers of children less than 5 years of age for 2 weeks. They found that "cost of care was one of the many factors preventing mothers from using orthodox medicine in rural areas" (p. 66). Healthcare for rural populations can be translated to the cost of transportation and feeding expenses while on a trip to the doctor (Okeke & Okeibunor, 2010). The cost of healthcare impacts the health-seeking behavior of the poor more than the behavior of the more affluent populations. Poor people are more likely to seek healthcare services if the cost of treatment is low and affordable than when they have to pay high out-of-pocket costs (Grundy & Annear, 2010).

In a study to determine the relationship between health-seeking behaviors and health systems, Hausmann-Muela, Mushi, and Ribera (2003) explained that, to a great extent, "health-seeking of households depends on their capacity and possibility at a specific moment to mobilize resources, both in material and social or symbolic terms" (p. 21). According to Abel-Smith and Rawal (as cited in Hausmann-Muela et al., 2003, p. 21), "even if direct costs are affordable, or if medical services are free, indirect costs (for transport, special food, 'under-the-counter' fees) can limit access to treatment or lead

patients to interrupt therapies." Direct cost and indirect cost of healthcare play a big role in when and how a client seeks healthcare. Indirect costs include transportation, accommodation, and feeding, whereas direct costs are payments for doctor visits, drugs, diagnostics, and supplies.

Acceptability

Clients perceive acceptability in the type of communication that transpires between them and their healthcare provider (Asnami, 2009), as well as the extent to which healthcare providers meet people's social, cultural, or ethnic needs (Hausmann-Muela et al., 2003). Acceptability has been found to be a key determinant in the choice of general practitioners in a study among rural Australian residents (Humphreys, Matthews-Cowey, and Weinand, 1997). Humphreys et al. (1997) concluded that healthcare will be more acceptable to people if "the rural doctors acquire suitable clinical and communication skills to meet the diverse needs of their patients, as well as an understanding of rural culture" (p. 577). Indeed, patients will not accept a service that alienates and disrespects them.

Community-Based Research as a Potential Tool for Change

Community-based research focuses on a topic relevant to the community, actively involves community members in the research process, and promotes positive social change (Centre for Community Based Research, 2011). The insufficiency or lack of community input in healthcare delivery poses a great barrier to care and results in the inequity of health outcomes and low outcomes from health expenditures (WHO 2008b). Studies on perceptions using community-based research indicated that such research can

promote community-based healthcare and improve health outcomes among various populations (WHO 2007).

Rust and Cooper (2007) emphasized the importance of community-based research and investigated how practice-based research contributes to the elimination of health disparities. Their study established strategies that may improve access to healthcare and reduce disparities in healthcare by recommending interventions that triangulate patients, providers, and communities to improve health outcomes.

Providing healthcare through consumer input has been applauded by the WHO (2007) as a tool to improve patients' satisfaction and use of healthcare. Providing services that meet community need has "been recognized as one of the six attributes of a health care quality, the others being safety, timeliness, effectiveness, efficiency and equity" (WHO, 2007, p. 5). Community-based research enhances bottom-up planning and improves better commitment and participation in healthcare decision making (Few, Harpham, & Atkinson, 2003). Wallerstein and Duran (2006) described community-based participation as a new model and "an alternative research paradigm, which integrates education and social action to improve health and reduce health disparities" (p. 312). In spite of the great importance and role of community-based participatory research in improving healthcare delivery through a collaborative effort of providers, researchers, and community members, many problems work against its implementation. According to the Agency for Healthcare Research and Quality (2009), factors such as insufficient community incentives, insufficient academic resources, and inadequate funding and funding mechanisms that are not sensitive to community involvement are among the most

pressing obstacles. Community-based research is a novel idea to incorporate community inputs in the policy, planning, and implementation of community-oriented healthcare.

Literature Related to Methodology and Methods

To present a unified discussion of the qualitative research tradition—including justification for using the chosen paradigm and explanations of why other likely choices would be less effective, as required by Walden University's evaluative structure—literature related to the methodology and methods is presented in this section.. In this study, I used a qualitative, community-based research design and case-study approach to explore the issue of healthcare access for the rural people of Isu.

Qualitative Research Design

Unlike quantitative research, which "explores traits and situations from which numerical data are obtained" (Mertler & Charles, 2005, p. 386), qualitative data aim to provide in-depth understanding of those traits and situations, in their natural setting (Trochim & Donnelly, 2008). Qualitative research begins with assumptions, a worldview, possibly using a theoretical lens, to investigate "the meaning individuals or groups ascribe to a social or human problem" (Creswell, 2007, p. 37). Thus, qualitative research is inductive, in contrast to quantitative research, which is deductive (Abusabha & Woelfel, 2003). It "rests on the principle of subjectivity … [whereas] quantitative research rests on the principle of objectivity" (Abusabha & Woelfel, 2003, p. 566). The qualitative researcher is a participant and is immersed in the data-collection process, in contrast to a quantitative researcher, who is removed and does not influence the data or information collected (Abusabha & Woelfel, 2003). Unlike quantitative research,

qualitative research does not seek to define rigid categories about populations or conditions under study, nor does it make large generalizations (Abusabha & Woelfel, 2003, p. 566).

By using input from people who experience or suffer in a situation, a qualitative research design is able to break the communication barriers that marginalize people from participating or contributing in issues that affect them. Qualitative, community-based research is collaborative because "it is inquiry completed 'with' others rather than 'on' or 'to' others" (Creswell, 2007, p. 22). This method of inquiry is appropriate to study a rural community like Isu because it is "self-reflective, collaborative, empowering, and supports actions for improvement" (Linville, Lambert-Shute, Frahauf, & Piercy, 2003, p. 210).

In this study, I explored the meaning of access to healthcare through the theoretical lens of Penchansky and Thomas's (1981) dimensions of access using subjective, inductive-analysis coding of data to understand the specific conditions associated with a limited population. Qualitative research was beneficial because it allowed collection of data that cannot be quantified, such as emotions, facial expressions, and environmental conditions (Yin, 2003). This characteristic was especially helpful in Isu, where many residents potentially could have been unable to read and write. In addition, qualitative research is beneficial because it positions the researcher as an instrument of data collection (Creswell, 2007). This characteristic was especially helpful in Isu where many residents may have been intimidated by data collection that lacked personal connections and where storytelling is an accepted cultural phenomenon.

A qualitative research design was chosen for this study because it was appropriate to answer the research questions, engage participants in discussions that recall experiences, and collaboratively share opinions on the issues that impact their access to healthcare in Isu. Using a qualitative study approach also enabled me to collect data in peoples' natural setting—community halls—take field notes, record experiences, transcribe, and write a comprehensive analysis of themes that emerged from the interviews, and share findings with the people. It also was most suitable to describe issues in detail that would not be possible using a quantitative study design. It provided an opportunity for various participants, irrespective of their different levels of education, to express themselves satisfactorily and engage in problems solving over the 5 weeks of the study.

Qualitative research is not without drawbacks. For instance, conducting qualitative research can be time consuming (Mehra, 2002; Trochim & Donnelly, 2008) and can encourage researcher bias in data collection and analysis. However, the time investment was insignificant in comparison to the wealth of knowledge I gained from conducting this type of research. In addition, I believe the awareness of the potential for researcher bias helped me avoid introducing bias into my study. Also, I believe using a second coder and conducting debriefing and member-checking sessions with participants helped me identify and eliminate bias in my study.

Case-Study Approach

According to Trochim and Donnelly (2008), a case study is an in-depth study of a specific individual, group, or context. Creswell (2007) added that, regardless of the

number of cases included, the exploration occurs in a bounded system (p. 73). Case studies are used to inquire into other similar individuals, groups and contexts. They typically involve the use of multiple methods of data collection, including interviews, as well as the description, analysis, and presentation of data (Creswell, 2007; Yin, 2003) and are used to gather in-depth data about "individual, group, organizational, social, political, and related phenomenon" (p. 1). In this case study, I used multiple methods of data collection (interviews and focus groups) to gather in-depth knowledge about a group of people (rural residents of Isu) and related phenomenon (healthcare access).

Before deciding on the case-study approach for my research, I considered other qualitative approaches, such as narrative, ethnographic, phenomenological, and grounded-theory approaches. Narrative research relies on accounts shared by individuals describing how they make meaning about a problem in their lives (Creswell, 2007). This approach was inappropriate for my study because I collected data using specific interview and focus-group questions to guide participant responses about particular experiences and perceptions. Ethnographic research refers to research that is conducted over an extended period and includes observation (Yin, 2003) for the purpose of describing a culture and its shared values and beliefs (Creswell, 2007). This approach was inappropriate in my study because I did not observe the participants, and I was limited by time. In addition, I was not seeking to describe cultural values and beliefs but rather perceptions associated with conditions of experience.

Phenomenological research refers to research that focuses on a defined common experience or problem of a group of people (Creswell, 2007). This approach was

inappropriate for my study because participants had varying experiences in their use of healthcare services, a phenomenon which I purposely did not define during data collection to promote the collection of a range of perspectives regarding the concept of access to healthcare. Grounded theory refers to research that aims to develop a theoretical foundation based on collected data (Creswell, 2007); this approach was not appropriate because my intent was not to generate theory but to explore conditions as they existed among participants and as they were expressed through participant perceptions.

A case study has the elements and characteristics to explore a world view of the people of a population regarding a phenomenon under study: in the case of this study, Isu and access to healthcare. It was effective in understanding Isu peoples' perceptions about the characteristics of the healthcare system that met or did not meet their healthcare needs. It provided the people the opportunity to express their views freely in words and emotions in their natural environment. A case study helps the researcher observe and record emotional expressions of the people that would not be captured in a quantitative study. In Isu, where little or no research has been done and not all people speak English, a qualitative case-study approach became the most effective choice to interact and record public views on an issue such as primary health care.

According to Yin, a case-study approach should be used when a study is focused to address how and why, when the context of the problem is essential to understanding the phenomenon, and to "gather extensive materials from multiple sources of information to provide an in-depth picture of the case (Creswell 2007, p. 96). Case-study methods have been used extensively in community-based prevention programs and are suitable for

explaining perspectives of the actual people involved or affected by the phenomenon (Tellis, 1997). To get a complete and true picture of healthcare access in Isu, a qualitative case study was used to explore various dimensions of perspectives about access to healthcare and to gather in-depth data. Using a qualitative case study ensures that issues are not explored in a single viewpoint, but through several lenses that allow "for multiple facets of the phenomenon to be revealed and understood" (Baxter & Jack, 2008, p. 544).

Summary

Healthcare, especially primary healthcare, is fundamental to the enjoyment of life and improved productivity. The neglect or inadequacy of primary healthcare services, especially to rural and the most vulnerable populations, has been a major problem confronting the world. Traditional healthcare existed in Nigeria prior to colonial times. The advent of colonialism was not only political and economic but impacted all aspects of the lives of people, including healthcare. Colonization was antagonistic to the traditional health system because traditional medicine did not conform to the Christian beliefs colonialists brought to Africa and was a barrier to the introduction of Western medicine and practice. Colonization thus decimated traditional healing, which was centered on primary care and holistic health. The Western medical system was discriminatory because it focused on the selective health of colonial employees and colonialists, based in urban areas, to the neglect of the rural health infrastructure.

Many years of reforms and development plans did not yield meaningful solutions to Africa's health problems because they were not developed from the ground up. Access to healthcare is not determined by the presence of a health facility alone, but by other

social, economic, cultural, demographic, logistic, and geographic factors, as well the as the availability of human and material resources, and above all, need. The mere fact that a health facility exists does not mean people can access it. Access to health care must be seen from the viewpoint of Penchansky and Thomas' (1981) five dimensions to consider all factors that may promote or inhibit healthcare access. To provide healthcare that meets community needs, community input is required through community-based research to identify problems, suggest solutions, and build community capacity to support and sustain the program. This project will contribute significantly to the literature and fill the gap in the literature regarding access to health care in Nigeria and in Isu in particular.

Concern for improving healthcare access has attracted individuals and international attention with the important role played by the Alma Ata Declaration in 1978. Since Alma Ata in 1978, the WHO, UNICEF, and various regional governments have embarked on reforms to improve healthcare and to achieve global health for all people. Even though these efforts have been laudable, what is lacking in my country of Nigeria, and in many other parts of Africa, is the inability to integrate community input into health-policy planning, development, and implementation. Following, Chapter 3 describes the methods used to collect data for this study.

Chapter 3: Methodology

The purpose of this qualitative case study was to explore the perceptions of rural community residents and healthcare providers regarding residents' access to primary healthcare services in Isu and to engage in community-based research to demonstrate its potential to promote resident access to healthcare services. In particular, the focus of this study was (a) the residents' perception of accessibility, affordability, accommodation, acceptability, and availability of government healthcare services, and (b) the characteristics of the healthcare system that hinder and promote residents' use of healthcare services.

This chapter includes a summary of the research design and approach, as well as the rationale for the selected design and approach. Finally, this chapter includes a detailed discussion of the data-collection process; data-collection tools; data-analysis process, including research questions and expectations; and procedures put in place for the protection of human participants.

Research Design and Approach

To investigate the phenomenon in this study, I designed the study in the following ways. I identified the phenomenon under investigation and selected a community to be studied. Then I chose a population and selected participants who would provide the required responses to the research questions I designed. I collected data using focus group and face-to-face interview techniques. Responses from participants were recorded and analyzed as they related to specific questions, and I identified specific themes in the study. The results of the data were presented to the participants to ensure validity and

data accuracy. Finally, a detailed discussion of the results was conducted to explain the perceptions of participants about access to health care in the Isu Local Government Area.

Research Questions

Research Question 1. What are the perceptions of healthcare providers (government healthcare administrators, nurses/midwives, and traditional healers) regarding residents' access to and use of primary healthcare services provided in rural Isu?

1a. What are healthcare providers' perceptions regarding the characteristics of the local government healthcare system that work well?

1b. What are healthcare providers' perceptions regarding the main challenges and barriers faced by the local government healthcare system?

1c. What are healthcare providers' perceptions regarding solutions to the main challenges faced by the local government healthcare system?

1d. What are healthcare providers' perceptions regarding the potential for closer relationships between the local government healthcare system and traditional healers?

Research Question 2. What are the perceptions of local community members regarding their access to and use of healthcare services in rural Isu? Specifically:

2a. What are residents' perceptions regarding characteristics of the local government healthcare system that fulfill residents' needs?

2b. What are residents' perceptions regarding the main challenges and barriers faced by the local government healthcare system?

2c. What are residents' perceptions regarding solutions to the main challenges faced by the local government healthcare system?

2d. What are residents' perceptions regarding confidence in the local government healthcare system and in traditional healers?

Research Question 3. What are the perceptions of healthcare providers and residents regarding community-based research as a means of promoting the use of healthcare services among the rural residents of Isu?

Role as a Researcher

As the researcher, I was the key instrument of data collection. For the purpose of this study, and as indicated by Creswell (2007) and Fink (2000), I served as an interface for interactions between participants who experienced the problem or phenomenon under study. I was responsible for designing semistructured interview questions and meeting with the participants to conduct individual interviews with healthcare administrators and to conduct focus groups with nurses and midwives, residents, and traditional healers in their local communities. In addition, I made assumptions, set delimitations, and analyzed, interpreted, and presented the data. As suggested by Yin (2003), to indicate the accuracy of the evidence, I used multiple sources to collect data on participant perceptions about healthcare delivery in Isu. Because qualitative research involving a human element such as the researcher and participants is subject to bias, to validate the data, I considered its credibility, dependability, confirmability, and transferability.

Qualitative research may be open to human or researcher bias due to influences such as prejudice and personal beliefs (Abusabha & Woelfel, 2003). To address this

problem, I adhered to good conduct and behavior during the interview. As recommended by Fink (2000) and Trochim and Donnelly (2008), I (a) did not indicate agreement or disagreement with participants during the interviews; (b) did act as an active observer, listener, and recorder; (c) did record only the expressed opinions of the participants; (d) drew conclusions inductively from observations; and (e) summarized findings, identified patterns, and corroborated all information to form an accurate representation of participant perspectives.

Setting

This study was conducted in Isu, Imo State, Nigeria. Based on characteristics identified by Umebau (2008), such as low income and poor infrastructure (conditions that facilitate various observable social, economic, and environmental issues), at the time of this study, Isu could be considered a rural community—one of the 774 local government areas in the 36 states of Nigeria and one of 27 local governments in Imo State (Embassy of the Federal Republic of Nigeria, 2011)—a southeastern region of Nigeria (Okafor & Fernandes, 1987). Currently, Isu is made up of 13 autonomous communities and covers an area of 221 square kilometers (Tulsi Chanrai Foundation, 2007). Its geography comprises vast areas of flat land suitable for farming staple foods such as yams, coco-yams (taro), sweet potatoes, cassavas, and a variety of vegetables, as well as maintaining a variety of trees indigenous to the area (palms, iroko, coconuts, oil-bean, raffia, bamboo, and mahogany; Okafor & Fernandes, 1987). As a result of land excavation and deforestation, the area suffered from a serious erosion problem (Igbokwe et al., 2008) that (a) contaminated water supplies (Hudec, Simpson, Akpokodje, & Umenweke, 2006),

(b) led to the destruction of houses and roads (Igbokwe et al., 2008; Hudec et al., 2006), and (c) promoted the proliferation of mosquitoes (Oladepo, Tona, Oshiname, & Titiloye, 2010).

In addition, Isu suffers from what Umebau (2008) referred to as urban bias: the concentration of allocated social amenities (health access, transportation, and job opportunities) in urban areas. For example, based on my personal observations (no government records are available about these details), Isu had very little government presence apart from the local government headquarters, a local police station, a motor vehicle-licensing post, a post office, six middle schools, and 16 elementary schools. In addition, administrative positions in healthcare planning are appointed and often politically motivated, and government healthcare administrators might not be residents of Isu or rely on local government healthcare facilities for healthcare services. For these reasons, government healthcare administrators might not have had firsthand experience with residents in the community and their healthcare needs.

Healthcare in Isu is based on the Ward Minimum Healthcare Package. As a means of delivering affordable and accessible healthcare to remote populations, in 2000, the National Primary Healthcare Development Agency introduced the Ward Minimum Healthcare Package, which describes a set of priority health interventions "that should be provided in primary health care centers on a daily basis at all times" (World Bank & Inter-American Development Bank, 2008, p. 14) but also subsidized by government funding so there is no or little cost to users (National Primary Health Care Development Agency, 2007). The updated 2007 Ward Minimum Healthcare Package used in Isu

includes an outline of basic intervention areas in which primary healthcare systems were encouraged to concentrate and achieve in full by 2012, including (a) control of communicable diseases (malaria, STI/HIV/AIDS), (b) child survival, (c) maternal and newborn care, (d) nutrition, (e) incommunicable-disease prevention, and (f) health education and community mobilization (World Bank & Inter-American Development Bank, 2008, p. 14).

Although the Minimum Healthcare Package staffing guidelines do not include medical doctors, the guidelines do indicate that health posts should have on staff one junior community-health extension worker (CHEW); primary healthcare clinics should have on staff two CHEWs and four junior CHEWs; and ward health centers (primary healthcare centers) should have on staff one community-health officer, one public health nurse, three CHEWs, six junior CHEWs, three nurses/midwives, and one (optional) medical assistant (National Primary Health Care Development Agency, 2007). In addition, the Minimum Healthcare Package includes guidelines related to equipment, drugs, infrastructure, and services for the primary health center (World Bank & Inter-American Development Bank, 2008).

Despite these guidelines, healthcare services are minimal. According to the most recent literature available, the government supports one hospital and an estimated 17 healthcare facilities: four functioning healthcare clinics (one primary healthcare center and three community health centers) and 13 healthcare posts in the local communities Tulsi Chanrai Foundation, 2007). The healthcare posts are locations established for the intermittent implementation of health-education programs (and may be a private, donated

space) such as those pertaining to disease management or healthcare programs such as vaccine distribution. These facilities offer limited hours of operation during the week (Nigerian High Commission, 2011); there are no provisions for physicians, laboratories, pharmacies, or emergency services (Adeyemo, 2005). Based in part on the lack of available government healthcare services, residents often turn to private-practice providers (Adeyemo, 2005) and traditional healers (Onwujekwe et al., 2011) for healthcare services.

Isu, as part of Nigeria, is characterized by poor socioeconomic conditions. According to the World Bank (2004a), 54.7% of Nigerians live below the national poverty line. The Federal Office of Statistics indicated the percentage to be much higher (70%; Omarioghae, 2008). This condition, however, is more prevalent in rural areas than in any other areas (Cohen et al., 2007).

As of 2006, Isu had a population of 164,328 people: 84,299 (51.3%) males and 80,029 (48.7%) females (National Population Commission, 2010). According to Chukwuezi (2001), the majority of younger males from rural areas tend to leave to go to school or migrate to urban areas to learn trades or become street vendors. Consequently, the residents of rural Isu tend to be predominantly young children, unemployed teenage girls, and old adults. Adults who remain in these areas tend to be either those incapacitated by ill health or those who survive as traditional healers, subsistence farmers, or petty traders. Sale of farm produce and petty trading of household items constitute the major source of income for the residents. The people of Isu predominantly speak Igbo. The population as a whole regards the family system with high esteem

(Ufearoh, 2010), is highly social, and is highly religious (Chukwuezi, 2001). The majority of the people of Isu are of the Christian faith (Chukwuezi, 2001).

The participants in this study provided a clear description of the local setting with regard to healthcare facilities in Isu. According to healthcare providers who participated in this study, in Isu, there are three health posts, eight health centers, and two primary healthcare centers. Health posts do not have a regular staff and are mobilized as the need arises. Typically, health posts are staffed by one junior CHEW.

Health centers, also known as community health centers, are located in community built facilities and serve entire communities. However, residents of the local government are free to visit any community health center at any time. The community health centers are headed by either a registered nurse or midwife, or a CHEW. None of these health centers meets the minimum staff requirement indicated by the National Primary Healthcare Development Agency.

Primary healthcare centers, also known as Ward health centers, may or may not be located in community built facilities, although they do serve as a community-based health facility. Primary healthcare centers include a more diverse staff and offer more diverse services. For example, in addition to general services, primary healthcare centers also include a maternal–child healthcare unit.

Study Participants

Participants for this study were healthcare providers and residents. Healthcare providers included healthcare administrators indirectly involved in providing healthcare services to the residents of the community, nurses/midwives, and traditional healers

directly involved in providing healthcare services to the residents of the community. Health administrators are the local government chairman and two other senior officials in the local healthcare system. Because the Isu Local Government Area chair oversees all aspects of the Isu Local Government Area including the primary healthcare system, for the purposes of this study, I considered the local government chair a healthcare administrator and included the chair in this study as a healthcare provider. Nurses and midwives were trained in Western medicine and understand the nuances of specialized medical certification. The other group of participants was residents who depend on the local health system for service and have some experience using the health system. To conduct this study, I chose and interviewed 27 participants: three health administrators, six nurses/midwives, six traditional healers, six female adult residents, and six male adult residents.

Sample

Inclusion and Exclusion Criteria

Inclusion and exclusion criteria for participants in this study varied based on participant type. However, all participants were required to be of legal age (18 years and older) to participate in the study. Typically, the age of government healthcare administrators, nurses and midwives, and traditional healers is 30 years or older. In addition, participants must have been willing and able to give informed consent and participate fully in all aspects of the study. No potential participants were excluded on the basis of race or gender.

Government Healthcare Administrators: Only those administrators who held senior administrative or leadership positions in the health department or a position directly involved in healthcare decision making at the local government level were eligible to participate in this study. This criterion helped ensure that only those thoroughly knowledgeable about all aspects of the government healthcare system were recruited for this study and thus, that I collected, as well as possible, the most accurate and detailed data about the conditions of the government healthcare system. Administrators also must have worked in this described capacity for at least 3 years. This criterion also helped ensure that these participants were knowledgeable about all aspects of the government healthcare system. Because government healthcare-administrator positions are political appointments, they are subject to change based on the political conditions of the area, which typically are dynamic. Thus, I chose a 3-year time frame to increase the likelihood of recruiting eligible government healthcare administrators.

Because the functions associated with government healthcare administration currently are not reliant on administrator/resident contact or relationships, administrator-residency status was not considered an inclusion or exclusion criterion in this study. With regard to inclusion criteria and so that I could collect data from anyone who was serving as the active chair during the time of my data collection, I did not restrict the years of service for the local government chair (considered a healthcare administrator for the purposes of this study). Regarding nurses and midwives, only those nurses who currently were working in government-supported healthcare facilities and midwives who were working either in government-supported healthcare facilities or in private practice,

providing healthcare services to residents in the local area, were eligible to participate in this study. This criterion helped ensure the recruitment of participants who best reflected my intended population of healthcare providers—those who work with the residents of rural Isu. Eligible nurses and midwives were licensed to practice and had no less than 3 years' experience providing direct healthcare services. This criterion helped ensure that these participants were knowledgeable about the government healthcare system as well as familiar with the residents they served. Because nurses and midwives are certified professionals, they are in a position to and tend to move around regularly based on availability of work. For this reason, I chose a 3-year time frame to increase the likelihood of recruiting eligible nurses and midwives. I excluded nurses who worked at the government hospital because typically, they do not work with the community residents who were the focus of this study.

Traditional healers: Only those who had been residents of Isu and served the local population for 5 years were eligible to participate. This criterion served to help recruit traditional healers who were familiar with the local government healthcare system as well as familiar with other residents. Also, to ensure that I recruited traditional healers who could share their perspectives on past experiences, I excluded traditional healers who indicated that they were unable to recall experiences related to their provision of healthcare to residents.

Residents: Only those who were familiar with the local government healthcare system and had been active residents of Isu for at least 5 years were eligible to participate in this study. This latter criterion helped ensure that recruited residents were familiar with

the local government healthcare system. To decrease the chance of cross-contamination of group participant type, I excluded residents if they worked as government healthcare administrators, nurses or midwives, or traditional healers. Finally, to ensure that I recruited residents who could share their perspectives on past experiences, I excluded residents who indicated that they were unable to recall experiences related to their use of or choice not to use available government healthcare.

Participant Selection and Recruitment

In qualitative research, the sample size is not intended to be representative of the population, but rather to establish an in-depth understanding of the population in relation to the research questions posed (Marshall, 1996). According to Onwuegbuzie and Leech (2007), a sample for qualitative study should not be "too large that it is difficult to extract thick, rich data or too small that it is difficult to achieve data saturation" (p. 242). As a general rule, Onwuegbuzie and Collins (2007) recommended a sample size of 12 participants for interviews and between three and 12 participants for focus group discussions. Based on time constraints imposed as the result of my travel to Nigeria to collect data, I determined to accommodate no more than three health administrators, six nurses and midwives combined, six traditional healers, and 12 residents in my study. I calculated that the perspectives and opinions of 27 participants selected from Isu would be able to provide reasonable data to understand the issues related to healthcare access in the Local Government Area.

I used purposive sampling methods. Purposive sampling is a nonprobability sampling method that is used when a researcher aims to gather perspectives of a

particular group of people (Babbies, 2010; Trochim & Donnelly, 2008, p. 49). The sample represents a choice of participants based on their knowledge and experience of the concept under investigation in the study (Babbie, 2010; Creswell, 2007; Polkinghorne, 2005). Because the success of my study depended on the perspectives of participants, in particular those with knowledge and experience specific to primary healthcare access in rural Isu, it was imperative that I selected only participants with this knowledge and experience. For that reason, the use of purposive sampling was appropriate for my study.

I recruited participants for my study in several ways based on the type of participant being recruited. To recruit government healthcare administrators, I contacted the Chairman in charge of Isu local government who also is in charge of the local primary health system, and requested his participation in the study (purposive). To recruit additional healthcare administrators, I sought from the Chairman a list of potential participants in the health department who met the inclusion criteria and whom I might ask to participate in interviews. I conducted this recruiting at the local government headquarters in Umundugba, Isu.

To recruit nurses and midwives employed by the local government, midwives in private practice, traditional healers, and residents, I (a) had flyers posted (see Appendices A, B, and C for the original flyer, the translated flyer, and the back translation, respectively) in healthcare and community centers, and in other public spaces before my arrival to Nigeria, and I posted additional flyers upon my arrival, (b) asked pastors to distribute flyers to their parishes, (c) held open informational meetings to introduce

myself and the purpose of the study, and (d) networked individually with people in the community (purposive). For the convenience of participants, I conducted meetings for (a) nurses and midwives at the local government headquarters in Umundugba, (b) traditional healers at the traditional healers' hall in Ekwe, and (c) residents in the community center in Nnerim. I held four informational meetings for recruitment purposes prior to conducting the focus groups (two in English for nurses and midwives and two in Igbo for traditional healers and residents, with translation as needed for individual participants in either group). Also, I asked community leaders and pastors to suggest potential participants I might ask to participate in the study (purposive). In addition, I asked all potential participants who attended informational meetings and/or whom I spoke with personally to share information about the study with residents they knew who may have had extensive experience with the primary healthcare system in Isu and thus be able to offer valuable insight to the study (snowball).

Data Collection Tools

I used instruments I developed to collect data for this study. To ensure the appropriateness of my interview and focus-group questions, I sought feedback from two qualitative research experts and made changes as suggested. As suggested by Kohrt et al. (2011), I ensured that the questions reflected the cultural and environmental setting of the study and could be understood by the participants (clear and unambiguous) so that participant responses would accurately reflect their perspectives about conditions in Isu. As suggested by Onwuegbuzie and Leech (2007), I also continuously monitored and

assessed the instrument throughout the interview progresses and made adjustments as necessary to fit participants' needs.

Because it was possible that some traditional healers and residents might not speak English (fluently or at all), I collected data from these participants in both English and the participants' local language, Igbo, as necessary. Because I am fluent in both the written and oral form of the language, I translated the questions and responses from Igbo to English and vice versa for participants who may have had difficulty expressing views clearly in English.

I used interview questions to collect data from government healthcare administrators (see Appendix D), and used focus-group questions to collect data from nurses and midwives (see Appendix E), traditional healers (see Appendices F, G, and H for the original questions, the translation, and the back translation, respectively), and residents (see Appendices I, J, and K for the original questions, the translation, and the back translation, respectively). I organized the interview questions and focus group questions by the research question they helped answer.

The interview questions for the government healthcare administrators, nurses and midwives, and traditional healers supported Research Questions 1 and 3 and focused on (a) how the healthcare system currently functions, (b) solutions to overcome identified challenges and barriers to healthcare implementation, (c) the role of traditional healers in the healthcare process, and (c) the value of community-based research. The focus group questions for residents supported Research Questions 2 and 3 and focused on (a) residents' use and perceptions of available healthcare services, (b) the effectiveness of

available healthcare services, (c) solutions for overcoming identified challenges and barriers to healthcare access, and (d) the value of community-based research.

Data Collection

Prior to collecting any data, however, I sought approval from the appropriate authorities. Specifically, I sought approval from Walden University's Institutional Review Board to conduct my study (07-06-12-0065704) and the Chairman of Isu to interview the chair and several key officials involved in healthcare planning (see Appendix L). I also sought support from local community leaders, pastors, and the leader of the local traditional healers (see Appendices M and N). Two local community leaders provided letters of support prior to data collection (see Appendix O). I collected data from residents and healthcare providers using a combination of interviews and focus groups over the course of 11 days (see Appendix P, Days 1–11). Although focus groups and interviews do not support the collection of data from as large a number of participants as do surveys, because my intent was to explore details associated with my topic rather than to seek broad insight, these data collection methods were appropriate for the study (Creswell, 2007).

Interviews

I conducted face-to-face interviews to collect data. According to Yin (2003), an interview is a qualitative tool for collecting information or data and can be either unstructured (without a plan for directing data collection), semistructured (with a plan for collecting data using open-ended questions and allowing for probing), or structured (with a plan for collecting data without allowance for probing). The interviews were

semistructured, which, according to Yin, indicates the use of open-ended questions to probe the *how* and *why* behind conditions, perceptions, or experiences. I chose this method because it promotes the opportunity to ask immediate follow-up questions to clarify issues (Trochim & Donnelly, 2008); an advantage unavailable with questionnaires in quantitative study methods. Also, this method was appropriate for interviewing the government healthcare administrators so that lower level administrators might feel comfortable speaking freely without fear of disciplinary action or intimidation for voicing concerns about the government and its healthcare system.

According to Creswell (2007), the quality of data collecting using interviews depends to a great extent on the framing of the interview questions and the experience of the interviewer in recording and transcribing information from the interview. In addition, the presence of an interviewer may influence the opinion or expression of perceptions of study participants (Trochim & Donnelly, 2008). To ensure the highest possible quality of collected data in this study, I sought feedback from experts in the field regarding the appropriateness of my interview questions and made adjustments as needed. In addition, I was born in Isu and, based on my personal understanding of the cultural and social beliefs and practices of the people of Isu, I anticipated that my presence as an interviewer would enhance my ability to collect accurate and thorough expressions of participant perceptions.

I began data collection by interviewing the chair of Isu and two other government healthcare administrators using semistructured interview questions. I conducted the interviews at the local government headquarters in Umundugba in private offices or a

private conference room provided by administrators. I asked for their permission to record our discussion. When participants offered information that was unclear or incomplete, I prompted participants for clarification and additional details. If a participant offered information that was not solicited but was relevant to the topic, I prompted the participant to provide additional details as appropriate. After I completed the individual interviews, I began conducting focus-group sessions.

Focus Groups

Another method of collecting data in a case study and one that I used in my study, is the focus group. Trochim and Donnelly (2008) defined the focus group "as a qualitative measurement method where input on one or more focus topics is collected from participants in a small-group setting where the discussion is structured and guided by a facilitator" (p. 120). According to Yin (2003), the focus group is an essential tool for collecting information from various individuals or groups for the purpose of converging evidence into a set of findings.

The focus group also is useful for improving participant interactions, conserving time (Creswell, 2007), and generating "detailed information about attitudes, expectations, opinions, and preferences of selected groups of participants" (Trochim & Donnelly, 2008, p. 148). According to Gibbs (1997), focus-group research is beneficial in that it helps the researcher gain insight into participants' shared experiences and understand conditions associated with a specific problem.

According to Abusabha and Woelfel (2003), the outcome of focus-group research depends on the expertise of the facilitator and the facilitator's ability to moderate the

group successfully. In addition, members of a focus group may be influenced by the presence of the researcher and may not be confident sharing their opinions (Trochim & Donnelly, 2008). However, because I have worked in supervisory positions, including positions requiring the organization of groups during community-development projects and served as both a religious preacher in the community and president of the local students' union, I felt confident that I would be able to manage my small focus groups. In addition, I anticipated that separating focus groups by general characteristics of participants (nurses and midwives, traditional healers, male residents, female residents) would promote the comfort level of participants and promote discussion in the groups. Finally, because I am familiar with the people in the area, I anticipated that their comfort level in the focus groups would be facilitated rather than hindered by my presence.

I conducted four focus groups: (a) nurses and midwives (at the local government headquarters, Umundugba), (b) traditional healers (at the traditional healers' hall, Ekwe), (c) male residents (at the community center, Nnerim), and (d) female residents (at the community center, Nnerim). I chose to divide the residents by gender to promote sharing by women who might otherwise have felt it was inappropriate to express opinions unlike those expressed by male residents from the community. I sought the consent of all participants to digitally record our discussions.

For each group, I assigned each participant a unique number. The participants wore identification badges with these numbers displayed. When participants responded to focus-group questions or made comments to one another, I identified who was speaking by calling out the participant's number into the digital recorder. I used prepared focus-

group questions to prompt participants to elicit information. When participants offered information that was unclear or incomplete, I prompted participants for clarification and additional details. If a participant offered information that was not solicited but was relevant to the topic, I prompted the participant to provide additional details as appropriate. I encouraged all participants to share their perspectives and worked to provide equal opportunities for each participant to share. I determined data saturation when I was no longer collecting new data and ended the focus groups at that time.

Data Analysis

Once all data were collected, I used Colaizzi's seven-step phenomenological method for analyzing qualitative data (Colaizzi, 1973, 1978). I used this method because, according to Colaizzi (1978), it is suitable for analyzing the perceptions of people regarding a phenomenon under study. Because the primary purpose of this case study was to develop an in-depth understanding of the perspectives of healthcare providers and residents in Isu, I used phenomenological data analysis approach to helped me understand those perspectives. This seven-step method is similar to those described in Creswell (2007) and Babbie (2010), but appeared simpler to understand:

1. Collect participant's descriptions of the phenomenon, access to healthcare. The researcher reads and rereads all the participants' descriptions and metaphors of the phenomenon to attain a sense of the whole.
2. Extract significant statements in relation to participants' perceptions about access to primary healthcare in Isu. Significant statements are extracted from

the original transcripts that together form the whole meaning of the phenomenon under investigation.

3. Formulate meanings. Significant statements are to be spelled out by the researcher. The researcher also is to formulate more general restatements and meanings for each significant statement from the transcript.
4. Organize formulated meanings into clusters of themes. The researcher is to find clusters that are common to all participants' experiences. Clusters are arranged from formulated meanings. (In this study, I organized theme clusters based on my research questions and Penchansky and Thomas', 1981, five dimensions of healthcare access.)
5. Exhaustively describe the investigated phenomenon. The researcher writes an exhaustive description of the phenomenon under investigation.
6. Describe the fundamental structure of the phenomenon. The researcher reduces the exhaustive description into an essential structure of the phenomenon.
7. Return to the participant. The researcher validates the findings with the participants, which may allow participants to clarify or reveal new data and ensure that inclusion of their intended meaning was conveyed in the fundamental structure of the phenomenon under study.

Before returning to participants to validate my findings, I engaged a second coder to determine intercoder reliability of the data. I asked the second coder to code approximately 20% of the transcribed data using Colaizzi's (1973, 1978) seven-step

method to organize formulated meanings into clusters of themes. Then, to identify potential weaknesses and discrepancies in my data interpretation and analysis, I compared with the second coder the various theme clusters the second coder and I developed. Finally, I made adjustments to the theme clusters based on discussion with the second coder, as I deemed appropriate.

According to my planned schedule, I met with the chair, other healthcare administrators, nurses and midwives, traditional healers, and residents (in gender-specific groups) to debrief them. I met each of the government healthcare administrators and the group participants in the same location in which the initial data-collection meetings took place. As indicated by Trochim and Donnelly (2008) and Yin (2003), this debriefing consisted of a review of my preliminary analysis based on the data I collected. Then, I conducted member checking (Colaizzi's Step 7, 1973, 1978). Member checking consists of providing study participants the opportunity to reject, confirm, or make corrections to data shared during debriefing (Trochim & Donnelly, 2008; Yin, 2002). Finally, I made adjustments to the theme clusters as I deemed appropriate, based on the feedback from the participants and further consideration of the data.

I present my findings in Chapter 4 in narrative form and in data tables, as appropriate. Specifically, I present my findings organized by research question and dimension of healthcare access. My interpretation of findings represents all data, including discrepant and nonconforming data.

Ensuring Validity and Reliability in Qualitative Research

With regard to research in general, Trochim and Donnelly (2008) defined validity, inclusive of reliability, as "the best approximation to the truth of a given proposition, inference, or conclusion" (p. 20). However, definitions of validity often differ based on the type of research to which they are applied. Because I conducted qualitative research based on observation, I propose my analysis approximates the truth based on Lincoln and Guba's explanation of validity as it applies to qualitative research (as cited in Creswell, 2007).

According to Lincoln and Guba, validation of findings is less appropriate when discussing observations than the establishment of confidence and trustworthiness in one's findings (as cited in Creswell, 2007). To establish such trustworthiness, Lincoln and Guba suggested examining one's findings with respect to credibility, transferability, dependability, and conformability (as cited in Creswell, 2007, pp. 202–203). These approaches, according to Creswell (2007), parallel traditional approaches used in validating quantitative studies. Therefore, I used these approaches to plan for valid study outcomes. I discuss the validity of my actual study outcomes in the Results section following the presentation of my results.

Credibility refers to establishing the believability of findings from the research participant's perspective (Trochim, 2006; Trochim & Donnelly, 2008). In this study, as indicated by Trochim (2006) and Trochim and Donnelly (2008), I established credibility through prolonged engagement with participants in the field and providing a vivid description of the data. Also, I established credibility by triangulating my data, that is,

collecting data from multiple sources (government healthcare administrators, nurses and midwives, traditional healers, and residents). In addition, I also improved the credibility of my study findings through participant engagement in the data-analysis process (i.e., debriefing and member checking).

Transferability refers to "the degree to which the result of the qualitative study can be generalized or transferred to other contexts or settings" (Trochim, 2006, Qualitative Validity section, para. 4). Although the results of my study cannot be generalized to other populations, by providing a thorough and accurate description of my study methodology, processes, assumptions, and limitations, I have improved the chances that another researcher may benefit from the transfer of concepts depicted in my results to other study conditions and populations.

In quantitative research, the concept of dependability refers to a study's capacity to be repeated by other researchers in other locations and under other conditions using similar measures (Trochim, 2006, Qualitative Validity section, para. 5). In qualitative research, which lacks measurement, this concept more accurately applies to the setting in the study—specifically, the researcher's responsibility for describing any changes that occurred during the course of the study and how those changes affected the researcher's approach to data collection and analysis (Trochim, 2006). To this end, I included in my final document thorough explanations of all adjustments made to data-collection procedures and preliminary data analysis, as appropriate.

Confirmability "refers to the degree to which the results could be confirmed or corroborated by others" (Trochim, 2006, Qualitative Validity section, para. 6). I

established confirmability by checking the data during my data-analysis process. I checked data by using a second coder to determine intercoder reliability, and also by conducting participant debriefing and member-checking sessions.

Protection of Human Participants

To protect the participants in this study, I conducted my study meeting all standards of ethical research practices. Prior to beginning work on this study, I completed the National Institutes of Health online course *Protecting Human Research Participants* (see Appendix Q). I reviewed and conformed to the provisions in the National Code of Health Research (2007) for doing research in Nigeria. In addition, the second coder, who also helped transcribe data, signed a confidentiality agreement (see Appendix R). Also, only participants who were of legal age to consent to participation were allowed to participate in this study. In addition, no participant was enticed or coerced to participate in any way, and all participants were asked to sign an informed consent in their respective languages, indicating in clear terms and language the purpose of the study and the expectations of participation in the study. In addition, the consent form indicated the voluntary nature of the study, the risks and benefits of participating in the study, and the lack of compensation for participation in the study. Finally, the consent form indicated procedures to maintain participant confidentiality and offered contact information for my advisor, the Walden University research participant advocate, and me, should participants have questions after the study concluded.

The consent form for the healthcare administrator interviews is presented in Appendix S). Because some traditional healers and residents may not have spoken

English (fluently or at all), I presented the consent form for focus groups (see Appendix T) in Igbo as well (see Appendices U and V for the translated consent form and the back translation, respectively).

I maintained participant confidentiality during and after the study in multiple ways. For example, I identified participants by an arbitrary participant number and kept their names separate from all collected data during all stages of data collection, analysis, and storage. While in Nigeria, I stored electronic files on a password-protected laptop computer, which I kept locked in a private room in my temporary residence when not in my immediate possession. I secured hard copy and digitally recorded data in a locking cabinet in a local community leader's office. When I returned to the United States, I transferred electronic data to my password-protected home computer, which remains in my secured home office. I will continue to secure hard copy and digitally recorded data in a locked file cabinet in the same location for 5 years, after which time I will destroy it.

Summary

In this study, I used qualitative research methods to explore the issue of healthcare access for the rural people of Isu. Data were collected in two ways: interviews and focus groups. To ensure that various perspectives on the topic were considered, I used four data-collection instruments. To analyze my data, I used Colaizzi's (1973, 1978) seven-step method for coding data. This process allowed me to identify the themes and patterns of perspectives among participant responses. To demonstrate the reliability of my data analysis, I triangulated my data by (a) collecting data from four types of participants (government healthcare administrators, nurses and midwives, traditional healers, and

residents), (b) using two types of data-collection methods (interviews and focus groups), and (c) using four data-collection instruments to gather various perspectives regarding the topic. In addition, I engaged a second coder to establish intercoder reliability and conducted debriefing and member-checking sessions with participants.

Chapter 4: Presentation of Results

The purpose of this study was to explore the perceptions of rural-community residents and healthcare providers regarding residents' access to primary healthcare services in Isu Local Government Area, Imo State, Nigeria and to engage in community-based research to demonstrate its potential to promote resident access to healthcare services. In this chapter, I present data I collected from 27 healthcare providers and residents using personal interviews and focus-group discussions, then analyzed using Colaizzi's (1973, 1978) seven-step method for analyzing phenomenological data and cataloging emerging themes (see Chapter 3). I present the participants' demographic information first followed by a thorough discussion of themes grouped by research question and dimensions of healthcare access. My interpretation of findings represents all data, including discrepant and nonconforming data. I also provide a summary of results and evidence of quality of my study.

Demographic Data

As shown in the Table, a total of 27 participants made up the sample in this study: three healthcare administrators (including the local government chairman), six nurses/midwives, six traditional healers, and 12 residents. The participants varied in age (33–78 years). They also differed in socioeconomic status, but all—with the exception of one administrator—reported living in the same community.

Of the three healthcare administrators, all had either college degrees or a nursing certification. One administrator had 6 years of experience; another had 10 years of

experience. The administrators had served in various functions, including counseling positions and health planning. Two administrators lived in the community they served.

Table

Participant Demographics

Variable	Health care administrator (n = 3)	Nurse and/or midwife (n = 6)	Traditional healer (n = 6)	Resident (n = 12)
Gender				
Male	2		4	6
Female	1	6	2	6
Education: highest level completed[a]				
College	2		1	4
High school				2
Middle school			1	2
Elementary school			2	4
Registered nurse and/or midwife	1	6		
Traditional healer			2	
Age				
30–40	1	3		3
41–50		2		2
51–60	2	1	1	3
61–70			1	1
71–80			1	3

[a] Some traditional healers indicated other levels of traditional education, thus participant demographics may represent more than 100% of the total study population.

The six nurses/midwives were directly involved in primary healthcare delivery in the local government. All six nurses/midwives held certifications as either a registered nurse or midwife (see the Table). Their ages ranged from 31 to 51 years. Each had more

than 3 years' work experience in the local-government primary-healthcare system. They were all women. At the time of this study, all were heading or had headed a community or primary healthcare center in the local-government primary-healthcare system.

Of the 12 residents, six were men and six were women. The residents' occupations varied but included three subsistence farmers, three teachers, five petty traders, and one retired civil servant. The residents all had at least one child and were either married or widowed. All the residents used and depended on healthcare services in the community.

The six traditional-healer participants had practiced traditional medicine for an average of 10 years and not only claimed competency in general services but claimed expertise in specialty areas as well. General services included treatment for malaria, typhoid, stomach ache, constipation, convulsions, and whooping cough. Some specialty areas included sexually transmitted diseases (often gonorrhea); fertility and miscarriage issues including bleeding, bites, and poisonings, fibroids, devilish or spiritual attacks, schizophrenia (commonly called madness), and spleen disease.

In the following sections, I present the theme clusters that represent the study's research questions. There are six theme clusters. I have categorized the 27 themes that make up the theme clusters using Penchansky and Thomas's (1981) five dimension of healthcare access.

Theme Cluster 1: Characteristics of the Local Government Healthcare System That Work Well

In Research Questions 1a and 2a, healthcare administrators, providers, and residents were asked about what characteristics of the local government healthcare system work well or met community needs. Four themes emerged from their responses:

Availability

Theme 1: Effectiveness of services. Several participants reported healthcare services had been able to reduce or prevent some deaths and sickness of children by making immunization accessible (when available) to the children in the community. Nurses/midwives and residents agreed that some incidences of deaths and mortality have been prevented because healthcare providers bring vaccines close to them, and residents do want to know when such vaccines are available for their children. Traditional healers (66.6%) agreed that local immunization of children by the health system has been helpful in preventing deaths and diseases of children. Participants (8, 16, 21, and 27) reported that female residents come to the primary healthcare centers principally for the health needs of their children.

Theme 2: Reliance of services on the skills of nurses/midwives. Primary healthcare in Isu is provided and managed generally by nurses, midwives, and other allied healthcare professionals (Participant 1) who are readily available. Participant 2 stated,

> We do not have a permanent doctor here, which is why it is called a primary healthcare center, though we have a visiting doctor who comes around on

stipulated days or week. We have permanent doctors at secondary healthcare centers.

Participant 3 explained, "We provide services to pregnant women seeking deliveries [of their babies], do circumcision and immunization of children, treat upper-respiratory-tract infections, and sometimes give tetanus injection to adults with cuts."

Accessibility

Theme 3: Proximity of services. Six nurses and midwives (100%) and two (67%) of the three healthcare administrators stated that the proximity of healthcare centers to the community was adequate to meet the needs of the community and reduce mortality. Participant 2 described primary healthcare as an obligation of the government to the people, especially for those in the rural areas who may not be able to pay for hospital treatment. When asked about proximity to healthcare centers and posts, four of the six nurses/midwives (67%) and nine of the 12 residents (75%) revealed that proximity to healthcare centers and posts to people have helped reduce incidence of such epidemics as polio, whooping coughs, measles, and tetanus. "Services are primarily for infants and children" reported participant 4, a nurse. Participant 5 stated, "It is essentially a grassroots healthcare to reduce infant and maternal mortality rate for rural residents in Isu."

Accommodation and acceptability

Theme 4: Timing of services. The health centers operate a 3-shift schedule to cover a 24-hour period each day to save lives, prevent disease, and promote better health for local residents of Isu, especially for those who may have limited resources for seeking

care from private doctors or for traveling to the hospital. All nurses/midwives (100%) and residents (83%) agreed that keeping the health centers open all times was important for the community.

Theme Cluster 2: Challenges and Barriers to the Primary Healthcare System

For Research Questions 1b and 2b, all respondents (including healthcare administrators, providers, and residents) described the main challenges and barriers faced by the local government healthcare system; 10 themes emerged from the responses:

Availability

Theme 5: Facilities are poorly maintained and lack essential amenities. Residents (100%) and healthcare providers (80%) said that healthcare centers lacked electricity, water, and sanitation supplies. Participant 1 reported that the primary health center has no placenta pit or site for disposal of organic wastes. Participant 21 reported that health centers are dirty, uncomfortable, or uninviting to patients. Participant 19 questioned, "How can a woman under labor begin to think about carrying water and/or providing a lamp if labor begins in the middle of the night? If government wants to do something, they should do it fine." Participants described the environment of many health centers as unattractive, poor, and badly kept. In addition, they reported that some health centers need new floors, windows, beds, nets, and even seats suitable for public use. Participant 20 lamented that some of the community health centers have no mosquito netting and that newborns are exposed to bites if they are not properly covered.

Participant 4 explained how daunting it was to deliver babies in the middle of the night with only kerosene lamps as a source of light and how inconvenient it is for new

mothers to wait until water is brought to them from their homes before they can shower after delivery. Participant 5, a healthcare provider, asked, "How can a healthcare center function without power to refrigerate vaccines or water for proper sanitation during and after delivery?" Participant 7 expressed concern that the health centers have no oxygen or equipment to resuscitate patients and no incubators for premature babies. The participant concluded, "It is God who is saving us most of the time."

Theme 6: Lack of medical equipment. Four of the nurses/midwives (67%) reported a lack of basic primary healthcare equipment that was both frustrating to them and discouraging to residents who need care. Participants 3, 5, and 8 complained that the government's inability to provide healthcare centers with basic medical equipment and supplies discouraged many residents from continuing to seek care at health centers. Residents (Participants 18, 19, and 27) reported that healthcare facilities needed to have a laboratory, x-ray equipment, labor rooms, beds, and netted windows. Participant 16 said the centers lacked the equipment to examine pregnant women properly and that even regular physical examinations are hardly done well: "My pregnant neighbor was delivering at the center and lost lots of blood. There was not blood transfusion, no doctor, and she nearly died, but God saved her."

Participant 25 remarked, "New diseases are here with us and you cannot treat them just by looking at the patient. They need lab to know what is really wrong before giving medicine." Participant 26 indicated that "it is dangerous and risky to rely on this kind of blind treatment for cure of diseases." Participants also reported that lack of transportation such as ambulance services at the centers interferes with their ability to

respond to emergency health situations. In addition, participants (2, 3, 5, 8) reported that most health centers generally lacked some important obstetric equipment such a vacuum extractor, forceps, sterile gloves, obstetric forceps, an obstetric table, and drugs essential for deliveries). Participants 12, 26, and 27 reported that patients feel greatly disappointed when the health centers do not have the essential drugs or equipment needed for their care.

Some resident participants (58%) were quick to point out that some of the health centers had no equipment to measure blood sugar or blood pressure. Participant 7 remarked, "Patients are becoming increasingly more demanding about their care and procedures. A local woman would ask for x-ray, and laboratory, blood pressure services—even when not necessary—and will be disappointed if such services are not provided."

Theme 7: Lack of an ambulance or other transportation. Lack of means of transportation has posed a great handicap to the operation of the local primary health system (Participants 1, 2, 7, 19, and 20) especially for reaching patients in emergency or critical health conditions in a timely manner. Participants 2 and 9 acknowledged that lack of transportation for the health centers and the residents pose a great handicap in their ability to respond to residents' health needs. Participant 9 added that the Isu Local Government Area has no public transportation or taxi services and thus, responding to emergencies is difficult even in simple cases that nurses and midwives can handle. Those residents who have their own transportation are still hampered by security issues and bad roads, especially when emergencies or labor occurs during the night (Participant 9).

Another participant said that chartering a taxi in times of emergency is very expensive even during the day; many residents are not able to pay for both transportation and health costs simultaneously (Participant 18). To underscore the importance of transportation in emergency situations, Participant 16 cited a specific case where the availability of transportation would have saved the life of a pregnant woman:

> A pregnant woman was bleeding at home. She was brought to the center in the night on a bicycle with blood over the place. There was not ambulance or transportation at the center to convey her to the hospital. Hours were wasted before a van was got to convey her to the hospital. She died on the way to the hospital.

Theme 8: Lack of a resident doctor. Participants 4 and 7, who are registered nurses/midwives, remarked,

> When patients come to the health center, they want to see a doctor and not a midwife or nurse or CHEW because they believe that only a trained doctor will be able give them a proper diagnoses for their diseases or sickness.

Another participant (27) added, "Nurses and midwives are no substitutes for trained doctors!"

Participant 3 added that "the local health system has only nurses and midwives, and CHEW, and many times residents are not satisfied seeing any of us for their cases. They prefer to see a doctor." Participant 18, complained,

> How can I go to a health center with no doctor, and after waiting long to see a nurse, get a prescription that is out-of-stock, and then have to go out looking for

> the drugs. It is better for me to go to a chemist [a drug store operated by local drug seller in the village] or see a traditional healer if it is what they can handle for me.

Participants 23 and 27 stated that they do not use primary healthcare centers because there is no doctor on duty and because of the increased cases of fake drugs in circulation.

Because the primary healthcare centers do not have regular doctors on staff and have little or no equipment, two participants (23 and 24) described the primary healthcare service as trial-and-error practices. Nurses and midwives remarked that operating a primary healthcare system without a doctor was hard for them, especially with emerging health needs of the aging population and complications from child delivery. Participants 11 and 25 remarked that some of the catastrophic deaths that have resulted from child birth could have been prevented if a doctor had been on duty during the emergency.

Most residents (83%) do not go to the healthcare centers for their personal health problems because the healthcare centers do not offer services that meet adult health needs. A participant (24) remarked that the health centers are staffed by nurses and midwives, and extension workers whose skills are inadequate to meet their health needs of adult members of the community. According to two participants (16 and 26), healthcare centers do not offer reasonable services for adults in the community because they lack the facilities and qualified staff to diagnose most adult problems.

Most of the residents (75%) perceived the experience and skills of nurses/midwives and CHEWs to be limited and feared trusting some of their health conditions to what they perceived to be trial-and-error practices. Participant 27 stated, “I

cannot trust my healthcare to a nurse or midwives." Pointing to swollen knees and hip, Participant 27 described having suffered terribly from those problems because the participant could not see a doctor or get proper medical help anywhere nearby.

Theme 9: A shortage of medical support staff to run the health center. Three participants said that the primary healthcare center lacked support staff capable of educating the public and creating awareness of the services it offers (3, 8, and 9). Participant 16 remarked, "I do not go to anyone because I do not know what services they offer." Some participants complained that the healthcare system does not have staff to do home visits, create awareness of their programs, or educate them on available services or disease prevention (5, 21, and 18).

Resident and healthcare providers remarked that the local healthcare system has no laboratory staff who can conduct basic tests (Participants 2, 3, 23, and 24), so nurses, midwives, and CHEWs rely on guess work to diagnose and prescribe drugs (Participants 23 and 24). The high cost of care and personal attitude of some residents impacted their ability to seek healthcare from primary healthcare facilities even when facilities were nearby.

Accommodation

Theme 10: Lack of essential drugs. Most healthcare providers (Participants 4, 5, 6, 8, 9, 10, and 13) and residents (17, 19, and 24) stated that the local healthcare system always has a shortage of essential drugs and healthcare supplies, which limits the ability of the nurses and midwives to give the highest level of service to residents. Participant 19 said that health centers are always "out of stock with drugs." Two participants (20 and

26) complained that the health centers required them to buy drugs from outside vendors, which exposed them to the potential of purchasing fake or adulterated drugs. Participant 19 told a story of a fake Ampicillin drug for children that contained baby food inside the bottle instead of the true antibiotic medicine. Three (50%) of six female resident participants confirmed this story, and reported that Ampicillin was commonly prescribed for children, but was not available at health centers so residents were forced to buy the drug from private patent-medicine stores. Participant 20 added, "Our children got sicker with consuming non-potent fake drugs, and we wasted our money for nothing."

Affordability

Theme 11: Excessive cost of care. With regard to excessive cost of care, Participant 17 shared this story:

> Mrs. [name withheld] delivered her baby in one of primary health centers. She has been coming to this center for antenatal. When she delivered, she was told that her baby had jaundice. The center did not have drugs and the nurse told her to bring money for her to buy the medication. The woman had no money. After 3 days, she was discharged to go home, though the nurse told her that her baby's case was serious. The woman went home and while the husband was trying to find money to buy the drug, the baby died.

At the end of this narrative, all the women sighed in disappointment. One participant said, "Does life not worth more than money? Why not treat her, save the baby, and she will pay later?" Another participant (13) described services at the health centers as too high for some patients and blamed that high cost for keeping some residents from seeking

care from primary health centers when they are sick. Some residents who cannot afford the cost of care are forced to adopt a "wait–and-see" attitude toward their health, hoping the sickness will go away.

Another participant (26) added, "They may visit patent drug vendors, traditional healers where they can negotiate the cost of care; or go to a prayer house." Five residents complained that the cost of care is high for some residents to pay. According to the participants, some mothers were unable to pay for certain injections or medications for their babies born sick and must go home and let the baby die a few days later. Contrary to orthodox medical practice, traditional healers provide services that residents can afford at all times. A participant (14) remarked, "No good medicine man or healer will prescribe drugs (herbs) beyond the reaches of the patient." The participants stated that providers of the English type of healthcare discredit traditional healthcare due to their greed and fear of competition. They described their relationship with the orthodox primary healthcare system as unacceptable, discouraging, and biased.

Other Concepts

Theme 12: Poor and irregular pay. Several participants reported a lack of professional development and compensation to deserving employees, resulting in low employee morale and decreased productivity.

Healthcare providers, mainly nurses and midwives, reported that lack of regular training and good reward system affected their attitude toward their work as well as their ability to do their work. One participant (5) said, "Our salaries are small and besides, not paid regularly." Another participant (7) added, "Sometimes we are owed up to 3 months

areas of salaries." Participant 9 reported, "We hardly go to any training or workshops nor do we receive any tuition reimbursement or bursary for advanced education."

Theme 13: Unstable leadership and local government politicking. Several participants spoke of the instability and selfish interests of local government leadership, and their interference with the objectives and performance of primary healthcare delivery**.** According to the majority of the 27 participants, frequent changes in leadership often mean that the local chairs are unsure in their positions and thus lose focus and indulge in practices to enrich themselves and their political forefathers. Two of the participants (2 and 3) reported that leadership of the local government does not involve health administrators or providers in budgeting issues or allocation of funds for the health department. Another participant (7) said that the primary healthcare department hardly has a formidable plan, as every new leader comes with a different plan or no agenda at all. A participant (22) also remarked that some national-level political leaders influence decisions at the local government level, causing the leadership to undermine essential community services, including primary healthcare. Residents felt that corruption among those in authority resulted in mismanagement of healthcare funds and misplacement of community priorities.

Theme 14: Healthcare professionals not involved in policy and budgetary decisions. Two participants (2 and 9) reported that the local government chair is the principal decision maker on healthcare and in many cases overrides the decisions of healthcare professionals at local government headquarters. Participant 2 added, "I am here as an obedient servant. I have not political clout and nobody listens when I

complain. I do not want to lose my job." Health administrators reported the absence of collaboration and consultation between the health department and the local-government leadership, which impacts the resolution of important healthcare issues and adversely affects service delivery. Two of the participants (2 and 3) revealed that proper resource allocation, budgeting, and health-center management are not practiced. One participant (5) reported that some healthcare centers are geographically located based on locations convenient to the government rather than being central to the general community. As a result, some who oppose the particular powers in office at a particular time do not go to the centers for care.

Theme Cluster 3: Solutions to the Challenges Faced by the Primary Healthcare System

For Research Questions 1c and 2c, all respondents (including healthcare administrators, providers, and residents) were asked about potential solutions to the challenges reported above. Four themes emerged from the responses of all participants:

Availability

Theme 15: Provide a comprehensive primary healthcare system. Most residents, nurses and midwives required that variety of qualified medical staff be employed by the local healthcare system to provide comprehensive healthcare service. For instance, Participant 9 said that healthcare cannot function well without doctors. Another participant (6) said, "Our primary healthcare are not designed like hospitals and cannot serve all needs unless nurses and midwives are given higher training and health centers equipped properly." Participant 15 said, "Our health centers should provide

services such as the ones by hospitals in the British days that had good doctors and medicine." Another participant (11) added, "Those days, nurses see you first and then send you to the doctor who will examine and write prescriptions." Three of the midwives/nurses (50%; 5, 8, and 9) suggested a free treatment for all children (0–59 months) would be one way of making healthcare accessible to children and those who cannot afford the cost of care. In addition, 81.48% of all participants recommended free or subsidized healthcare for those who are most in need and those who are unable to afford the cost of care in the Local Government Area.

Another participant suggested that health centers be supplied with essential drugs (Participant 17). Of the participants, 91.6% of residents and 77.7% of healthcare administrators and nurses/midwives suggested that health centers should be supplied with essential drugs to encourage community use.

Theme 16: The local primary healthcare system should employ medical doctors. Eleven of the 12 residents (92%) said that they needed a healthcare center with a doctor present. Participant 27 said, "Most of our health needs are not what nurses and midwives can handle. We do not become pregnant, and we are not little children." Generally, residents perceived effective healthcare from the standpoint of efficiency and effectiveness in meeting their needs rather than on the availability of physical infrastructure or staff who lack skills to help them. Some participants believed that most of their health needs are beyond the expertise and training of nurses and midwives at the health centers. Many residents (83%) expressed that they needed a doctor-run healthcare

system that would reduce the incidence of pregnancy-related deaths, heart attacks, stroke, and other diseases such as typhoid fever and malaria.

Theme 17: Fund the health system, equip and maintain the facilities. For this themes, 78% of healthcare administrators and nurses/midwives suggested that adequate funds be allocated to the primary healthcare system. 83% of nurses and midwives recommended better training and improved professional development for primary health staff, and 91.6% of resident participants suggested the need for well maintained and well-equipped health facilities. One nurse (Participant 6) concluded, "Our primary healthcare should be supplied with trained staff, adequate drugs, and proper equipment and maintained before it can function efficiently."

Accessibility

Theme 18: Provide mobile clinics and ambulances to improve access and respond to emergencies. Healthcare administrators, providers, and residents shared similar opinions on the solutions to the challenges and barriers residents face in accessing primary healthcare in Isu. Two participants (23 and 27) requested a mobile clinic to reach out to those who are home bound and very old people who are in great pain with arthritis and other age-related diseases. Participants 1, 2, 7, 19, and 20 suggested that the local health system be provided with well-equipped ambulance services to respond to emergencies and save lives.

Theme Cluster 4: Relationships between Local Health System and Traditional Healers

For Research Question 1d, healthcare administrators and providers were asked their perceptions regarding the potential for closer relationships between the local-government healthcare system and traditional healers. Three themes emerged from this question:

Accessibility

Theme 19: Some orthodox health providers disregard traditional healing. The primary health system considers traditional healing to be crude, unscientific, and diabolic, thereby affecting some residents' attitude to accessing traditional care when in need. Three nurses/midwives (50%) and a healthcare administrator (33%) described traditional healing practice as unscientific or crude. These three nurses/midwives perceived care by traditional healers to be associated with a high risk of contamination or cross infection. They recommended reducing risks associated with traditional healing practice through proper education and regulation of practice by an approved government agency. A participant (5) described some traditional healers as charlatans who complicate issues and deceive clients with unnecessary rituals instead of giving them potent drugs or herbs. Traditional healers had a different view about primary healthcare: 83% of traditional healers were of the view that English medicine (primary healthcare) has lost a genuine concern or passion for healing and patient care; instead it is interested in making profit from consumers.

Other Concepts

Theme 20: No professional relationship exists between traditional healers and the primary healthcare system. Traditional healers are not officially involved in or regarded as part of the local health system operated by the local government. Views varied among different participants. Participant 2 said that traditional healers should be permitted to provide services that the primary healthcare system does not offer, such as bone setting for fractures and dislocations or care for snake and dog bites. Two participants considered the involvement of traditional religion in healing as idolatry, according to the predominant Christian belief in Isu. Two nurses and one healthcare administrator decried the appearance and level of education of traditional healers as unfit for an association as health-profession colleagues.

Three traditional healers (50%) think that greediness on the part of the orthodox trained professionals is the key issue in isolation and disregard of traditional healing practice. One participant (14) described government healthcare providers as being more concerned with making money than with patients' care and health service.

Traditional-healer participants (11 and 15) said that they are called by the spirits of the ancestors to provide affordable services—not to be concerned with profit making as is the practice in orthodox medical practice. Participant 11 indicated, "Government primary healthcare systems look at money and not at the well-being of the patient. We, traditional healers do not do so. We cure and you pay later! Ndu ka aku [life is worth far more than wealth]." Participant 10 remarked, "Ogwu di ire, akota onye gworo ya [When a healing is effective, people tell the story to others, and more business comes]."

Participant 12 added, “We are here to heal and not to make profits as are the orthodox healthcare providers.”

Theme 21: Traditional healers want recognition and legitimacy. In spite of the services traditional healers render to complement the services of the primary healthcare system, they are still struggling for integration and recognition by the local health system. Participant 9 recommended that for traditional healers to be recognized and considered part of the primary healthcare system, they “should be educated by the government on the basic concepts of care for pregnant women and delivery of babies just like the traditional birth attendants.” Participant 6 said, “Traditional healers should be allowed to treat certain diseases such as typhoid fever, malaria, bone setting, and evil attack which they are already known to cure.” Some healthcare administrators, nurses, and midwives consider traditional healing to be fetishist and crude.

Participant 13, a traditional healer retorted

> Religion has made many people believe that traditional healing is equal to idolatry [worshipping of false/another god], so the use of traditional healing by people for cure are sought in secret or mostly by those who are or do not care about their Christian beliefs.

Another participant 15 queried, “Do we not believe in God? What about doctors who are not Christians or do not go to church?” Participant 10 cautioned, “Religious groups should not preach against the power or potency of herbs and our abilities to heal because they are given to us by God.” Participants described traditional healing as a tradition that cannot be separated from the people.

Theme Cluster 5: Residents' Confidence in the Healthcare System

Research Question 2d, residents were asked about their perceptions regarding confidence in the local government healthcare system and in traditional healers. Four themes emerged from the responses of the 12 respondents to this question:

Availability

Theme 22: Participants trusted traditional medicine because they found the services affordable, available, and accessible. Participants 17, 23, and 26 reported that response times by traditional healers are significantly better than response times by staff at health centers, where one can wait hours for service. Participant 22 indicated that "herbs do help me a lot and I trust their efficacy than consuming chalk [fake or adulterated drugs] as medicines." Participant 27 stated, "Traditional healers have a sense of commitment and urgency to serve." Other participants (14 and 15) who have used or had experiences with those who have used traditional healers attested to the truth of this statement. Another participant (14) remarked that traditional healers consider the ability of the patients in figuring charges for their drugs. According to the participant, "You can always negotiate the price you want to pay or pay by installments."

Some women participants (33%) had no confidence in traditional healing due to their religious beliefs or dislike for the appearance of the healers. In the same condemnation, a participant (21) expressed that, "Going to a "dibia" [meaning traditional healers] is against my religious belief."

Accommodation

Theme 23: Healthcare-provider attitudes impacted residents' healthcare use. Some resident participants (50%) complained of a poor attitude of some healthcare employees, citing examples such as tardiness to work, leaving early, rudeness, delays, and a lack of a sense of urgency. Participant 21 complained, "It takes forever to get your card when you there. You have to beg them some of the time." Another participant (20) added, "Sometimes you have to pay for another card and there is not follow up with your previous case or sickness." Participant 20 shared a story:

> I took my sick child to the clinic and the baby was crying uncontrollably. As I reached the clinic, the baby was still crying and I beckoned on the nurse to take the baby from me. I said, nurse take this child from me, take this child from me. I begged and nobody listened. I took my child outside to avoid disturbing others. I was sad and disappointed on how I could be so neglected with my sick baby. My child cried agonizingly until I was called to see the nurse. … Some of the nurses have their hearts at the back [are heartless].

Two resident participants (17 and 20) cited that they go to a particular healthcare center because of the good attitude of the staff there.

Acceptability

Theme 24: Some participants were confident in primary healthcare services. Some participants trust primary healthcare to the extent that it met their needs during pregnancy and the immunization of their children. Two female residents (33%) of six female residents only expressed satisfaction with and confidence in the services of the

local primary healthcare system. One participant (17) said she received adequate care during pregnancy and delivery, whereas another (Participant 20) said she had all her children immunized at the health centers. One participant (17) expressed full confidence in the primary healthcare system and indicated that her satisfaction came from being able to get appropriate care during her two pregnancies and ongoing healthcare for her two children.

Theme 25: Some participants were not confident in primary healthcare services. Reasons that influenced participants' confidence in the primary healthcare systems depended on the extent to which it met their individual needs or those of members of their families. All six male participants (100%) had no confidence in the primary healthcare system because it did not provide any services that met their needs. Participants 23 and 27 stated that they do not use the primary healthcare centers because of the increased cases of fake drugs in circulation. According to them, "primary healthcare give English medicines which has many imitations in the market today." Another two participants (24 and 26) described the services at the primary healthcare centers as "trial and error" because of the absence of resident doctors at the centers. Participant 20 trusts the capabilities of the healthcare centers, but not when cases become complex or require urgent attention. When asked why, Participant 20 indicated that the lack of equipment and no doctor at the centers was very discouraging and disturbing because they would not be prepared to take care of the participant if complications arose during delivery. Similarly, Participant 19 indicated that willingness only to go to health centers with very minor health issues.

Theme Cluster 6: Role of Community-Based Research in Primary Healthcare

For Research Question 3, all respondents (including healthcare administrators, providers, and residents) were asked about their perceptions regarding community-based research as a means of promoting the use of healthcare services among the rural residents of Isu.

Community-Based Research

Response from all the respondents resulted in the following two themes:

Theme 26: Participants want to be involved in community-based research. The majority of participants (81.48%) welcomed the idea of community-based research. Other participants (18.5%) were concerned about whether local primary health leadership would actually value and use their input to improve healthcare delivery. Of residents, 83.3% expressed willingness to participate in community research if contacted on time. Two participants (7 and 25) recommended that some type of reward be given to encourage people to participate in the research. Four (66.6%) of six traditional healers indicated interest in participating at any time called to do so.

Theme 27: Community-based research improves resident access to primary health care. Most participants were receptive of community-based research and considered it an innovative approach to improve resident access to primary health care. Generally, 93% of all participants—health administrators, healthcare providers, and residents—perceived community-based research to be an innovative path to a better local healthcare system. Healthcare administrators and midwives/nurses (2, 3, 8, and 9) agreed that a community-based research approach to healthcare can help nurses and midwives

share their opinions about their challenges and strengths, as well as the feedback they receive from residents, which in turn will provide the primary healthcare system with an opportunity to improve healthcare delivery for residents. Participant 3 (a healthcare administrator) said, “Residents will tell us what they like or dislike about us, our services, and whole healthcare system. In this way we can do better.” Participant 8 (nurse/midwife) stated that “community healthcare is community owned, so it makes sense to interact with them from time to time, including hearing their opinions about us who are giving the healthcare.”

Participant 16 (resident) added, “Involving us will be a good idea, but the government is greedy and would not like us to know what they are doing.” Traditional healers (Participant 14) remarked that community-based research was innovative, but questioned whether orthodox healthcare providers would afford them due respect with regard to their opinions.

Summary of Results

Grouped by theme, the results of this study provide insight about the research questions posed for this study. Specifically, the results of this study provide insight into the experiences of the residents of Isu about their access to healthcare services as well as their expectations of primary healthcare services. Results from this study also provide insight into some of the difficulties and challenges of providing effective healthcare services that affect the use of primary healthcare services in the Local Government Area as well as possible solutions to these problems.

Results indicated that the characteristics of the current healthcare system can only support maternal and childcare rather than addressing the communities' desire for comprehensive care (Theme Cluster 1: RQ 1a and 2a). The inability of the local health system to offer comprehensive care is inherent in the many challenges and barriers facing it, ranging from no doctor on site, and a shortage of drugs, to poor funding and inadequate maintenance and equipment of the healthcare facilities (Theme Cluster 2, Research Questions 1b and 2b). Various participants' responses suggested some possible solutions to the problems, such as having doctors and drugs on site and providing free and subsidized healthcare; these factors would improve their access to healthcare (Theme Cluster 3, Research Question 1c and 2c). Considering the complementary role of traditional healers, participants feel that they should be recognized to offer specific services, but need some training to avoid cross contamination in care (Theme Cluster 4, Research Question 1d).

Services of traditional healers are still patronized by residents despite the lack of recognition by the local healthcare system. Services of traditional healers are still valuable to residents as they continue to patronize them due to their affordability and accessibility in time of need in certain cases (Theme Cluster 5, Research Question 2d). The community-based research approach used in this study received strong support from participants (Theme Cluster 6, Research Question 3).

The overall results of this study show how committed community members were to issues of their health and the desire for change. The research results presented above focused on the characteristics of the healthcare system that impact healthcare access;

barriers and challenges affecting the healthcare and possible solutions; traditional healers in the healthcare process; and the value of community-based research in improving community access to healthcare.

Discussion of the results of this study, described under the specific Theme Clusters, is presented in Chapter 5.

Evidence of Quality

According to Trochim and Donnelly (2008), evidence of quality in a qualitative study is best described in terms of credibility, transferability, dependability, and conformability, and how well the results of a study approximate the truth. Because I conducted qualitative research, I judged the quality of my study results using these concepts as applicable to my study. Evidence exists that my study results are confirmable and credible and, therefore, approximate the truth with regard to healthcare administrators and residents' perspectives about residents' access to healthcare and the potential for community-based research to serve as a means of promoting the use of healthcare services.

One piece of evidence indicating confirmability of my results is that the second coder identified themes similar to those I identified. For example, both the second coder and I identified proximity of services, timing of services, effectiveness of services, inadequate medical equipment, shortage of essential drugs, lack of a resident doctor, and high cost of care (see Appendix W).

One piece of evidence indicating both credibility and confirmability of my results is that the participants had few corrections to make to my debriefing/member-checking

notes. One healthcare administrator suggested I clarify that although doctors tend to be a priority at the secondary-care level than at the primary level, it does not mean that primary healthcare centers should not have a doctor. One nurse suggested I add mandatory professional development for nurses and midwives to acquire new clinical skills annually, funded by the local government. Another midwife asked that I clarify what I mean by "midwives and nurses are not substitutes for doctors," thinking that I was undermining their role in the primary healthcare system. One traditional healer clarified that they actually are not asking to compete with orthodox healthcare, but be allowed to perform their own services without unnecessary antagonism from orthodox healthcare practitioners. No residents made suggestions with regard to my interpretations of the data; however, they urged that the results be made available to the government to encourage government to improve their healthcare.

Another example of credibility in my study is the result of my prolonged engagement with participants. By spending time with participants, I was able to build a rapport with them and earn their trust so they shared intimate experiences with me. For example, one participant described begging nurses at a clinic for help for her sick child who was crying in agony and the discouragement the woman felt about the heartless treatment. The sharing of such private and personally painful experiences suggests that participants trusted me and shared truthful experiences.

Another example of credibility in my study is the result of the triangulation of data. The data I collected from the four different groups of participants using two different data-collection instruments were similar among the groups. That the four groups

generally agreed on the conditions associated with healthcare access for residents in Isu suggests that the data I collected were valid.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this case study was to explore the perceptions of rural community residents and healthcare providers (government healthcare administrators including local government chairs and senior healthcare administrators, nurses and midwives, and traditional healers) regarding residents' access to primary healthcare services in Isu, and to examine the benefit of using community-based research to promote resident use of those healthcare services. Despite the presence of local healthcare service in the community, many people still die from preventable causes. As a result, it becomes expedient to explore the opinions of healthcare providers and residents on the reasons for and against their use of local primary healthcare services. A total of 27 participants were interviewed to collect data for this study. Isu Local Government Area was chosen for this study because it possessed the characteristic of a rural community with limited access to essential amenities including healthcare (Adeyemo, 2005; Hudec et al., 2006; Umebau, 2008).

To gather various perspectives on the topic, I used two data-collection methods (interviews and focus groups) and four data-collection instruments. To analyze my data, I used Colaizzi's (1978) seven-step method for coding data. This method provided a rigorous tool to analyze human experience in real life and in the environment where a problem exists to explore health access issues in Isu. The main foci of the study were (a) how the healthcare system currently functions, (b) residents' use and perceptions of available healthcare services, (c) the effectiveness of available healthcare services, (d) solutions to overcome identified challenges and barriers to healthcare implementation,

(e) the role of traditional healers in the healthcare process, and (f) the value of community-based research. Results from this study, as shown in Chapter 4, are briefly summarized below. Chapter 5 interprets the key findings from this study as they relate to the specific themes in Chapter 4 and concludes with a summary of results, limitations, and recommendations for further study. I explain the interpretation under the specific theme clusters.

Summary of Key Findings

The following key results emerged from the study:

- Although healthcare centers are located in every community in the Local Government Area, the primary healthcare system is mostly focused on maternal health and child healthcare. (Theme Cluster 1: RQ 1a and 2a).
- The local primary healthcare system is faced with many challenges such as shortages of health providers (doctors in particular), drugs, and supplies; lack of basic equipment and facility amenities; poor facility maintenance; and inadequate funding. (Theme Cluster 2: RQ 1b and 2b).
- Political instability and poor leadership at the local government level has greatly interfered with the performance of the primary healthcare system and kept it from achieving its healthcare objectives. (Theme Cluster 3: RQ 1b and 2b).
- Participants' proposed that having doctors and drugs on site, and providing free and subsidized healthcare, among many others solutions, would improve their access to healthcare (Theme Cluster 3: RQ 1c and 2c).

- Traditional healers should be recognized and certified to treat certain diseases in which they have expertise and also be trained to improve their skills to reduce cross contamination in practice. (Theme Cluster 4 RQ 1d).
- A poor healthcare provider work ethic and attitude hampers residents' access to primary healthcare services. (Theme Cluster 5: RQ 2d).
- Residents still trust and use traditional healers because of the acceptability, availability, accessibility, and affordability of their services. (Theme Cluster 5: RQ 2d).
- Participants perceive community-based research as innovative and a valuable source of feedback for the local health system to improve access to primary healthcare for the residents of Isu. (Theme Cluster 6: RQ 3).

Interpretation of Findings

In this subsection, I discuss my interpretation of the findings presented in Chapter 4. The categories are elements of the primary healthcare system that work well (Research Questions 1a and 2a), barriers to the successful implementation of the primary healthcare system (Research Questions 1b and 2b), solutions to the challenges faced by the primary healthcare system (Research Question 1c and 2c), relationships between the healthcare system and traditional healers (Research Question 1d), residents' confidence level in the primary healthcare system (Research Question 2d), , and the potential role of community-based research about the primary healthcare system (Research Question 3).

Elements of the Primary Healthcare System that Work Well (Research Questions 1a and 2a)

The basic elements of the primary health system that work well were proximity to healthcare services, a 24-hour operation schedule, availability of nurses and midwives, and efficiency of services to women in labor and child health.

The local healthcare system maintains health facilities or posts in every community, including a primary healthcare center at local-government headquarters. Proximity of the healthcare facilities to residents was important to improving access to immunization of children and providing services to some women in labor (Federal Ministry of Health & National Primary Health Care Development Agency, 2009). The health facilities are managed by registered midwives/nurses and CHEWs to provide basic maternal and child healthcare services. CHEWs treat minor illnesses and provide health education and promotion services to the community. Studies show that patients who are exposed to health literacy are in a better position to manage their health than those who lack it (McMurray, 2007).

The operation of primary healthcare in Isu revolved around the skills of nurses/midwives and CHEWs. This was so because of the shortage of medical doctors and their preference to work in urban areas rather than rural areas. Nurse/midwives and the CHEW workforce are the most available health labor force willing to work in rural areas and thus have become the focal beacon of the local healthcare labor supply (Ladipo, 2009). Though some residents were pleased with the role of midwives and nurses in baby deliveries and care, many also regarded the absence of doctors as a serious deficiency in

the system. The use of an hourly contracted medical doctor did not work well because doctors have private clinics and were not available, even on scheduled days; residents expected a doctor-run health system with nurses, midwives, and CHEWs providing support services. Residents have long associated midwives with the running of maternity homes located in communities, where they perform deliveries and circumcisions, provide ante- and postnatal maternity care, and treat simple wounds—but do not function as doctors. Nurses, in contrast, are known for working in hospitals with doctors rather than alone, and performing expected duties at healthcare centers. Essentially, nurses' jobs are to promote health, educate the community on disease prevention, and help patients cope with illness, whereas doctors are trained to diagnose and treat illnesses in patients (American College of Rheumatology, 2012; U.S. Bureau of Labor Statistics, 2012). Also, CHEWs generally are known for providing health education, doing home visits, and sometimes giving vaccinations. Men and women have different health needs as they age (WHO, 2012), and those needs will not be met by nurses, midwives, and CHEWs operating the local healthcare system. A doctor's care cannot be substituted in that way.

Residents were more critical of the lack in the basic characteristics of the healthcare system than were health administrators, nurses, and midwives, who were interested in protecting their jobs. Traditional healers clearly see the problem with the nature of the current healthcare system structure but also have no power to make any changes—or even to make simple suggestions.

Though the local health system has endeavored to improve "access" by bringing healthcare facilities closer to the people, it struggles to meet the goals of National Health

Policy, which is to bring about a comprehensive healthcare system, based on primary health care that is promotive, protective, preventive, restorative, and rehabilitative to all citizens within the available resources, so that individuals and communities are assured of productivity, social well-being and the enjoyment of living (Abdulraheem, Olapipo, & Amodu, 2012; Adeyemo, 2005). The local health system is also deficient in defining characteristics of primary health care, as defined by the Declaration of Alma-Ata (International Conference on Primary Health Care, 1978): focusing on essential health, accessibility to all individuals and communities, sustainability and reliability, community participation, equity, and a sound scientific base. Health is a fundamental human right, and the characteristics of the local primary healthcare system greatly impact the ability of rural residents to access healthcare equitably and efficiently (International Conference on Primary Health Care, 1978). In contrast, the primary healthcare system does not offer services that meet all needs of individuals and families in the community, nor are the services universally accessible.

The operation and functionality of the local healthcare system is confusing and inadequate: operated by nurses, midwives, and CHEWs, it provides basic maternal and child health services and basic first aid. This situation has prompted residents and some providers to ask, “What actually is primary healthcare?” if it cannot provide services that meet community needs. This question asks to know if healthcare-system administrators really understand the healthcare needs of the community and what the health system should be doing. Residents’ views demand that the services and operation of a primary health system emanate from economic, political, and sociocultural conditions common to

the community it serves, as indicated in the Declaration of Alma-Ata (International Conference on Primary Health Care, 1978). It is the expectation of residents that an ideal primary healthcare system should be functionally efficient and effective at all times and have the capability to attend to their primary health needs. Contrary to this expectation, some healthcare administrators and providers understood access to primary healthcare in the context of location, whereas residents understood primary healthcare in the context of functionality—that is the ability of the primary healthcare facility to meet every residents' healthcare needs, irrespective of age, gender, or socioeconomic status. This conceptual controversy seemed to have influenced the perceptions of healthcare providers about the type of services they offered people.

In the opinions of residents and some healthcare providers, running a primary healthcare facility without a doctor is risky and has affected most residents' attitude about seeking care from local health centers. Using all-female staff as providers was not welcome to some men who felt certain issues were too private to discuss with a female provider. Having all female providers was not acceptable to certain demographics of the community either (Liu & Dubinsky, 2000). The primary healthcare workforce is dominated by women and lacks diversity. The nature of nursing and midwifery professionals in Nigeria attracts more women than men, and as a result, the chances of facilities being staffed with male nurse/midwife providers in the local healthcare system are low. Workforce diversity in the healthcare setting is seen as a means of providing relevant and effective services (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003, p. 73).

As nations look into the future of global healthcare access, it is essential that healthcare planners, providers, administrators, and stakeholders look into the new expectations from the viewpoint of the healthcare system. Little can be achieved if the current characteristics of healthcare systems do not respond to changing times. Studies have pointed to basic attributes that a healthcare system must possess to be effective and provide equity of care. For instance, according to The Regenstrief Center for Healthcare Engineering (2006), healthcare systems should conform to the following qualities:

1. Safety: healthcare should be safe and not cause injury to the patients.
2. Effectiveness: providing services based on scientific knowledge.
3. Patient-centeredness: sensitive to patients' values and health needs, as well as opinions.
4. Timeliness: prompt service, avoiding unnecessary delays in providing service to clients.
5. Efficiency: avoiding waste in equipment and in supplies.
6. Equitability: providing care that meets all needs irrespective of gender or socioeconomic factors. (pp. 4–5)

In view of these attributes, the local healthcare system in Isu still struggles, operationally and organizationally, to meet the criteria of the primary healthcare system that communities and some healthcare providers expected.

Considering the current situation in the local healthcare system, it may be more acceptable to residents to have fewer healthcare centers that are well-run, well-staffed, and well-equipped than to have several that are poorly maintained and badly run, without

drugs and equipment. Administrators' ideas of a functional primary healthcare system is political rather than operational, a condition expressed in Penchansky and Thomas's model of healthcare access (1981, p. 127). This kind of thinking may have accounted for the development of a healthcare system that lacks the necessary attributes necessary to support the rural health care and health education needs indicated by the residents. This fundamental difference can be resolved by adhering to the three accountability relationships of (a) voice (between citizens/clients and politicians/policy makers), (b) compact (between policy makers and providers), and (c) client (between providers and clients (World Bank, 2004b).

Barriers to the Successful Implementation of the Primary Healthcare System (Research Questions 1b and 2b)

Primary healthcare delivery in Isu is faced with numerous challenges (Themes 5-14). The similarity in the concerns perceived by the different groups of participants indicated that the local healthcare system has obvious performance concerns. Central to the challenges was the human factor in the provision of healthcare services; this is the greatest challenge facing the primary healthcare system (Theme 13). Poor leadership and corruption, in particular, appear to be principal concerns. Many residents cited that unhealthy politics has led to bad leadership at the local government level as well as across the whole Nigerian government system, denying them the opportunity to elect people who will care for them. Many residents and some health administrators clearly expressed that services for local residents were not being provided as a result governmental impositions. According to the literature, poor leadership and political

instability have been responsible for the unsuccessful implementation of many government policies and programs on healthcare delivery (Abdulraheem et al., 2012, p. 13). Instead of working for the general good, local government leadership is pressured to serve the interests of their benefactors to the detriment of the needs of the general public. With corruption in leadership, public accountability has no place, but contributes significantly to the failure of the local government primary healthcare system. Healthcare administrators who run the system and residents who depend on the system for care found this situation to be frustrating. Issues such as poor funding, lack of facility maintenance, and poor equipping of facilities stemmed from poor leadership at the local government level (Themes 5, 6, 7, 10, and 12). Isu Local government gets a monthly allocation from the Federal Government to funds its operation including primary healthcare, but the underlying issues associated with poor or lack of funding of the PHC system is beyond the scope of this study and warrants a further study.

The intended benefit of locating healthcare centers in every village is being thwarted by the inability of the local healthcare system to embrace a team spirit and create a vision to identify and solve problems and challenges affecting the system. Some of the problems were beyond the control of professional healthcare administrators and healthcare providers in the Local Government Area. Oftentimes, these administrators and healthcare providers have no input in funding or allocation of resources. According to the literature, lack of agreement about organizational missions and politicized decision making often underlie difficulties affecting the vigilance of public healthcare functions, affecting public health functions (Novick, Morrow, & Mays, 2008, p. 38). Political

instability and corruption resulted in the following barriers to the local healthcare system in Isu: (a) inadequate funding of healthcare facilities—funds meant for healthcare are diverted to other interests, (b) poor employee morale resulting in poor healthcare-worker attitude, (c) ill-equipped and poorly maintained health centers, (d) failure to provide doctors at health centers (Fan & Habibov, 2009; Onwejekwe et al., 2010), (e) lack of essential drugs including vaccines (Ridde, 2011; World Bank, 2004a), (f) lack of community involvement (Rust & Cooper, 2007; Wallerstein & Duran, 2006), (g) no accountability, and (i) excessive cost of care (Abdulraheem, 2007; Hausmann-Muela, Ribera, & Nyamongo, 2003). In a study of primary healthcare services in Nigeria, Abdulraheem et al. (2012) found that primary healthcare facilities are in various stages of disrepair, with equipment and infrastructure being absent or obsolete, and the referral system almost nonexistent (p. 5). All these factors are signs of a failing healthcare system (World Bank, 2004b).

Participants' concerns about the condition of primary healthcare in Isu do not appear to be ones that can be resolved without a change in the status quo. To transform the system, there must be a shift in the current paradigm of leadership from political leadership to community leadership by health professionals who are not under the control of the local-government leadership system. Only strong leaders can enact change in the healthcare system. Primary healthcare leadership must possess the "depth and breadth of leadership skills that are responsive to health needs, appropriate in the social and regulatory context, and visionary in balancing both workforce and client needs" (McMurray, 2007, p. 1). The current arrangement, if it continues, will not foster change,

and thus morbidity and mortality rates will not be reduced, and improved access to healthcare for rural residents will not be realized. Transformation requires that leaders engage in systemic thinking by looking into the current situations or demands for primary healthcare services in order to make future plans (Novick et al., 2008).

Solutions to the Challenges Faced by the Primary Healthcare System (Research Question 1c and 2c)

To improve access to primary healthcare, data suggested the changes are necessary to improve primary healthcare delivery in the Local Government Area. To improve access to healthcare and quality of services provided, participants recommended the following:

- Establish a mobile clinical unit and ambulance services;
- Employ doctors at all healthcare facilities to properly diagnose illness, prescribe medications, and oversee the work of nurses, midwives, and other healthcare workers;
- Provide all health facilities with necessary tools and equipment, and maintain them;
- Provide a regular supply of drugs and medical supplies;
- Provide professional development for healthcare staff and improved pay; and
- Provide free healthcare for all children 0–59 months, and subsidized care for those who cannot afford to pay for healthcare services.

The perspectives of residents mirrored those of healthcare providers and administrators and both groups of participants acknowledged that the challenges translate into poor quality of service for residents.

Residents and healthcare providers emphasized the importance of regular staff training and professional development to prepare them for their responsibilities. Residents, in particular, indicated that healthcare staff should be trained in better customer service and human relations, as these are equally part of health care. Training, as Abdulraheem et al. (2012) suggested, can enhance employees' knowledge base and equip them with modern skills and concepts in primary healthcare delivery as they relate to rural communities. Also, participants preferred having fewer well-equipped and managed facilities with a regular doctor to severely scattered, ill-equipped health facilities throughout the community.

In addition, residents want mobile clinics to reach out to those who are home bound and provide more extension workers who can conduct home visits and create awareness of the services offered by the local health system. Mobile clinics have been shown to be cost -effective in preventing chronic disease, controlling healthcare costs, and reducing health disparities in underserved or remote communities (Hill et al., 2012; Oriol et al., 2009).

Popular participant opinions suggested that an initial step in the solution process lies in having leadership that is accountable to the people. Simply, there is lack of accountability in public service in Nigeria, a situation that also affects the operation of the primary healthcare system in Isu (Khemani, 2006). Part of the reason may stem from

an unclear definition of the extent and limits of responsibilities shared between state health ministries, ministries of local government, and local government councils (Khemani, 2006, p. 5). This accountability is derived from sharing power between providers and customers, and increasing community involvement in planning and monitoring healthcare services (World Bank, 2010).

Local government leadership must take responsibility for the effective operation of primary healthcare at the local government level. Data from this study indicated that problems of access to healthcare can be minimized if there is leadership that ensures (a) services are provided as expected, (b) adequate funds are allocated to provide services, (c) proper services are provided according to identified needs, and (d) good performance is rewarded and inappropriate behavior that leads to poor outcomes is punished. When leaders begin to think in these directions, it may be possible to have (a) improved provider–community communication and understanding, (b) maintained and well-equipped health facilities, (c) a well-funded health system with staff to meet areas of most need, and (d) comprehensive healthcare that considers the socioeconomic needs of the community.

Closer Relationships with Traditional Healers (Research Question 1d)

Result shows that the local primary health system does not relate well with the traditional healer. Traditional healers are generally not recognized in the orthodox healthcare system as colleagues or primary healthcare providers. Findings indicated that the local healthcare system still perceives traditional healers as indulging in crude and unscientific practices. Prejudice exists between providers of orthodox medical healthcare

and providers of traditional healing care (Theme 19). Residents still use traditional health providers. In spite of the global call for integration of traditional medicine and practitioners in the primary health system to reduce cost and minimize physician shortages, the local healthcare system has not explored the potential for integrating traditional healers into the local healthcare system. Traditional medicine and healers provide cost-effective local resources and knowledge for disease prevention and treatment (Bodeker, Carter, Burford, & Dvorak-Little, 2006). Bodeker et al. (2006) showed that traditional medical care and therapies have been used extensively in the United States, South Africa, India, and Australia.

Many Africans continue to use traditional medicine provided by traditional healers because traditional medicines are effective and holistic in nature (Ityavyar, 1987; WHO, 2007). The fact that traditional medicine and healers continue to play a significant role in African culture and concept of disease and cure, it has been relevant to pursue an approach to review the role of traditional medicine in primary healthcare and embrace its successful services. The problems seem to be that orthodox primary healthcare providers have not devoted time to study the role of traditional healers and the impact of traditional medicine in primary healthcare. Also, there is still attachment to a colonial mentality that anything traditional is unscientific, crude, and diabolic. Traditional healing care has some inexplicable phenomena that cannot be explained scientifically. Africans are bound to their culture, and traditional healing and medicine are inseparable parts of it. Perhaps the best place for the local government to begin is with a clear understanding of traditional medicine. Traditional medicine incorporates many of the long-held beliefs and customs

that are specific to the culture of the people. It is on this basis that traditional medicine is used to treat and cure various ailments in society as a complement to orthodox medical practices (WHO, 2007).

The current negative orthodox healthcare-system view of traditional medical practice is based on a long history of bias toward traditional medicine stemming from the practice's attachment to traditional religion (Ityavyar, 1987). Because some residents have continued to use traditional healers irrespective of the continued wave of antagonism and discredit by the Western medical system in Nigeria, healthcare policy makers need examine how best to use local healer potential to extend primary healthcare to rural residents.

Working toward understanding and accepting the role of traditional healers' may result in a shift of the relational paradigm between the local-government healthcare system and traditional healers, from one of condemnation to one of consideration. An established working cooperation between the orthodox healthcare system and the traditional-healing system would encourage mutual communication, which could provide a method to share medical knowledge and improve services offered by traditional healers. A close relationship with traditional healers also affords the opportunity for traditional healers to gain some understanding of modern medicine, and thus to help in disease prevention for conditions such as HIV/AIDS. A closer relationship with training in preventive and comprehensive healthcare will help them "gain prestige in their local communities and respectability in the broader society by having links with modern medicine" (Green, 2004, para 7). A closer relationship will turn antagonism into

friendship, bring mutual cooperation, and encourage exchange and transfer of knowledge among orthodox healthcare providers and traditional healers. This situation will improve community access to healthcare and promote good health by reducing mortality and morbidity (Cohen et al., 2007; International Conference on Primary Health Care, 1978; Irwin et al., 2006). Rural communities can enjoy good access to healthcare if traditional healers are engaged to complement orthodox healthcare services and to minimize issues associated with the shortage of trained medical doctors in rural areas.

Residents' Confidence Level in the Primary Healthcare System and Traditional Healing (Research Question 2d)

Results of residents responses indicated that confidence level in the use of traditional healers and the local health system varied. Many factors can affect the confidence level of patients in a system. Among the factors contributing to the loss of confidence was fear that they would not be treated well because of low staff skill level, misdiagnoses, or unprofessional behavior from some health staff. Patients will often lose confidence in a healthcare or provider whose skills or expertise are short of patients' needs (Vadlamudi, Adams, Hogan, Wu, & Wahid, 2007).

With regard to the primary healthcare system, residents' confidence levels rose mostly due to the services provided efficiently by healthcare staff. Patients usually chose a health system they believe has the capability to diagnose, treat, and care for them well (Rudzik, 2003). Confidence in the healthcare system is associated with the satisfaction patients get from using a healthcare facility.

The reliance of the Isu local primary healthcare system on the competencies and experiences of nurses/midwives, however, was a major reason for the loss of confidence in the system among many residents. This was caused by the inability of the system to handle life-threatening and emergency medical conditions, resulting in catastrophic outcomes for the community. According to Rudzik (2003), "Patients become unwilling to spend time and energy if they lack confidence in the system, which can lead indirectly to serious health consequences" (p. 249). This system failing supports the reason older residents do not use healthcare system services for their personal care and thus suffer untold medical conditions from undiagnosed and untreated high-blood pressure, diabetes, chronic pulmonary conditions, arthritis, and heart diseases (Amella, 2004; National Academy on an Aging Society, 1999).

Though some people have little confidence in the local health system, others have confidence in traditional healers and in the local healthcare system. According to Dr. Welile Shasha, WHO country representative for South Africa, "Generally, confidence in both traditional healing and the Orthodox primary healthcare system comes from the fact that both services complement one another in the communities." (WHO, 2004, p. 1). Furthermore, Dr. Shasha added that studies have shown 80% of Africans depend on African traditional medicine because it is their cultural heritage, and it is accessible and affordable in times of need.

People in Isu still live in their natural traditional setting, see traditional healers, and hear about them. As a result, most residents are familiar with traditional healers, their reputations in treating diseases such malaria, fibroid, madness, and convulsion with

herbs, and their service are within reach. Ascribing to confidence the reason residents seek care from traditional healers, Green (2004) wrote, "Traditional healers are found everywhere, unlike doctors who tend to work primarily in the larger towns and cities. Healers are culturally acceptable; they explain illness and misfortune in terms that are familiar, that are part of local belief systems" (p. 1).

This accessibility underscores the reasons and need for the services of traditional healers in communities where patient–doctor ratio is high. The role of traditional healers is in primary healthcare delivery and is receiving great attention worldwide. Traditional healers have been shown to play a crucial role in public health and were identified as "crucial nodes in any planned interventions for controlling the spread of HIV/AIDS" in a study in Zimbabwe (Simmons, 2011, p. 477).

This notwithstanding, opinions are split on the levels of confidence in both services. Lower levels of confidence in traditional healers or use of traditional medicine were not based on the efficacy of drugs or effectiveness of traditional healers, but on strict religious beliefs. The high level of confidence in traditional healers and services were from participants who have patronized them for specific reasons and found them better for the treatment of their medical conditions. Christian religious beliefs have played a role in downplaying the importance of traditional medicine, causing some residents to reject the practice as inauthentic medicine. Such concepts were crafted by colonialists and quickly accepted by the indigenous orthodox medical practitioners in the area (Ityavyar, 1987).

Generally, the current level of service and operation of the primary healthcare system in Isu does not give the residents any hope to sustain them in time of sickness. The myriad of problems found in this study affected the effectiveness of healthcare centers and the capacity of health staff to provide needed services. In addition, with more maternal and child healthcare services offered than anything else, those who are not served by these services, such as men and women over childbearing age, lost confidence in the system. This condition reflects Penchansky and Thomas's (1981) concept of healthcare organization and how organization of services affects people's perceptions of those services and often results in a loss of confidence. The primary healthcare system does not accommodate the needs of the growing aging population, and as a result, discriminates in its care to the community. Most residents in rural communities are poor and have limited or no income. Not getting healthcare due to the inability to pay was a reason for loss of confidence in healthcare service (Rudzik, 2003). A World Bank (2010) study in Nigeria equally identified that "lack of equipment and the cost of the service" discouraged residents from seeking healthcare from primary healthcare centers (p. 31). Access to healthcare is limited to residents who are unable to get adequate care or pay for the services when available. Therefore residents do not find it encouraging to seek healthcare in a facility without equipment and the services they cannot afford to pay.

Healthcare-worker attitude at the healthcare centers was another cause of resident's lack of confidence. Good health care begins with a warm and caring welcome of the patient by healthcare workers. An Igbo adage says that asking, "How are you doing?" to a sick person has healing power. As a result, Igbos place great importance on

facial or emotional expression of their healthcare provider. People tend to interpret others' feelings and intentions through facial expressions, which give them insight as to whether they are welcomed or respected. Penchansky and Thomas (1981) explained that people will not seek healthcare if they feel unwelcome or unappreciated (not accommodated) by the health clinic. The attitude of a service provider to clients constitutes a barrier to accessing healthcare (Higgs et al., 2001). When people are sick, they need compassion and care, rather than distress given to them by their providers.

In summary, residents' loss of confidence in the primary healthcare system was a result of absence of doctors, shortage of essential drugs, inadequately equipped facilities, unaffordable cost of care, and staff lack of professionalism. For residents in Isu, the lack of doctors and equipment in facilities translates to compromised care, which leaves them feeling resentful. The lack of comprehensive care and the possibility of misdiagnoses cause patients to lose confidence and limit their ability to seek care from the local healthcare system (Rudzik, 2003). It can be argued, from all indications, that residents will seek confidence in a system they trust can treat them well. The continued growth in confidence in traditional healers is based on their affordability, accessibility, accessibility, mutual respect, and holistic care (Bodeker et al., 2006; Simmons, 2011).

Potential Role of Community-Based Research in Primary Healthcare

Participants' responses, shown under Theme Cluster 6, draw attention to the desire of participants to be part of the healthcare decision-making process. Although participants in this study felt that community involvement was an innovative idea, healthcare providers and administrators have not previously used this option to assess the

relevance of the local primary healthcare system to the community. No one person has a dominion of ideas. Building a healthy community requires that diverse individuals are brought together into community partnerships designed to find lasting solutions and to establish connectedness based on mutual responsibility and respect (Higgs et al., 2001, p. 3; World Bank, 2004b). Similar partnerships need be established in the Isu community to incorporate various individual perspectives into efforts to improve the health of the community. Results from this study indicate that community members have ideas that could be used to bring about significant improvement in community access to healthcare services. Not much can be achieved in any primary healthcare system without an understanding of the needs or circumstances impacting how people benefit from the healthcare system. Public health providers and administrators should, as a part of the decision process, build local capacity and coalitions in the community to share responsibilities and use available community resources toward the achievement of that goal (Bartholomew, Parcel, Kok, & Gottlieb, 2008; Novick et al., 2008).

Community involvement in planning and implementing primary healthcare has been perceived as necessary for an improved healthcare system and to ensure accountability and better allocation of resources. However, most participants feared that corruption keeps those who control primary healthcare from involving them. Involving consumers in their own health decision-making process gives them power to control factors that cause diseases and promotes facilities that cure those same diseases (Regenstrief Center for Healthcare Engineering, 2006). The potential for community involvement in their own healthcare decision and implementation process will help

develop, build, and sustain an effective and empowered community:, engage the community in dialogue, disseminate information, and mobilize people for action, and enhance continued use of community primary healthcare services (Abdulraheem et al., 2012).

The local healthcare system in Isu will benefit from the local health system when healthcare providers, administrators, and residents share common information about the healthcare system and local healthcare needs. Using community-based research will improve the local system's capacity-building and partnership in healthcare planning, management, and use.

Applying the Conceptual Framework to the Results

This section will review whether primary healthcare services in Isu satisfy each of the five dimensions of access to healthcare explained by Penchansky and Thomas (1981). The availability dimension of healthcare access is not met in the local healthcare system, which could not employ a full-time doctor, have qualified support staff, supply drugs, or provide a variety of services that meet community needs. Access to healthcare is limited or even denied when the extent of services offered by a healthcare system does not offer services that meet the needs of the population (Cham et al., 2005). Themes 6, 8, 9, and 10 clearly indicated that the absence of a doctor on site and shortage of other qualified support staff were serious setbacks for people to access the services they needed (Fan & Habibov, 2009). Lateness to and absence from work among healthcare personnel equally discouraged residents' use and access to local healthcare services.

Accessibility to healthcare services was limited by many problems, even though healthcare centers were located in villages. Proximity alone does not constitute access to healthcare (WHO, 2000a). Even though health centers and health posts are located in close proximity to communities, most residents' access to healthcare is still limited when viewed from the perspective of Penchansky and Thomas's (1981) understanding of access. The benefit of proximal location of healthcare facilities to residents was lost when pregnant women and residents were unable to get transportation to or from healthcare centers in emergency situations. Responses from residents and healthcare providers indicated that the ability to give care to clients has been limited greatly by the inability of patients to access healthcare and by healthcare providers' failure to extend care on time during emergencies (Themes 7 and 8). The failure of the healthcare system to have an ambulance or motorized public-transportation system was a great detriment to healthcare access for the residents of Isu (World Bank, 1993).

People will seek care from a provider they consider to be sensitive to their values and understand them. This is referenced as accommodation by Penchansky and Thomas (1981). Using nurses, midwives, and CHEWs alone to provide primary healthcare services was not conducive to the men and women who felt that their needs were beyond healthcare-facility capabilities, and could not get treatment as needed (Liu & Dubinsky, 2000). Also, the attitude of some healthcare staff was not acceptable to most residents and was among the factors that determined if they should return for sick care to the healthcare center. Disrespect creates an impression of unacceptability in the mind of the patient.

Affordability is a key issue in the access to healthcare. Studies have implicated cost of care (ability to pay) as having a great impact on accessibility and affordability of healthcare (Long & Masi, 2009; Penchansky & Thomas, 1981). Residents of Isu pay for healthcare services on a cash basis and usually at the point of service. There is no health insurance or credit card system in use for Isu residents, so residents must pay out-of-pocket at the point of service, and sometimes, payment is expected before care can begin. Cost of care creates a deep lack in the ability of many rural residents and has been found to be a major cause of impoverishment among low-income residents. It is not uncommon among rural and low-income residents to be confronted with choosing between high-cost healthcare, school fees for children, or paying for food (Jacobs, Ir, Bigdeli, Annear, & Damme, 2012). Without the ability to pay, residents are more likely to postpone care, a situation that is not helpful in critical or serious disease conditions. As a result, poor residents who have been denied or refused treatment because of their inability to pay for healthcare services considered the current healthcare system to be unacceptable.

Overall, the Isu local healthcare system is in need of repair to respond to community needs and to manage its resources effectively within its current capacity. Even though Isu has made tremendous efforts in providing services close to people, such proximity and availability of infrastructure did not constitute access because of many deficient elements in the system. Other concepts generated from this research directly or indirectly impacted the degree of access residents have to healthcare. Themes 12, 13, 14, 19, 20, and 21 describe concepts that residents consider need attention to improve overall access to healthcare in the community. Addressing these issues will result in a better

policy and management of the healthcare system and will create new dimensions in addressing healthcare challenges.

Isu residents will benefits from fewer healthcare centers that are well managed, well provided, and maintained, and have qualified medical doctors and other allied staff. This will enable healthcare providers and administrators the opportunity to review how well the services met the needs of the community.

Limitations of the Study

This study is only preliminary research into the perceptions of participants regarding access to primary healthcare in Isu. This study may not have exhausted all perceptions of residents or produced comprehensive results in that (a) I designed the instrument; a self-designed instrument may not have produced the best outcomes, (b) I interviewed a small number of participants, (c) I spent a short time in gathering data and limited my expenses, and (d) my experience may have affected data validity or trustworthiness.

Implications for Social Change

I was prompted to conduct this study by the need to identify specific healthcare-access issues and challenges in Isu and to discover means to address those issues and challenges. Understanding the issues affecting residents' access to healthcare will help to inform local government leadership and stakeholders about the need to

- improve community participation in healthcare decision-making processes as well as the implementation of healthcare services;

- educate the community on primary healthcare services and tailor those services to identified needs; and
- develop a ground-up model of a primary healthcare system using available resources that satisfies the expressed needs of the people of rural Isu.

At a policy level, the findings from this study indicate that the crisis situation of primary healthcare in Nigeria is also present in Isu. Problems of health access are not generated in a vacuum but from the lived experiences of people in the community who are impacted by the operation and provision of healthcare services. Results of this study highlight the deficiencies in the ability of the primary healthcare system to provide services for all ages and socioeconomic groups in the community. It will also provide healthcare administrators, providers, and residents opportunities to seek change that will improve access to healthcare delivery. The closeness of healthcare centers to residents is a commendable improvement and demonstrates the primary healthcare system's effort to improve healthcare delivery. However, the primary healthcare system is not effective and its capacity to provide needed services to the residents of Isu needs to be reevaluated. The findings from this study point to the need for healthcare providers and administrators to redefine primary healthcare in Isu in the community context of availability and functionality, replacing the current discriminatory paradigm. Primary healthcare should be offered from the perspectives of the consumers and not from that of the provider or administrator alone.

I will share the final results of this study in presentations at appropriate academic conferences and in papers in appropriate journals. I also will share the results of this

study with stakeholders from the study site initially via e-mail and paper-copy correspondence to the government healthcare chair and via paper-copy correspondence to community leaders, pastors, and the leader of the traditional healers. I will ask the government healthcare chair to share the study results with other healthcare administrators as well as the nurses and midwives; I will ask community leaders and pastors to share the study results with nurses, midwives, and residents; and I will ask the leader of the traditional healers to share the study results with the traditional healers. I also will conduct in-person, informational follow-up meetings and presentations during subsequent visits to Nigeria and may do so in such locations as the (a) government headquarters in Umundugba, (b) the traditional healers' hall in Ekwe, and (c) the community center in Nnerim.

Conclusion

The present state of PHC in Isu is deplorable. The current lack of doctors, basic drugs, medical supplies, equipment and support staff is causing many Nigerians to live unhappily, suffer diseases, and die prematurely from preventable causes. There is an urgent need to align health programs and services with the healthcare needs of the community. Administrators need to become aware that infrastructure or buildings alone do not suffice for a primary healthcare system. PHC objectives in Isu cannot be achieved unless administrators and providers address obstacles identified in this study that prevent residents from accessing healthcare services, irrespective of their social, economic, geographic, and cultural conditions. Access to healthcare services should always be

explored in the context of the population or environment in which those services are provided.

Many authors have shown that a lack of access to PHC inhibits the seeking of appropriate care by the most vulnerable members of any community and ultimately is responsible for poor health outcomes (Cohen et al., 2007; Hossen, 2010; WHO, 2008b). For example, Kaseje (2006) estimates that 50% of the African population lacks access to modern health facilities and, consequently, experiences low levels of immunization and high levels of maternal, child, and infant mortality. The promise of PHC was always to minimize the burden of disease in this vulnerable population (Cohen et al., 2007), but a lack of access continues to prevent this promise from being realized. This study demonstrates the many reasons why this continues to be the case in Isu.

Recommendations for Action

One area that needs immediate attention is the restructuring of the leadership of the local health system and health department to ensure checks and balances. Policy and planning decisions need to be informed by a committee that includes representatives from the community, healthcare professionals, the local government primary health department, and religious/humanitarian organizations, to ensure that policies and programs are tailored to the needs of the community. Such an administrative structure would ensure that various inputs are used in the management of healthcare-service delivery, and that funds and resources are properly managed through better oversight, more accountability, and checks and balances.

The second area of action is to employ a permanent medical doctor at the primary healthcare center. Results of this study show that many residents do not use the health centers because there are no doctors on duty; a situation that has had adverse health consequences. The local healthcare system, in the interim, can employ a full-time physician who will be either centered at local government headquarters or visit community health centers on a schedule, but with specific days at the headquarters. Alternatively, the structure can include medical interns from the state university to provide services at the health centers.

Third, the local healthcare system should establish a cooperative arrangement between the PHC system and traditional healers. This will promote a better working relationship between them, and enable the local health system to assess and utilize the potentials of traditional healers in primary healthcare system. A closer relationship would promote understanding, offer opportunities for training traditional healers on basic hygiene, and recognize that traditional healers are well placed to offer certain specialized services in the community. According to WHO (2009), primary healthcare should include collaboration between physicians and traditional healers, so that together they can respond to the expressed health needs of the community. Traditional healers can promote access to care and complement the services of the local primary healthcare system..

The fourth recommendation is to create a program of public of public health education and home visits. By employing more CHEWs, the local health system can provide home visits, create service awareness, and conduct health education and health promotion in the community. This program should also be equipped with a mobile clinic

capability to take care of emergent cases that may arise during visits and at other needed times.

The fifth recommendation is to provide all healthcare centers with water, power, basic equipment and medical supplies. It is equally important that healthcare facilities be maintained and kept in clear manner and be comfortable.

The sixth recommendation is for the PHC system should broaden its view of primary healthcare with the input of healthcare workers and residents, and in accordance with international PHC standards.

Finally, the local healthcare system must find a way to subsidize care for the most vulnerable members of the community, so that serious cases can be treated without asking for money before saving lives. Considering the nature of community, the local health system can work with traditional leaders and village heads on how to collect money from patients after such life-endangering threats have been averted.

These recommendations can be accomplished if the local government can set aside a certain percent of its monthly allocation from the Federal Account for primary healthcare services. In addition, the local government can levy a certain amount on all taxable adults in the community to support its PHC program.

Recommendations for Further Research

Research should be conducted to more thoroughly examine the delivery of and access to primary healthcare in Isu with regard to the use of community-based research—in particular, the delivery and implementation of a community-feedback protocol to share

concerns and ideas with the local government as a means of providing direction for improvement of the primary healthcare system. Additional studies should be conducted to determine how healthcare administrators and providers can best foster positive resident attitudes toward the local primary healthcare system, which could lead to improved resident-confidence levels in the system and thus improved resident access to primary healthcare.

As a way to remedy the shortage of physicians in rural areas, I suggest that research should be conducted on how nurses, midwives, and health extension workers can receive additional advanced training to improve their skill and knowledge base. This advanced training would put them in a position to manage rural primary healthcare facilities during times of physician shortages.

Final Thought

Conducting research is often exciting to the beginner. This situation may cause the researcher to delve into an area quite unknown. The actual research process brings the reality of delving to the unknown to solve a problem. Situations often considered simple become intense, challenging tasks; such is a doctoral dissertation. My research was motivated by passion. I had difficulties in many ways, but the hope of bringing the problem of my community to a worldview encouraged me to continue in the face of difficulties. My advice to future students is to choose a simpler topic that can be researched in a short period of time.

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Appendix A: Recruitment Flyer—Original Version

You may be able to help improve access to healthcare in Isu.

How can you help?

- Share your opinion about healthcare practices and access to healthcare care in Isu.
- Describe what you know about healthcare in the Isu community.
- Explain what you expect from the local government primary healthcare services.

Who can participate?

- Nurses/midwives with 3 or more years of experience who work at the community health centers, healthcare posts, or maternity clinics.
- Traditional healers who live in Isu and have provided healthcare to the people for a minimum of 5 years.
- Residents of Isu 18 years and older who have lived in Isu for 5 or more years.

How do I find out more or sign up to participate?

- Contact the researcher, Raymond Chimezie, in Nnerim Ndugba.
- Attend an informational meeting:
    - nurses/midwives: local government headquarters (date, time or date, time).
    - traditional healers: traditional healers hall, (date, time or date, time).
    - residents: community center, (date, time or date, time).

Appendix B: Recruitment Flyer—Igbo Translation

I ga enwe ike inye aka ga-eme ka ndị mmadu na-anara ọgwụgwọ n'ụlọ ọgwụ ahuike nọ n'Isu.

Olee otu I ga-esi eme nke a?

- Kọwara ndi mmadu uche ma ọ bụ ebumnobi gị gbasara make otu na ụzọ esi enweta ọgwụgwọ n'ụlọ ahuike n'Isu.
- Kọwaa ihe niile i maara make ụlọ ahuike nọ n'obodo Isu.
- Kọọ kpọmkwem ihe i na-atụ anya inweta n'ụlọ ahuike nke gọmenti.

Kedu ndi ga-eso n'ihe nchọputa a?

- Ndi ọghọnwa ma ọ bụ ndị isi ọghọnwa ndị nwere amamihe banyere ụrụa ihe dike afọ ato ma ọ bụ karia, ndị na-arụ uloogwu ahụike nke ndi obodo, ụlọ ahuike ndị ọzọ, ma ọ bụ n'ụlọ ọgwụ ọmụmụ nwa.
- Ndị dibịa ọdịnala ma ọ ọbụ dịbia mkpamkpa akwụkwọ bi n'Isu ma na-agwọ ndi mmadu kamgbe ihe rurule afọ ise ugba a.
- Ndị bi n'Isu karịrịla ma gbakwara karịa afọ iri na asatọ, na ndị okenye birile n'Isu ihe dịka afọ ise ma ọ bụ karịa.

Olee otu mu ga-esi achọputa kwa ọfọdụ ihe ọzọ ma ọ bụ soro na-ọmụmụ ihe a?

- Kpọturụ onye nchọputa ihe ọmụmụ a bụ Mazi Raymond Chimezie, n'obodo
- Kpọturu kwa onye isi obodo ma ọ bụ onye isi nzu[redacted]
- Bia nzukọ ebe enwere ihe ọmụmụ dik[redacted]
  (a) Ndi ọghọnwa/Ndi isi ọghọnwa: Ebe isi ọchịchị ime obodu, Ụmụdụgba (Ubọchị……, Oge……)
  (b)Ndị djbja ọdjnala ma ọ bụ dịbịa mkpamkpa akwụkwọ: N'ụlọ ọgbakọ dị n'Ekwe (Ụbọchị……, Oge……..)

Appendix C: Recruitment Flyer—Back Translation

Your Help May Improve Access to Healthcare in Isu!

How You May Help!

- Share what you know about healthcare services and how convenient it serves your needs.
- Describe your opinions and all you know about healthcare in the Isu community.
- State exactly what you expect from the government primary healthcare services in Isu.

Who Can Participate?

- Nurses/midwives with 3 or more years of experience in healthcare delivery, and who work at the local government community primary healthcare centers.
- Traditional healers or herbalists, who live in and provide services to the people of Isu.
- Residents of Isu who are 18 years or more in age, and live in Isu for 5 years or more.

How Do I Find Out More or Sign Up to Participate?

- Contact the researcher, Raymond Chimezie, in Nnerim Ndugba.
- Come to an informational meeting:

Nurses and midwives: come to the local government headquarters, Umundugba (Date…., Time….).

Traditional healer/herbalist: come to the traditional healer hall, Ekwe (Date…, Time…).

Residents: come to the community center (Date…; Time….).

Appendix D: Interview Questions for Government Healthcare Administrators (including the local government chairman)

Name and Title of Administrator:

Date:

Thank you for agreeing to be interviewed about your perceptions regarding residents' access to local primary health care services in rural Isu.

RQ1(background information)

1. How would you describe the government primary healthcare in this community?
2. What kinds of people use government healthcare services the most?

RQ1a

3. What are the objectives of the government's local primary healthcare system, and how well are you achieving them?
4. What do you perceive to be the level of confidence that residents have in the government's local healthcare services?

RQ1b & 1c

5. What do you perceive to be the main challenges or barriers that affect residents' access to healthcare, and what solutions could you suggest?

6. What procedures are in place to accommodate residents' complaints or reports about poor service?

RQ1d

7. What do you see as the role of traditional healers in primary healthcare for residents?
8. What benefit do you see for meeting with local traditional healers to discuss how to improve local health services? Would you be willing to do so?

RQ3

9. In your opinion, what is the value of asking nurses, midwives, and community members for their views about healthcare services?

Conclusion: Is there anything else you would like to tell me about?

Thank you for your time. I will be showing you the results of our discussion at our next meeting.

Appendix E: Focus Group Questions for Nurses and Midwives

Names and Titles of Participants:

Date:

Thank you for agreeing to be interviewed about your perceptions regarding residents' access to local primary health care services in rural Isu.

RQ1(background information)

1. How would you describe the government primary care services you offer?
2. What kinds of people use your services the most?

RQ1a

3. What are the health objectives of the services you provide, and how well are you achieving them?
4. What do you perceive to be the level of confidence that residents have in your services?

RQ1b & 1c

5. What do you perceive to be the main challenges or barriers that affect residents' access to healthcare, and what solutions could you suggest?
6. What procedures are in place to accommodate residents' complaints or reports about your services?

RQ1d

7. What do you see as the role of traditional healers in primary healthcare for residents, and to what extent do you work with traditional healers?
8. What benefits do you see to meeting with local traditional healers to discuss how to improve local health services? Would you be willing to do so?

RQ3

9. In your opinion, what is the value of asking community members their views about healthcare services?

Conclusion: Is there anything else you would like to tell me about?

Thank you for your time. I will be showing you the results of our discussion at our next meeting.

Appendix F: Focus Group Questions for Traditional Healers—Original Version

Names and Titles of Participants:

Date:

Thank you for agreeing to be interviewed about your perceptions regarding residents' access to local primary health care services in rural Isu.

RQ1(background information)

1. How would you describe the services you provide to this community?
2. What kinds of people use your services the most?

RQ1d

3. What do you perceive to be the objectives of the government's local primary healthcare system, and how well do you think those objectives are being met?
4. What do you perceive to be the main challenges in providing the healthcare people need, and what solutions can you suggest?
5. What do you see as the role of traditional healers in primary healthcare for residents, and to what extent do you work with the government?
6. What is your relationship to the government's primary healthcare services?
7. What do you see as the benefits to meeting with local healthcare providers to discuss how to improve local health services? Would you be willing to do so?

8. What benefits to you see to providing services to residents if they were referred to you for special care by a government facility? Would you be willing to do so?
9. What do you do when you are not capable of handling a particular case?
10. What benefits do you see to referring cases beyond your expertise to the government health centers and other traditional healers? Would you be willing to do so?

RQ3

11. In your view, what is the value of asking community members their views about healthcare services?

Conclusion: Is there anything else you would like to tell me about?

Thank you for your time. I will be showing you the results of our discussion in our next meeting.

Appendix G: Focus Group Questions for Traditional Healers—Igbo Translation

Igbo Version: Mkparịta Okwu ndị Dibịa Mkpamkpa Ahịhịa
(Focus Group for Traditional Healers)

(Ntoola Okwu)

RQ1(background information)

1. Kedụ udị ahụike I na-enye ndị obodo a?
2. Olee kwanụ udị ndị mmadụ I na-enye ọgwụgwọ ahụike?

RQ1d

3. Kedụ ịhe ndị I chere bụ ebumnọbi gọmenti ime obodo gbasara ahụike ọhanaeze. I chere na-ebum n'ọbi a na-emezu?
4. Gịnị ka I chere bụ mmekpahụ ma ọ bụ akamgba chere inweta ahụike n'ebe a? Gịnị ka aga eji gboo nsogbu ndịa?
5. Gịnị ka ị chere ga-abụ ọrụ ndị dibịa mkpamkpa ahịhịa na dibịa ọdinala na-ebe ahụike ndị obodo dị?
6. Kedụ udị mmekọrịta di na-etiti ha na gọmenti?
7. Olee uru ọ ga-aba ma ndị dibịa mkpamkpa ahịhịa na dibịa ọdịnala na-enwe mmekọ gbasara ụzọ a ga-esi nweta ahụike bụ kpọmkwem? Ọ ga-amasị gị isoro?
8. Kedụ uru ọ ga-aba ma ọ bụrụ na ulọ ahụike gọmenti zitere gị ndị ọna ka i gwọọ? I ga-achọ mmekọ dị otua?
9. Gịnị ka Ị ga-eme mgbe n'ịnweghị ike ịgwọ nrịanrịa onye orịa nwere?
10. O nwere uru ọbara ma ịkpọgara ụlọ ọgwụ gọmenti ma ọ bụ ndu dibịa ọzọ nrịanrịa karịrị ihe I maara agwọ? Ọ ga-amasị gị ime otua?

RQ3

11.N'ime uche gị, olee kwanụ uru dị na mkparịta okwu ma ọ bụ ijụ ndị ọha obodo echiche ha gbasara udị ahụike a na-enye ha?

Appendix H: Focus Group Questions for Traditional Healers—Back Translation

RQ 1 (background information)

1. Could you describe the type of healthcare services you render to this community?
2. Who are the people who use your services most?

RQ 1d

3. What reasons do you think that government has in mind for setting up local healthcare services? How can you explain whether these reasons are being accomplished or not?
4. What do you perceive to be the main challenges in providing the healthcare people need, and what solutions can you suggest?
5. How would you describe the role of traditional healers in providing primary healthcare services to Isu residents? To what extent have you collaborated with the local government in your role as healthcare providers?
6. Describe your relationship with the government primary healthcare services?
7. What would be the benefits for meeting with local government healthcare providers to discuss means of improving community healthcare services? Would you be prepared to do so?
8. What would be the benefits if government healthcare providers referred some special cases to your traditional care? Would you be willing to accept such a relationship?

9. What do you do when you are incapable of handling or treating a particular sickness from a client?
10. What would be the advantage of referring cases beyond your competence to the government primary healthcare center and to other traditional healers? Would you be willing to do so?

RQ 3

11. What is your opinion about asking community members their views regarding the nature of healthcare services provided to them in Isu Local Government Area?

Conclusion: Do you have any other thing you would like to share or comment about healthcare in Isu Local Government Area?

Thank you for your time and contribution. The result of our discussion will be shared with you all during our next meeting.

Appendix I: Focus Group Questions for Residents—Original Version

Names and Titles of Participants:

Date:

Thank you for agreeing to answer a few questions about your perceptions regarding residents' access to local primary health care services in rural Isu.

RQ2(background information)

1. How do you or your family get healthcare when you are sick?

RQ2a

2. Which government healthcare facilities do you or your family use, and under what circumstances?
3. In what circumstances do you or your family use a traditional healer for healthcare services?
4. In what ways do the government healthcare services meets your needs?
5. Please describe an experience when you were unable to get the care you needed from the government healthcare system.

RQ2b & 2c

6. What do you perceive to be the main problems in people getting the healthcare they need, and what solutions can you suggest?

RQ2d

7. What is your level of confidence in the government healthcare system?
8. What is your level of confidence in traditional healers?

RQ3

9. What in your view is the value of asking community members their views about healthcare services?

Conclusion: Is there anything else you would like to tell me about?

Thank you for your time. I will be showing you the results of our discussion in our next meeting.

Appendix J: Focus Group Questions for Residents—Igbo Translation

Focus Group Interview for Residents (IGBO VERSION)

RQ2 (Ntoala Okwu):

1. Kọwaa etu gị na ezinaụlọ gi si enweta ahụike ma ahụ sogbuwe ụnụ?

RQ2a

2. Olee ụlọ ahụike gọmenti gị na ezinaụlọ gị na-aga enweta ahụike? Kedụ udị nsogbu ahụ na-eme ka ụnụ na-aga ebe ahụ?
3. Kedụ ọnọdụ ga-eme ka gị ma ọ bụ ezinaụlọ gị gaa choọ ahụike n'aka ndị dibịa mkpamkpa ahịhịa?
4. Kedụ ụzọ ụlọ ahụike nke gọmenti si egbo mkpa ahụike gị ma ọ bụ nke ezinaụlọ gị?
5. I nwere ike ịkọwa mgbe n'ịnweghị ike inweta ahụike n'ụlọ ahụike nke gọmenti dị n'ịme obodo?

RQ2b & 2c

6. Kedụ ihe ịchere bụ mmekpa ahụ ma ọ ihe mgbochi nọ n'nweta ahụike? Kedụ etụ a ga-esi gbuoo mkpa dị otua?

RQ2d

7. Kedụ etụ ntụkwasị obi gị ha na-ebe ụlọ ahụike gọmenti nọ?
8. Kedụkwanụ, ntụkwasị obi na-ebe ndị dibịa mkpamkpa ahịhịa ma ọ bụ dibịa ọdịnala dị?

RQ3

9. N'ime uche gị, o nwere uru dị na I mara uche ndị obodo gbasara ahụike ha n'enweta n'aka ahụike gọmenti?

Mmechi Okwu: Enwere ihe ọzọ i chọrọ ka m mara?

Ndeewo! A ga m akpaturụ gị gbasara isi okwu pụtara n'mkparịta okwu anyị na-oge ọzọ?

Appendix K: Focus Group Questions for Residents—Back Translation

RQ 2 (Background Information)

1. Explain how you and/or your family receive healthcare when you are sick?

RQ 2a

2. Which government healthcare center do you or your family use, and under what conditions?
3. Under what conditions would you or your family seek healthcare from a traditional healer?
4. In what ways do the government healthcare services satisfy your health needs?
5. Could you describe a time or circumstance in which the government healthcare delivery system failed to meet your need or that of your family member?

RQ 2b & 2c

6. What do you understand to be the major hindrances people encounter in getting the needed healthcare they want from the local government healthcare service? What suggestions do you have to remove these hindrances?

RQ 2d

7. How can you describe your trust or confidence in the healthcare services provided by the government in Isu?
8. To what extent do you trust the services of traditional healers?

RQ 3

9. What is your opinion about asking community members their views regarding the nature of healthcare services provided to them in Isu Local Government Area?

Conclusion: Do you have any other thing you would like to share or comment about healthcare in Isu Local Government Area?

Thank you for your time and contribution. The result of our discussion will be shared with you all during our next meeting.

Appendix L: Letter of Introduction—Chairman

Chairman

Isu Local Government Area

Umundugba, Imo State, Nigeria

May 2012

Dear Chairman,

My name is Raymond O. Chimezie and I am a doctoral candidate at Walden University. For my doctoral research, I am interested in conducting a study on the perceptions of Isu community residents and healthcare providers regarding residents' access to current primary healthcare services provided by the government. Research studies have demonstrated that certain populations do not access available healthcare for a variety of reasons and often with negative outcomes. What is not known, however, is (a) how Isu residents' access to healthcare is perceived by both those residents and healthcare providers, (b) whether such perceptions could be affecting their use of government healthcare services, and if so, (c) what healthcare model might better express the primary healthcare needs of the population. To answer these questions, I would like to interview you and three other healthcare administrators in your office. I also would like to interview nurses and midwives, traditional healers, and residents and will contact local

community leaders and pastors to seek support in this area. I have received the appropriate permissions to collect data, and I will keep all data confidential.

I have intended this letter to serve as a means of both introducing myself and requesting support for my data collection efforts. This research is important because it will provide insight into what residents perceive about available primary healthcare services as well as barriers or challenges to providing effective healthcare for these residents. Your assistance in conducting this research is critical. Should you have any questions, I can be reached by phone at 1-510-703-7798 or by e-mail at Raymond.chimezie@yahoo.com.

Sincerely,

Raymond Chimezie

Doctoral Candidate

Walden University

Appendix M: Letter of Introduction—Community Leader/Pastor

Community Leader/Pastor

Nnerim Autonomous Community

Isu Local Government Area

Umundugba, Imo State, Nigeria

May 2012

Dear HRH Eze Stanley Egbe,

My name is Raymond O. Chimezie and I am a doctoral candidate at Walden University. For my doctoral research, I am interested in conducting a study on the perceptions of Isu community residents and healthcare providers regarding residents' access to current primary healthcare services provided by the government. Research studies have demonstrated that certain populations do not access available healthcare for a variety of reasons and often with negative outcomes. What is not known, however, is (a) how Isu residents' access to healthcare is perceived by both those residents and healthcare providers, (b) whether such perceptions could be affecting their use of government healthcare services, and if so, (c) what healthcare model might better express the primary healthcare needs of the population.

To answer these questions, I would like to interview nurses and midwives and residents in your community. I also would like to interview government healthcare administrators and traditional healers, and I will contact the appropriate offices to seek support in this area. I have received the appropriate permissions to collect data, and I will keep all data confidential.

I have intended this letter to serve as a means of both introducing myself and requesting support for my data collection efforts. I hope that you will post my recruitment flyer in public community areas as well as distribute the flyer to residents as it is feasible. This research is important because it will provide insight into what residents perceive about available primary healthcare services as well as barriers or challenges to providing effective healthcare for these residents. Your assistance in conducting this research is critical, and I anxiously await your feedback. Should you have any preliminary questions, I can be reached by phone at 1-510-703-7798 or by e-mail at Raymond.chimezie@yahoo.com.

Sincerely,

Raymond O. Chimezie
Doctoral Candidate
Walden University

Appendix N: Letter of Introduction—Leader of Traditional Healers

Leader of Traditional Healers

Nnerim Autonomous Community

Isu Local Government Area

Umundugba, Imo State, Nigeria

May 2012

Dear Sir,

My name is Raymond O. Chimezie and I am a doctoral candidate at Walden University. For my doctoral research, I am interested in conducting a study on the perceptions of Isu community residents and healthcare providers regarding residents' access to current primary healthcare services provided by the government. Research studies have demonstrated that certain populations do not access available healthcare for a variety of reasons and often with negative outcomes. What is not known, however, is (a) how Isu residents' access to healthcare is perceived by both those residents and healthcare providers, (b) whether such perceptions could be affecting their use of government healthcare services, and if so, (c) what healthcare model might better express the primary healthcare needs of the population.

To answer these questions, I would like to interview traditional healers in your community. I also would like to interview government healthcare administrators, nurses and midwives, and residents, and I will contact the appropriate offices to seek support in this area. I have received the appropriate permissions to collect data, and I will keep all data confidential.

I have intended this letter to serve as a means of both introducing myself and requesting support for my data collection efforts. I hope that you will distribute my recruitment flyer to traditional healers in your area. This research is important because it will provide insight into what residents perceive about available primary healthcare services as well as barriers or challenges to providing effective healthcare for residents of Isu. Your assistance in conducting this research is critical, and I anxiously await your feedback. Should you have any preliminary questions, I can be reached by phone at 1-510-703-7798 or by e-mail at Raymond.chimezie@yahoo.com.

Sincerely,

Raymond O. Chimezie

Doctoral Candidate

Walden University

Appendix O: Letters of Support From Community Leaders

HIS ROYAL HIGHNESS

EZE STANLEY IKECHUKWU EGBE

(OBI OHA I OF NNERIM NDUGBA)

Isu L.G.A., Imo State, Nigeria
E-mail: stanegbe@yahoo.com / Phone: 08083077459 / 08069777511

Our Ref :..... *Your Ref :.....* *Date :.....*

Dear Mr. Chimezie.

I am in receipt of your letter of introduction and request to conduct a research in my community.

You request is accepted and I will inform my Community about your study. Let me know if you need any special assistance from me or member of my Community to conduct your study.

Please inform me at least a week in advance before your arrival to begin this study using the information on this letter head.

We are looking forward to your study in our Community.

Thanks for your regard.

Yours sincerely,

H.R.H. EZE STANLEY IKECHUKWU EGBE
OBI OHA 1 of NNERIM NDUGBA

THE PALACE OF HRH EZE CHARLES NNAJI
EZE UDO II

Traditional Ruler of Amurie-Omanze Autonomous Community
Isu LGA, Imo State Nigeria

April 1, 2012

Dear Mr. Chimezie,

Thank you for your letter of introduction and request for assistance to conduct a research in our community. Our community will be delighted with your study. I assure you of my support and that of my community. We are looking forward to receiving you and your team in our community for this study.

Sincerely your,

HRH Eze Charles Nnaji
Eze Udo II
Amurie-Omanze Autonomous Community
Isu Local Government Area

Appendix P: Data Collection and Analysis Procedures

Prior to visit: Community leaders will post recruitment flyers and pastors will distribute flyers to parishioners.

Day 1: Visit personally with the local government chairman, local community leaders, pastors, and the leader of the traditional healers and confirm arrangements to hold two informational meetings in the community center. Confirm interview with the chairman for the following day. Conduct first informational meetings (one in English for the nurses/midwives and one in Igbo for the traditional healers and residents with translation as needed for individual participants in either group).

Day 2: Conduct interview with the chairman and confirm arrangements to interview the two other healthcare administrators the following day. Schedule debriefing and member checking session for Day 28. Begin transcribing chairman's interview. Post additional flyers in the community. Network with nurses/midwives, traditional healers, and residents (potential participants) to personally promote my study and encourage resident participation (build trust and recruit participants).

Day 3: Conduct interviews with remaining two healthcare administrators. Schedule debriefing and member checking sessions for Day 28. Begin transcribing healthcare administrators' interviews. Continue networking nurses/midwives, traditional healers, and residents (potential participants).

Day 4: Continue transcription of interviews and begin preliminary data analysis. Continue networking with nurses/midwives, traditional healers, and residents (potential participants).

Day 5: Complete transcription of interviews and begin preliminary data analysis. Continue networking with nurses/midwives, traditional healers, and residents (potential participants).

Day 6: Continue data analysis of interview transcripts. Continue networking with nurses/midwives, traditional healers, and residents (potential participants). Schedule focus groups for Days 8-11: 6 (nurses and midwives), 6 (traditional healers), 6 (male residents), and 6 (female residents), respectively. Conduct second informational meetings (one in English for the nurses/midwives and one in Igbo for the traditional healers and residents with translation as needed for individual participants in either group).

Day 7: Continue data analysis of interview transcripts. Continue networking with nurses/midwives, traditional healers, and residents (potential participants).

Days 8–11: Conduct focus groups and begin transcription of focus group responses. Schedule debriefing and member checking sessions for Days 29 (nurse and midwives, and traditional healers) and Day 30 (male and female residents).

Days 12–15: Complete transcription of focus group responses.

Days 16–22: Complete data analysis of focus group transcripts (and interviews if needed).

Day 23: Provide a sample of data to second coder for analysis.

Days 25–26: Compare my analysis with that of the second coder to determine inter-coder reliability and make adjustments as appropriate.

Day 28: Conduct debriefing and member checking sessions with the chairman and three healthcare administrators. Begin making adjustments to interpreted data based on participant feedback.

Day 29: Conduct debriefing and member checking sessions with the nurses and midwives, and traditional healers. Begin making adjustments to interpreted data based on participant feedback.

Day 30: Conduct debriefing and member checking sessions with the male and female residents. Begin making adjustments to interpreted data based on participant feedback.

Day 30–31: Complete adjustments to interpreted data based on participant feedback.

Appendix Q: National Institutes of Health Certificate

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Raymond Chimezie** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 01/30/2010

Certification Number: 379845

Appendix R: Second-Coder Confidentiality Agreement

Confidentiality Agreement for Second Coder

Name of Signer: Desmond Oparaku

During the course of my activity in collecting and coding data for the research *Perceptions of Rural Residents and Healthcare Providers in Isu Local Government Area of Imo State, Nigeria Regarding Access to Primary Healthcare Services for Rural Residents: A Case Study*, I will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of confidential information can be damaging to the participant.

By signing this Confidentiality Agreement I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
5. I agree that my obligations under this agreement will continue after termination of the job that I will perform.
6. I understand that violation of this agreement will have legal implications.
7. I will only access or use systems or devices I'm officially authorized to access and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

By signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Hand written signature: _____ Date: _____

OR

Electronic signature (email address): desoparaku@yahoo.com__ Date: May 7, 2012_

Appendix S: Consent form for Individual Interviews

Perceptions of Rural Residents and Healthcare Providers in Isu Local Government Area of Imo State, Nigeria, Regarding Access to Primary Healthcare Services for Rural Residents: A Case Study

You are invited to participate in a research study of perceptions of access to primary healthcare for rural residents of Isu. You were selected as a possible participant because of your knowledge and/or experience related to the topic. Please read this form and ask any questions you may have before acting on this invitation to be in the study. This study is being conducted by Raymond Chimezie, a doctoral candidate at Walden University, Minnesota, Minneapolis, United States of America.

Background Information

The purpose of this study is to explore the perceptions of rural community residents and healthcare providers (government healthcare administrators, nurses and midwives, and traditional healers) regarding residents' access to primary healthcare services in Isu and to examine the benefit of using community-based research to promote resident use of those healthcare services. Specifically, I will seek to gather information regarding (a) the perceived accessibility, affordability, accommodation, acceptability, and availability of government healthcare services, (b) characteristics of the healthcare system that both

hinder and promote residents' use of healthcare services, and (c) the potential for community-based research to promote residents' use of available healthcare services.

Procedures

If you are a healthcare administrator (chairman of the local government or hold a senior administrative position in the local government healthcare), you will be asked to participate in a face-to-face individual interview arranged in your office at the local government headquarters. In addition, all participants will be asked to participate in a follow-up session to be held approximately 1 week after participating in the interviews or focus groups. During this follow-up session, I will share my preliminary findings and ask for your feedback regarding my interpretation of the collected data. Each meeting will last approximately 1 ½ hours.

Voluntary Nature of the Study

Your participation in this study is strictly voluntary and will not affect you adversely in any way. Your identity will not be shared with any local government authority or residents in Isu. You are free to withdraw from the study at any time without penalty of any kind and your withdrawal will not affect your relationship with the investigator, the local government, or Walden University.

Risks and Benefits of Being in the Study

No anticipated risks are associated with participation in this study. However, in the event you experience stress or anxiety during your participation in the study, you may terminate your participation at any time. You may refuse to answer any questions you consider invasive or stressful.

The potential benefit of participating in this study may come in the form of improved primary healthcare delivery by the local government that will meet the expressed needs of the residents of Isu and the inclusion of community residents in future primary healthcare planning and implementation.

Compensation

There is no form of compensation for participation.

Confidentiality

The records of this study will be kept private. In any report of this study that might be published, the researcher will not include any information that will make it possible to identify any participant. Research records will be kept in a locked file; only the researcher will have access to the records. Interviews will be digitally recorded for purposes of providing accurate description of your experience. However, the recorded data will be destroyed at the completion of the study, which will be within 1 year. Hardcopy data will be destroyed after 5 years.

Contacts and Questions

You may ask any questions you have now. If you have questions later, you may contact the primary researcher Raymond Chimezie by phone at (510) 703-7798 or by e-mail at Raymond.chimezie@yahoo.com. You may also contact my advisor Dr. Michael Schwab by phone at 1-800-925-3368 or by e-mail at michael.schwab@waldenu.edu. The Research Participant Advocate at Walden University is Dr. Leilani Endicott. You also may contact her by phone at (800) 925-3368 (ext. 2393) or by e-mail at Leilani.Endicott@waldenu.edu.

Statement of Consent:

I have read the above information. I have asked questions and received answers. I will receive a copy of this form from the researcher. I consent to participate in the study.

_____

Printed Name of Participant

_____ _____

Signature of Participant Date

_____ _____

Signature of Investigator, Raymond Chimezie Date

Appendix T: Consent Form Focus Group—Original Version

Perceptions of Rural Residents and Healthcare Providers in Isu Local Government Area of Imo State, Nigeria, Regarding Access to Primary Healthcare Services for Rural Residents: A Case Study

You are invited to participate in a research study of perceptions of access to primary healthcare for rural residents of Isu. You were selected as a possible participant because of your knowledge and/or experience related to the topic. Please read this form and ask any questions you may have before acting on this invitation to be in the study. This study is being conducted by Raymond Chimezie, a doctoral candidate at Walden University, Minnesota, Minneapolis, United States of America.

Background Information

The purpose of this study is to explore the perceptions of rural community residents and healthcare providers (government healthcare administrators, nurses and midwives, and traditional healers) regarding residents' access to primary healthcare services in Isu and to examine the benefit of using community-based research to promote resident use of those healthcare services. Specifically, I will seek to gather information regarding (a) the perceived accessibility, affordability, accommodation, acceptability, and availability of government healthcare services, (b) characteristics of the healthcare system that both

hinder and promote residents' use of healthcare services, and (c) the potential for community-based research to promote residents' use of available healthcare services.

Procedures

If you are a **nurse or midwife, a traditional healer, or a resident**, you will be asked to participate in a focus group discussion arranged in the local community center. In addition, all participants will be asked to participate in a follow-up session to be held approximately 1 week after participating in the interviews or focus groups. During this follow-up session, I will share my preliminary findings and ask for your feedback regarding my interpretation of the collected data. Each meeting will last approximately 1 ½ hours.

Voluntary Nature of the Study

Your participation in this study is strictly voluntary and will not affect you adversely in any way. Your identity will not be shared with any local government authority or residents in Isu. You are free to withdraw from the study at any time without penalty of any kind and your withdrawal will not affect your relationship with the investigator, the local government, or Walden University.

Risks and Benefits of Being in the Study

No anticipated risks are associated with participation in this study. However, in the event you experience stress or anxiety during your participation in the study, you may terminate

your participation at any time. You may refuse to answer any questions you consider invasive or stressful.

The potential benefit of participating in this study may come in the form of improved primary healthcare delivery by the local government that will meet the expressed needs of the residents of Isu and the inclusion of community residents in future primary healthcare planning and implementation.

Compensation

There is no form of compensation for participation.

Confidentiality

The records of this study will be kept private. In any report of this study that might be published, the researcher will not include any information that will make it possible to identify any participant. Research records will be kept in a locked file; only the researcher will have access to the records. Interviews will be digitally recorded for purposes of providing accurate description of your experience. However, the recorded data will be destroyed at the completion of the study, which will be within 1 year. Hardcopy data will be destroyed after 5 years.

Contacts and Questions

You may ask any questions you have now. If you have questions later, you may contact the primary researcher Raymond Chimezie by phone at (510) 703-7798 or by e-mail at Raymond.chimezie@yahoo.com. You may also contact my advisor Dr. Michael Schwab by phone at 1-800-925-3368 or by e-mail at michael.schwab@waldenu.edu. The Research Participant Advocate at Walden University is Dr. Leilani Endicott. You also may contact her by phone at (800) 925-3368 (ext. 2393) or by e-mail at Leilani.Endicott@waldenu.edu.

Statement of Consent:

I have read the above information. I have asked questions and received answers. I will receive a copy of this form from the researcher. I consent to participate in the study.

_____

Printed Name of Participant

_____ _____

Signature of Participant Date

_____ _____

Signature of Investigator, Raymond Chimezie Date

Appendix U: Consent Form Focus Group—Igbo

Nkwenye Akwụkwọ Azịza

Isi Okwu: *Nhụta ndị bi n'ime obodo na ndị na-enye ọgwụ ahụike n'ọchịchị ime obodo Isu nke steeti Imo, ndị Naijiria ịnara ọgwụgwọ n'ụlọ ọgwụ ahụike maka ndị bi n'ime obodo: Ebe ihe ọmụmụ hiwere isi.*

A na-akpọ gị oku ka i isoro na ndị ga-eme nchọputa ihe ọmụmụ maka ndị mmadụ na-anara ọgwụgwọ ha n'ụlọ ọgwọ ahụike e hiwerele ndị ime obodo Isu. A họrọla gị dịka out onye ga-eso na nchọputa a n'ihi mmụtagị na,ma ọ bụ ihe ị mara maka isiokwu a. Biko, guọ akwụkwọ azịza a ma juọkwa ajụjụ ọ bụla i nwere tupu i zaa oku a, akpọrọ gị maka ihe ọmụmụa a.

Onye ọmụmụ nchọputaa bụ Raymond Chimezie, bụ onye nke na-agụ nzere dọkịnta na mahadum nke Walden no n' United States ma ọ bụ America.

Ntụala Ozi Nchọputa

Ebumunuche ihe ọmụmụa bụ ka achọputa Nhụta nid bi n'ime obodo na ndị na-enye ọgwụ ahụike (ndị na-achịkọta ụlọ ọgwụ ahụike, ndị na-elekọta ndị ọrịa, na ndị ọghọ nwa, na nid dibịa mgbọrọgwụ na mkpa akwụkwọ) banyere nid ime obodo ịdị na-anara ọgwụ n'aka ndị ọgwụ ahụike n'Isu. Ihe ọmụmụa ga-agbado ụkwụ n'ajụjụ na uche ndị ime obodo ka achọputa nghọta na ebumunuche ndị mmadụ ka e nwee ike mee ka ime obodo na-aga n'ụlọ ahụike a na-anara ọgwụha. Ị gwa gị eziokwu, a gam achọ i nweta ihe mgba ama banyere (a) out ndị ihe ọmụmụ a doro anya ga-esi enweta

Translation

bụla na-adịghị nha ọ bụla, nkwụsị gị agaghị emetụta ihe ọ bụla jikọrọ gị na onye nchọputa ihe a, ọchịchị ime obodo, ma ọ bụl mahadum nke Walden.

Ọghọ m na Uru a na-enweta site n'ihe Ọmụmụ a

Onweghị ọghọm ọ bụla a na –enweta site n'ihe ọmụmụa. Anaghị ama ụma, I nweee ahụ nsogbu ma ọ bụ ndọkasị ahụ n'oge ihe ọmụmụ a, i nwere ike ịkwụsị mgbe ọ bụla. I nwekwara ohere ịkwụsị ajụjụ ọ bụla na-ewetara gị nsogbu ma ọ bụ ndọkasị ahụ mgbe ọ bụla. Uru a ga-enweta site n'iso na ndị ihe ọmụmụ a nwere ike ịbịa n'ụdị inwe ụlọ ọgwụ ahụike bụ igba nke sitere n'aka ọchịchị ime obodo ma burukwa ọchịchọ ndị Isu na igbakwunye ndị bi n'ime obodo ịtụ atụmatụ na mmeputa inwe ụlọ ọgwụ ahụike n'obịa n'ihu.

Ikwụ Ugwọ

Onweghị ugwọ ọ bụla a na-akwụ ndị so n'ọmụmụ ihe a.

Ihe Nzuzo

Akwụkwọ n'ile e jiri mee ihe ọmụmụ abụghị nke a ga-agba n'anwụ. Ihe ndeputa ọ bụla sitere n'ihe ọmụmụ a nke enwere ike ibiputa, onye nchọputa agaghị egosi ihe ọ bụla ga-egosi aha onye ọ bụla so n'ọmụmụ a, ederede onye nyocha a ga-abụ ihe aga ezo ezo; ọ bụ soso onye nchọputa a ga-emetụ edemede ndịa aka. Ajụjụ onụ n'ile ka ga-eji kọmpịta okwu ede iji wee nweta kpọmkwem nkọwa nile achọrọ. Ka o sina dị, mkpụrụ okwu nile etinyere na kọmpịta bụ ihe aga-emebi oge ihe ọmụmụ a gwụchara, nke ga-abụ otu afọ kpọm.

ọgwụ, I nwe ike ikwu ụgwọ ọgwụ, e nwekwara ohere ebe obibi ndị ọrịa, a na-anabata nid mmadụ nke ọma, ott ndị mmadụ si anabata ụlọ ọgwụ a ma e nwere ụlọ ọgwụ gọmenti ahụike nọ nso, (b) ihe ndị e jirimara ụlọ ọgwụ ahụikema nid na-egbochiri na ndị na-akwalite ndị mmadụ ịdị na-aga n'ụlọ ọgwụ a, (c) na nchọputa ime obodo e mere, ọ ga-akwalite nid bi n'ime obodo idi na-anara ọgwụ n'ụlọ ahụike.

Usoro

I bụrụ onye isi nchịkọta n'ụlọ ọgwụ ahụike ma ị chọrọ ka i soro n'ihe ọmụmụ a, a ga-agwa gị ka i soro na-ajụjụ onụ a haziri n'ụlọ ọrụ ahụike unu.

I bụrụ onye na-elọkọta ndị ọrịa, ma ọ bụ onye ọghọnwa, onye dịbịa mgbọrọgwụna mkpa akwụkwọ ma o bu onye obodo, a ga-agwa gị ka i soro na mkpaịta ụka ịhụ n'ịhụ a haziri n'ụlọ ọgwụ n'ime obodo. Na mgbakwunye, nid niile so n'ọmụmụ ihe ka a ga-agwa ka ha sorokwa na mkpaịta ụka na-eso nke mbụ nke a ga-eme kwa izu ka ajụchara ajụjụ onụ ma ọ bụ mkpaịta ụka nke otu. N'oge mkpaịta ụka nke na-esota nke mbụ,aga m agwa ndị madụ maka ihe mbụ m chọputara ma gwakwa ha ka ha weghachi azụ uche ha banyere ihe nkọwaputa m. Nzukọ ọ bụla ga-ewe ihe dika out awa n'ụkara.

Ọmụmụ Ihe Nweputa Onwe

Osuso I so n'ọmụmụ ihe a bụ gị weputar onwe gị na onweghị uzọ ọ bụla ọ ga-esi enye gị nsogbu. Onweghi onye ọ bụla gị na ya na-azọ njirimara gị ọzọ n'isi ọchịchị ime obodọ ma ọ bụn ndị ọha obodo Isu. I nwere ohere ịkwụsị ihe ọmụmụa mgbe ọ

Ebe Mkpọturụ na Ajụjụ

I nwere ike ịjụ ajụjụ ọ bụla I nwere ugbu a. I nwere ajụjụ n'ikpeazụ, I ga-akpọturụ onye isi nchọputa aha ya bụ Raymond Chimezie site n'ekwenti nọ (510) 703-7798, ma ọ bụ site n'ozi nke Raymond.chimezie@yahoo.com. I nwerekwara ike ịkpọturụ onye ndụmọdụ mmụ Dọkịnta Michael Schwab site na-ekwentị nọ. 1-800-925-3368, ma ọ bụ site n'ozi (e-mail) Michael.schwab@waldenu.edu. Onye ọkaekpe onye nchọputa a nọ na mahadum nke Walden bụ dọkịnta Leilani Endicott. I nwere ike ịkpọturụ ya site n'ekwentị nọ na 1-800-925-3368 (mkpakala 2393), ma ọ bụ site n'ozi "email" Leilani.Endicott@waldenu.edu.

Nkwere:

A gụọla m ma ghọta kwa ihe edere na nkọwa ha dum. A jụọla m ajụjụ nweta kwa aziza. Ekwenyere m iso n'ihe ọmụmụa.

_____

Aha onye kwenyere

_____ _____

Mbịanye aka Date

_____ _____

Mbianye aka onye na-eme ihe nchọputa, Raymond Chimezie Date

Appendix V: Consent Form Focus Group—Back Translation

Opinion of Residents and Healthcare Providers Regarding Access to Primary Healthcare services in Isu Local Government Area, Imo State Nigeria: Isu Local Government Area as a case of study.

You are called to participate in a research study to find out the opinion of the people in Isu about their access to healthcare. You have been selected just as one of the participants of this program in view of your wealth of knowledge and of your expertise about this very topic. Please read carefully through this form and you may of course ask any question before you honor this invitation about this study. The person conducting this research is Raymond Chimezie, a doctorate degree student of Walden University, Minnesota, Minneapolis, United States of America.

Background Information:

The aim of this research is basically to discover the awareness of the residents and healthcare service providers (government health administrators, nurses and midwives, and traditional healers) with regard to residents in Isu who will benefit from using community-based research to enhance the awareness of residents in using healthcare services.

Precisely, this study will gather information about (a) the perceived accessibility, affordability, accommodation, acceptability, and availability of health center around the vicinity (b) things that hinder residents from patronizing the centers and things that motivate residents' interest in the healthcare centers and (c) what role community-based research can play to empower or motivate residents zeal to use their healthcare services.

Procedures:

Nurses or midwives, traditional healers or residents will be asked to take part in the vital group discussions organized in your local healthcare center. In addition, every participant will be asked to join the subsequent discussion to be held one week after the previous focus group meeting. During the follow-up discussion, I will relate to the people my initial findings and also ask them for their views with regard to my interpretation of the available data. We shall not spend more than 1 ½ hours on each meeting.

Voluntary nature of the study:

Your participation in this study is out of your freewill. Participants will not suffer any risks in this study. None of your personal information will be shared with anybody in the local government, Isu community, or any person in Isu. Any participant can stop participating in this study at any time without any repercussion, and your discontinuing will not affect your relationship with the researcher, the local government, or Walden University.

Risks and Benefits of Being in the study:

No risks will be encountered for those taking part in this study. In case you experience any stress or anxiety when the study is in progress, you are free to withdraw. You are also free to refuse answering any question that you find stressful or unnecessary.

The benefit we could get from participating in this study could be in the form of improved healthcare delivery by the local government that will serve the needs of the residents of Isu. It could make the local government to include the residents of Isu in the future planning and implementation of the healthcare delivery.

Compensation:

Participants in this study will not be paid or receive any kind of reward.

Confidentiality:

Researcher's records will be kept secret. The researcher will not include any information in the report that could be traced to any person who participated in this study. The reports of the researchers will be confidential; and only the researcher will be able to use or have access to them. All interviews will be digitally recorded for the purpose of correct documentation and understanding of your experiences. However, all the data in digital format will be destroyed at the end of the study within one year, while written or hardcopy records will be destroyed after 5 years.

Contacts and Questions:

You may ask your questions now. If you have any questions later, please contact the lead investigator, Raymond Chimezie at 510-703-7798 or by email at Raymond.chimezie@yahoo.com. You may also direct your questions to my supervisor Dr. Michael Schwab by phone at 1-800-925-3368 or by email at Michael.schwab@waldenu.edu. The Research Participants Advocate at Walden University is Dr. Leilani Endicott. She can be reached at 1-800-925-3368 (ext. 2393) or by email at Leilani.Endicott@waldenu.edu.

Statement of Consent:

I have read and understood the information above. I have also asked questions and received responses. I will receive a copy of this form from the researcher. I agree to participate in the study.

_____

Printed Name of Participant

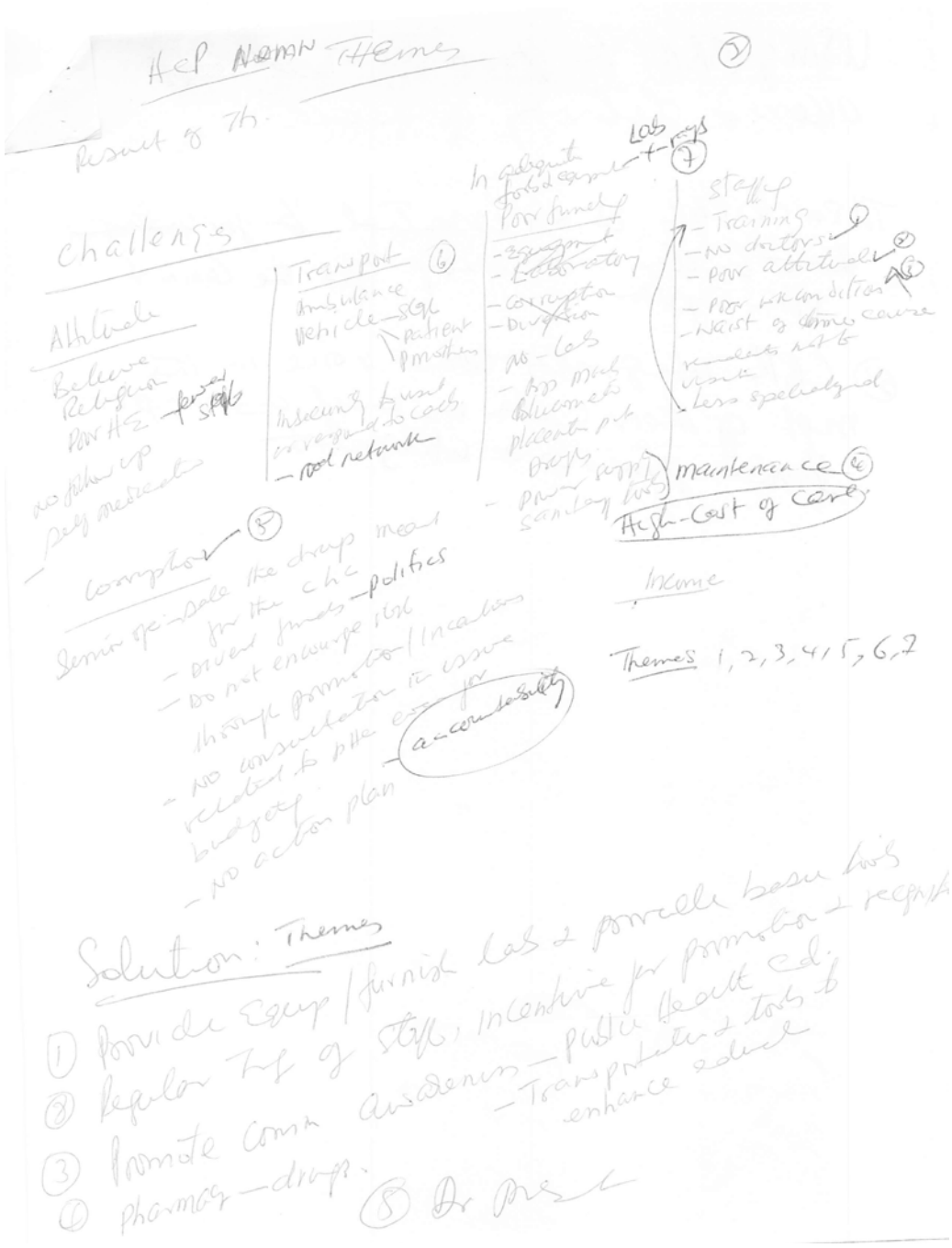
_____ _____

Signature of Participant Date

_____ _____

Signature of Investigator, Raymond Chimezie Date

Appendix W: Example Coding Notes



Nurses & midwives ①

RQIA - essential service to the pple
- Svc to rural comm.
- Proximity to the pple
- Svc to women + chdn.
- Immunisation + epidemics
- Centre around local needs comm
- Convenience of time - 24hrs
- Convenience of location - Proximity
- Routine services is accessibility + available
- Has reduced mortality + LOS effectiveness
- Nurses + MW are available to treat minor illness
- He is available
- First Aid care
- Deliveries
- Pregnancies - reduce death

Themes - to develop
① Proximity to health cares improve access
② Suitable/ Convenient time of Svc/operation
③ Nurses/ midwives provide care ④ Svc is available to villages/comm.

2nd Coder Draft Sheet

Data Coding for Health Providers (Nurses & Midwives)

1. What are the perceptions of healthcare providers (government healthcare administrators, nurses/midwives, and traditional healers) regarding residents' access to and use of primary healthcare services provided in rural Isu?

1a. What are healthcare providers' perceptions regarding the characteristics of the local government healthcare system that work well?

- Health education is provided by the community health workers on things like routine immunization and the health conditions which would require the person to come to the health center.
- Environmental health officers supervise the environment to ensure that dumping of refuse is reduced to improve environmental sanitation.
- Child Immunization Program for infants
- Reduction in child mortality rate partly due to increased availability of malaria drugs
- Reduction in childhood epidemic disease such as polio and Hepatitis B because of immunization of children.
- Health centers are closer to the people than before.
- They offer 24 hours service.

Themes:

1. ~~Closeness of healthcare~~ → Proximity of care
2. improved access → combine w/ #1
3. Expanded time of service/operation improved availability
4. Improved preventive care due to expanded immunization for children

effect of closeness/proximity

1b. What are healthcare providers' perceptions regarding the main challenges and barriers faced by the local government healthcare system?

- No doctors on duty
- Lack of laboratories
- No ambulance to help in emergency situations
- Poor transportation network
- Security issues
- High cost of care
- Lack of professional development
- Low pay and poor benefits

- Political barriers; political crisis. Because the health facility is not sited in the domain of a particular village those villagers will then refuse to make us of the health center.
- Inadequate drug supply, equipment, structures (buildings), power supply, security
- Inadequate financial resources. Government isn't sending workers to training to further their education

Themes:

1. Absence of doctors on duty services provided by midwives & nurses only
2. Inadequate equipment
3. High cost of care
4. Shortage of drugs and health supplies
5. No laboratory or x-ray equipment
6. Politics of leadership — instability & corruption
7. Lack of funding and proper management
8. Low employee moral (no training, poor benefits)

1c. What are healthcare providers' perceptions regarding solutions to the main challenges faced by the local government healthcare system?

- Funding of local government system appropriately
- Employ doctors to help midwives and nurses
- Provide free care to women and children

Themes:

1. Hiring a doctor to provide comprehensive care
2. Free treatment to reduce financial burden
3. Provide ambulance and transportation
4. Equip the centers
5. More staff

1d. What are healthcare providers' perceptions regarding the potential for closer relationships between the local government healthcare system and traditional healers?

- Don't see role for traditional healers because they use archaic methods and unsanitized tools which promote infections
- Traditional healers can get training by government to reach them important and basic concepts of care to reduce mortality rates of children and pregnant mothers; help treat diseases such as malaria and typhoid.
- Would like to work as the supervisors of the traditional healers to help them to modernize their methods

- Traditional healers can be useful in certain areas like bone setting, snake bite, poisons, convulsions

Themes:

1. Traditional healers need training in preventive care
2. Unscientific care — disregard / disrespect of traditional Health Care
3. Not much education — received traditional healing educ.
4. Attachment to traditional religion (disregard for traditional religion)

3. What are the perceptions of healthcare providers and residents regarding community-based research as a means of promoting the use of healthcare services among the rural residents of Isu?

- Good idea
- Improves awareness of healthcare services
- Closer relationship between providers and patients/community
- Integrates community voice in the management of the local healthcare system
- May increase service utilization and community support

Themes:

1. Means of involving community
2. Better understanding and support - better rapport
3. Improved utilization of services
4. Awareness of services

Curriculum Vitae

Raymond O. Chimezie

Richmond, CA 94801

Raymond.chimezie@yahoo.com

Education

Doctor of Philosophy: Public Health - Community Health Promotion and Education

(expected graduation date: 6/2012)

Walden University: Minneapolis, MN

Master of Arts in Education: Instructional Leadership (2006)

Argosy University: San Francisco, CA

Certification

- California Multiple Subject Teaching Credential with CLAD (2006)
- Emergency Management Services Certifications: IS 00100.a and IS 00700.a (Civil Air Patrol, USAF Auxiliaries, 3/2010)

Academic Employment

- Teacher, elementary and middle grades (2003–present)

West Contra Costa Unified School District, Richmond, CA

Other Professional Experience

- Health educator (volunteer) Disease management outreach for patients and community (2009–2011). Kaiser Permanente, Health Education Department, Pinole, California.
- Member Chronic Disease Management Ethnic Health Institute of the Alter Bates Summit Medical Center, Oakland, California (2011-present)
- Emergency and disaster management/control responder (volunteer), (2009-present) Contra Costa Medical Reserve Corps, Contra Costa County, California

Presentations

Diabetes: Causes and Management. Presented at Barrett Terrace & Plaza Apartments (residential facility), Richmond, CA. (10/27/11)

Membership

- United Teachers of Richmond, California. Health committee member. (2009–2011).
- Nigerian Institute of Management (1991-present)